NSQHS Standards
Guide for Small Hospitals

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AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS
STANDARDS

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Introduction

The *National Safety and Quality Health Service Standards* (the NSQHS Standards)[1] were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in consultation with jurisdictions, technical experts and a wide range of other organisations and individuals, including health professionals and patients.

The primary aim of the *NSQHS Standards* is to ensure that systems are in place to protect the public from harm and to improve the quality of care provided by health service organisations. The *NSQHS Standards* provide a:

- quality assurance mechanism that tests whether relevant systems are in place to ensure minimum standards of safety and quality are met
- quality improvement mechanism that allows health service organisations to realise developmental goals.

For the purpose of this Guide, a **small hospital is a health service with 50 beds or less**. However, the information in this Guide may have a broader application and may be of use for other services implementing the *NSQHS Standards*.

Small hospitals and flexible standardisation

Standardisation is a fundamental concept in safety and quality and there is strong evidence that when standard processes are implemented outcomes improve. However the standardisation of any process must be designed and integrated to fit the context of the specific health service. Health services vary widely, and have different functions, sizes, locations, structures and service delivery modes.

Small hospitals have specific features that mean that the approaches that they use and the systems that they put in place will need to be different from larger facilities. These features relate to characteristics such as the number of beds, the location of the hospital, the number and skills mix of the workforce, the services delivered, the nature of the local community and the referral networks with other hospitals.

In considering how a health service puts in place systems to meet the *NSQHS Standards*, and provides evidence as part of their accreditation process, small hospitals need to consider their local context and the risks that they face. Systems, tools, processes and protocols should be:

- based on best available evidence
- aligned with external policy and legislative requirements, such as those from a local health network, private hospital group, state or territory
- based on an awareness and understanding of the key risks facing the hospital
- adapted to the local context.

Note: Jurisdictions have adopted different descriptions of the governance structure providing health services. These include networks, districts, boards or area health services. Where the term 'local health network' is used, please assume the terminology is applicable to your particular jurisdiction.

The *NSQHS Standards Guide for Small Hospitals* (the Guide)

This Guide is designed to support the implementation of safety and quality improvements in line with the *NSQHS Standards*. It is based on information relevant to small hospitals that has been previously published in the *Hospital Accreditation Workbook*[2] and in the *Safety and Quality Improvement Guides*[3] (ACSQHC 2012). This Guide has been specially tailored for small hospitals, but should be used in conjunction with these other documents.

The *Hospital Accreditation Workbook* and *Safety and Quality Improvement Guides* for each of the 10 *NSQHS Standards* can be downloaded from: www.safetyandquality.gov.au/our-work/accreditation/nsqhss/safety-and-quality-improvement-guides-and-accreditation-workbooks/

The aim of this Guide is to provide:

- an overview of the intent of the items and actions in the *NSQHS Standards*
- suggestions for strategies that could be used to meet the requirements of the *NSQHS Standards*
- a list of key resources to support implementation of these strategies.

This Guide suggests quality improvement actions that are particularly relevant for small hospitals. These should not be interpreted as being mandatory or exhaustive. In other words, health service organisations can choose their own improvement actions for each criterion, that are specific to their own local context. As a result, the evidence that is the output of quality improvement activities will also vary.

Getting started

Firstly, it is important to understand how your hospital fits within the broader environment. Processes that are run externally do not need to be duplicated by each small hospital. Your role is to ensure that these processes are working effectively within your health service.

When the strategies and systems that you need to implement are in place at state, territory, or local health network level, or within your private hospital group, you should follow their direction and develop operational or business procedures to apply these strategies in the local context. This may pre-determine what systems are in place and the evidence that is produced about your quality improvement activities in this area.

In some cases, it will be necessary to develop locally-specific quality improvement programs and systems to help you to meet the requirements for a particular item in the *NSQHS Standards*. In such cases, it may be useful to align your systems with those of your local referral hospitals. For example, you may be able to adapt policies and procedures from other health services so that they are suitable for use in your health service.

The Commission has developed a number of resources to support the implementation of systems to help your hospital meet the requirements of each Standard. Links to these resources are available from: www.safetyandquality.gov.au/our-work/accreditation/resources-to-implement-the-national-safety-and-quality-health-service-standards/

Quality improvement approach

All of the *NSQHS Standards* operate within a quality improvement framework. Examples of common approaches include Clinical Practice Improvement or Continuous Quality Improvement. This *NSQHS Standards Guide for Small Hospitals* is designed for use in the context of an overall organisational approach to quality improvement, but is not aligned to any particular approach.

The quality improvement approach used within the *NSQHS Standards* means that many of the items in the Standards are structured according to a quality improvement cycle. This approach is illustrated in the following table.

Quality improvement step	Example
Developing policies, procedures and/or protocols **This could occur centrally at a local health network level, private hospital group, state or territory, or at a local level**	**9.1.2** Policies, procedures and/or protocols for the organisation are implemented in areas such as escalation of care
Implementing the policies, procedures and/or protocols locally	**9.4.1** Mechanisms are in place to escalate care and call for emergency assistance
Monitoring of compliance with, and performance of the policies, procedures and/or protocols **This could occur centrally and/or locally**	**9.4.2** Use of escalation processes, including failure to act on triggers for seeking emergency assistance, are regularly audited

Risk management

The risks across health services vary and factors that influence the risk profile of an organisation include the type of services, the location, size, and complexity of care provided. For small services, not all of the Standards will present the same level of risk. For example services delivering blood or blood products infrequently, while needing to have in place policies and processes to ensure safe management when blood is delivered, have an overall low risk profile. The investment in managing this risk will generally be less, but focussed effort is required on the occasion blood is administered.

Each health service organisation will need to identify a risk matrix to be used in their organisation.

Who has to address the risk management issues?

- **The health system** – the risk may be outside the control of an individual organisation.
- **The organisation** – the risk may be corporate or clinical in nature.
- **The team that is delivering the care** – the risk may come from the pattern of work or team dynamics.
- **An individual** – the risk may be skills, knowledge or situation based.

What are the principles of risk management?

Avoid risk	If a risk cannot be eliminated then it must be managed.
Identify risk	Assess the risks and identify who and what is involved.
Analyse risk	By examining how a risk can occur, consider what the likelihood and consequences are of this risk occurring.
Evaluate risk	Determine how the risk can be reduced or eliminated.
Treat risk	Manage the risk by determining: who is responsible for taking actions; when and how this will be monitored.

What are the steps to identifying risks?

- Who is at risk?
- What is involved?
- Why can it happen?
- How likely is it?
- What are the consequences?
- What can be done?
- Is the solution applied to the situation?

The risk analysis requires you to assess whether the risk is likely to be common or rare, and severe or mild. The sources of data that may help you understand how likely it is for the risk to occur in the clinical environment include:

- monitoring and audit results
- surveillance data
- complaints
- observations.

What is successful risk management?

Health services will need to develop an action plan to prioritise strategies and resources to address the risks. These strategies will be influenced by a baseline review or gap analysis of the current governance arrangements, systems, processes, practices and their effectiveness. Collaborating across the organisation can improve risk management success.

How can collaboration help reduce risk?

Collaboration:

- Identifies risks that are not always obvious to those providing or managing the service.
- Recognises how risks have an impact upon other areas (e.g. Workplace Health and Safety, education and consumers).
- Provides an opportunity to develop and utilise a standardised tool for identification and analysis of risk.
- Allows for organisation-wide implementation, monitoring and evaluation of the effectiveness of risk management strategies.

Terms and definitions

Accreditation: A status that is conferred on an organisation or an individual when they have been assessed as having met particular standards. The two conditions for accreditation are an explicit definition of quality (in this case, the *NSQHS Standards*) and an independent review process aimed at identifying the level of congruence between practices and quality standards.[4]

Acute health care facility: A hospital or other healthcare facility providing healthcare services to patients for short periods of acute illness, injury or recovery.[5]

ACSQHC: Australian Commission on Safety and Quality in Health Care (the Commission).

Advance care directive: Instructions that consent to, or refuse the future use of specified medical treatments (also known as a healthcare directive, advance plan or another similar term).[5]

Advanced life support: The preservation or restoration of life by the establishment and/or maintenance of airway, breathing and circulation using invasive techniques such as defibrillation, advanced airway management, intravenous access and drug therapy.

Adverse drug reaction: A drug response that is noxious and unintended, and which occurs at doses normally used or tested in humans for the prophylaxis, diagnosis or therapy of disease, or for the modification of physiological function.[6]

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

Adverse medicines event: An adverse event due to a medicine. This includes the harm that results from the medicine itself (an adverse drug reaction) and the potential or actual patient harm that comes from errors or system failures associated with the preparation, prescribing, dispensing, distribution or administration of medicines (medication incident).

Agreed tool: An instrument that has been approved for use within a health service organisation.

Antibiotic: A substance that kills or inhibits the growth of bacteria.[7]

Antimicrobial: A chemical substance that inhibits or destroys bacteria, viruses and fungi, including yeasts or moulds.[7]

Antimicrobial stewardship: A program implemented in a health service organisation to reduce the risks associated with increasing microbial resistance and to extend the effectiveness of antimicrobial treatments. Antimicrobial stewardship may incorporate a broad range of strategies including the monitoring and reviews of antimicrobial use.[7]

Approved patient identifiers: Items of information accepted for use in patient identification, including patient name (family and given names), date of birth, gender, address, medical record number and/or Individual Healthcare Identifier. Health service organisations and clinicians are responsible for specifying the approved items for patient identification. Identifiers such as room or bed number are not to be used.

Audit: A systematic review of clinical care against a pre-determined set of criteria.[8]

Basic life support: The preservation of life by the initial establishment of, and/or maintenance of, airway, breathing, circulation and related emergency care, including use of an automated external defibrillator.[9]

Blood: Includes homologous and autologous whole blood. Blood includes red blood cells, platelets, fresh frozen plasma, cryoprecipitate and cryodepleted plasma.[10]

Blood products: Plasma derivatives and recombinant products excluding medication products.[10]

Terms and definitions (continued)

Carers: People who provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness or general frailty.[11] Carers include parents and guardians caring for children.

Clinical audit: A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.[12]

Clinical communication: An exchange of information that occurs between treating clinicians. Communication can be formal (when a message conforms to a predetermined structure; for example in a health record or stored electronic data) or informal (when the structure of the message is determined solely by the relevant parties; for example, in a face-to-face or telephone conversation).[13]

Clinical governance: A system through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. This is achieved by creating an environment in which there is transparent responsibility and accountability for maintaining standards and by allowing excellence in clinical care to flourish.[14]

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.[15]

Clinical indicators: A measurable component of the standard, with explicit criteria for inclusion, exclusion, time frame and setting.[16]

Clinical workforce: The nursing, medical and allied health workforce who provide patient care and students who provide patient care under supervision. This may also include laboratory scientists.[1, 17]

Clinician: A healthcare provider, trained as a health professional. Clinicians include registered and non-registered practitioners, or a team of health professionals providing health care who spend the majority of their time providing direct clinical care.

Communication material: For patients and carers or consumers this may include brochures, fact sheets, letters, newsletters, presentations, posters, social media, trusted web sites and videos. For the workforce this may include agenda papers, letters, meeting papers, memos, minutes and actions items, terms of reference and reports.

Competency-based training: An approach to training that places emphasis on what a person can do in the workplace as a result of training completion.

Complementary healthcare products: Vitamin, mineral, herbal, aromatherapy and homeopathic products, also known as 'traditional' or 'alternative' medicines.[18]

Consumer (health): Patients and potential patients, carers and organisations representing consumers' interests.[19]

Consumer engagement: This involves different types and levels of engagement with consumers that reflect the different goals, audiences and purposes for seeking engagement. Different types of consumer engagement range from processes to inform or disseminate information, which have a low level of engagement, to formal partnerships with a high level of public involvement and influence. Aiming to have active and informed consumers as equal partners in decision-making processes at all levels of the healthcare system is therefore the central concept for both consumer engagement and patient-centred care. Examples of different strategies that can be used to engage consumers are included in the Safety and Quality Improvement Guide for *Standard 2: Partnering with Consumers* (ACSQHC 2012).[20]

Terms and definitions (continued)

Consumer medicines information: Brand-specific leaflets produced by a pharmaceutical company, in accordance with the Therapeutic Goods Regulations (*Therapeutic Goods Act 1989*), to inform patients about prescription and pharmacist-only medicines. These are available from a variety of sources: for example, a leaflet enclosed within the medication package or supplied by a pharmacist; or a computer printout, provided by a doctor, nurse or hospital, and obtained from the pharmaceutical manufacturer or from the internet.[6]

Continuous improvement: A systematic, ongoing effort to raise an organisation's performance as measured against a set of standards or indicators.[21]

Credentialing: Refers to the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of a practitioner for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality healthcare services within specific organisational environments.[22]

Critical friends group: A small group of consumers, carers and/or healthcare providers with experience and/or expertise relevant to a healthcare organisation. The group is convened to provide advice and feedback to that healthcare organisation on specific issues, including safety and quality improvement activities.

Disease surveillance: An epidemiological practice that involves monitoring the spread of disease to establish progression patterns. The main role of surveillance is to predict, observe and provide a measure for strategies that may minimise the harm caused by outbreak, epidemic and pandemic situations, as well as to increase knowledge of the factors that might contribute to such circumstances.[7]

Emergency assistance: Clinical advice or assistance provided when a patient's condition has deteriorated severely. This assistance is provided as part of the rapid response system, and is additional to the care provided by the attending medical officer or team.[5]

Environment: The overall surroundings where health care is being delivered, including the building, fixtures, fittings and services such as air and water supply. 'Environment' can also include other patients, visitors and the workforce.

Escalation protocol: The protocol that sets out the organisational response required for different levels of abnormal physiological measurements or other observed deterioration. The protocol applies to the care of all patients at all times.[5]

Evaluation: A systematic analysis of the merit, worth or significance of an object, system or program.[8]

Evidence-based practice: Care where experience, judgement and expertise are integrated with knowledge about effectiveness gained from a systematic overview of all relevant high quality research evidence.

Fall: An event that results in a person coming to rest inadvertently on the ground or floor or another lower level.[23]

Guidelines: Clinical practice guidelines are 'systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific circumstances'.[24]

Terms and definitions (continued)

Governance: The set of relationships and responsibilities established by a health service organisation between its executive, workforce and stakeholders (including consumers). Governance incorporates the set of processes, customs, policy directives, laws and conventions affecting the way an organisation is directed, administered or controlled. Governance arrangements provide the structure through which the corporate objectives (social, fiscal, legal, human resources) of the organisation are set and the means by which the objectives are to be achieved. They also specify the mechanisms for monitoring performance. Effective governance provides a clear statement of individual accountabilities within the organisation to help in aligning the roles, interests and actions of different participants in the organisation to achieve the organisation's objectives. In these Standards, governance includes both corporate and clinical governance.

Hand hygiene: A general term referring to any action of hand cleansing.

Healthcare associated infections: Infections that are acquired in healthcare facilities (nosocomial infections) or that occur as a result of healthcare interventions (iatrogenic infections). Healthcare associated infections may manifest after people leave the healthcare facility.[25]

Healthcare Provider Identifier: Allocated to healthcare providers involved in providing patient care.

Healthcare Provider Identifier – Organisation: Allocated to organisations (such as a hospital or medical clinic) where healthcare is provided.[26]

Health outcome: The health status of an individual, a group of people or a population that is wholly or partially attributable to an action, agent or circumstance.

Health service organisation: A separately constituted health service that is responsible for the clinical governance, administration and financial management of a service unit(s) providing health care. A service unit involves a grouping of clinicians and others working in a systematic way to deliver health care to patients and can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.

Health service record: Information about a patient held in hard or soft copy. The health service record may comprise clinical records (such as medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts), administrative records (such as contact and demographic information, legal and occupational health and safety reports) and financial records (such as invoices, payments and insurance information). See *Patient clinical record*.

High-risk medicines: Medicines that have a high risk of causing serious injury or death to a patient if they are misused. Errors with these products are not necessarily more common, but the effects can be more devastating. Examples of high-risk medicines include anticoagulants, opioids and chemotherapy.[27]

Hospital: A healthcare facility licensed by the respective regulator as a hospital or declared as a hospital.

Human factors: Study of the interactions between humans and other elements of a system, and the profession that applies theory, principles, data and methods to design in order to optimise human wellbeing and overall system performance.[28]

Incident: An event or circumstance that resulted, or could have resulted, in unintended and/or unnecessary harm to a person and/or a complaint, loss or damage.

Terms and definitions (continued)

Individual Healthcare Identifier: Allocated to all individuals enrolled in the Medicare program or those who are issued with a Department of Veterans' Affairs treatment card, and others who seek health care in Australia.[26]

Infection: The invasion and reproduction of pathogenic or disease-causing organisms inside the body. This may cause tissue injury and disease.[7]

Infection control or infection control measures: Actions to prevent the spread of pathogens between people in a healthcare setting. Examples of infection control measures include targeted healthcare associated infection surveillance, infectious disease monitoring, hand hygiene and personal protective equipment.[7]

Informed consent: A process of communication between a patient and their medical officer that results in the patient's authorisation or agreement to undergo a specific medical intervention.[29] This communication should ensure the patient has an understanding of all the available options and the expected outcomes such as the success rates and/or side effects for each option.[30]

Interventional procedures: Any procedure used for diagnosis or treatment that penetrates the body. These procedures involve incision, puncture, or entry into a body cavity.

Invasive devices: Devices inserted through skin, mucosal barrier or internal cavity, including central lines, peripheral lines, urinary catheters, chest drains, peripherally inserted central catheters and endotracheal tubes.[31-32]

Mandatory training: Compulsory training designed to ensure healthcare workers have the required knowledge and skills to practice safely in their areas of responsibility.

Medication: The use of medicine for therapy or for diagnosis, its interaction with the patient and its effect.

Medication authorities: An organisation's formal authorisation of an individual, or group of individuals, to prescribe, dispense or administer medicines or categories of medicine consistent with their scope of practice.

Medication error: Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient or consumer.[33]

Medication history: An accurate recording of a patient's medicines. It comprises a list of all current medicines including prescription and non-prescription medicines, complementary healthcare products and medicines used intermittently; recent changes to medicines; past history of adverse drug reactions including allergies; and recreational drug use.[34]

Medication incident: See *Adverse medicines event*.

Medication Management Plan (MMP): A form that contains a comprehensive medication history form with space for recording information, prompts for obtaining patient information, dedicated space for documenting medication issues during the care episode and a medication discharge checklist.

Medication management system: The system used to manage the provision of medicines to patients. This system includes dispensing, prescribing, storing, administering, manufacturing, compounding and monitoring the effects of medicines as well as the rules, guidelines, decision-making and support tools, policies and procedures in place to direct the use of medicines. These are specific to a healthcare setting.

Medications reconciliation: The process of obtaining, verifying and documenting an accurate list of a patient's current medications on admission and comparing this list to the admission, transfer, and/or discharge medication orders to identify and resolve discrepancies. At the end of the episode of care, the verified information is transferred to the next care provider.

Medicine: A chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental welfare of people. Prescription, non-prescription and complementary medicines, irrespective of their administration route, are included.[35]

Terms and definitions (continued)

Monitoring plan: A written plan that documents the type and frequency of observations to be recorded as referred to in *Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care*.[8]

Near miss: An incident that did not cause harm, but had the potential to do so.[36]

Non-clinical workforce: The workforce engaged in a health service organisation who do not provide direct clinical care but support the business of health service delivery through administration, hotel service and corporate record management, management support or volunteering.

Non-prescription medicines: Medicines available without a prescription. Some non-prescription medicines can be sold only by pharmacists or in a pharmacy; others can be sold through non-pharmacy outlets. Examples of non-prescription medicines include simple analgesics, cough medicines and antacids.[35]

Open disclosure: An open discussion with a patient about an incident(s) that resulted in harm to that patient while receiving health care. The criteria of open disclosure are an expression of regret and a factual explanation of what happened, the potential consequences and the steps taken to manage the event and prevent recurrence.[37]

Orientation: A formal process of informing and training workforce upon entry into a position or organisation, which covers the policies, processes and procedures applicable to the organisation.

Patient: A person receiving health care. Synonyms for 'patient' include 'consumer' and 'client'.

Patient-care mismatching events: Events where a patient receives the incorrect procedure, therapy, medication, implant, device or diagnostic test. This may be as a result of the wrong patient receiving the correct treatment (such as the wrong patient receiving an X-ray) or as a result of the correct patient receiving the wrong care (such as a surgical procedure performed on the wrong side of the body or X-ray of the wrong side of the body, resulting in an adverse event). Organisations may elect to include other forms of patient care mismatching (for example provision of an incorrect meal resulting in an adverse event) in their reporting; however these should be recorded separately.[38]

Patient-centred care: The delivery of health care that is responsive to the needs and preferences of patients. Patient-centred care is a dimension of safety and quality.

Patient clinical record: Consists of, but is not limited to, a record of the patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care. See *Health service record*.

Patient information: Formal information that is provided by health services to a patient. Patient information ensures the patient is informed before making decisions about their health care.

Patient blood management: Involves a precautionary approach and aims to improve clinical outcomes by avoiding unnecessary exposure to blood components. It includes the three pillars of blood management:

- optimisation of blood volume and red cell mass
- minimisation of blood loss
- optimisation of the patient's tolerance of anaemia.[39]

Patient master index: An organisation's permanent listing or register of health information on patients who have received or are scheduled to receive services.[40]

Terms and definitions (continued)

Patient/procedure matching protocols: Protocols that provide guidance regarding the steps that should be taken to correctly match patients to their intended care.[38]

Performance review: A form of appraisal and evaluation of an employee's performance of assigned duties and responsibilities. It is any form of activity that provides a way to help identify areas for performance enhancement and to help promote professional growth. It can be formal or informal, through discussion or in writing. Evidence may include reports on compliance with a structured performance management system; records of individual performance improvement discussions and plans; records of training undertaken to address identified gaps in skills and knowledge; and use of probation programs, or records of regular feedback sessions between a supervisor and their team member(s) such as diary records.

Periodic review: Infrequent review, the frequency of which is determined by the subject, risk, scale and nature of the review.

Point of care: The time and location where an interaction between a patient and clinician occurs for the purpose of delivering care.

Policy: A set of principles that reflect the organisation's mission and direction. All procedures and protocols are linked to a policy statement.

Prescription medicine: Any medicine that requires a prescription before it can be supplied. A prescription must be authorised by an appropriately registered practitioner.[41]

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'.

Procedure: The set of instructions to make policies and protocols operational. These are specific to an organisation.

Protocol: An established set of rules used for the completion of tasks or a set of tasks.

Rapid response system: The system for providing emergency assistance to patients whose condition is deteriorating. The system includes the clinical team or individual providing emergency assistance, and may include on-site and off-site personnel.[5]

Recognition and response systems: Formal systems that help the workforce to promptly and reliably recognise patients who are clinically deteriorating, and to respond appropriately to stabilise the patient.[5]

Regular: Performed at recurring intervals. The specific interval for regular review, evaluation, audit or monitoring and so on needs to be determined for each case. In these Standards, the time period should be consistent with best practice, be risk based, and be determined by the subject and nature of the review.

Relevant documentation: This may include emails, file notes, information posted on workforce notice boards, message books, notes, memos, minutes, records of workforces meetings, reports, workforce emails, written notes of ad hoc meetings. See *Communication material*.

Risk: The chance of something happening that will have a negative impact. It is measured by consequences and likelihood.

Risk management: The design and implementation of a program to identify and avoid or minimise risks to patients, employees, volunteers, visitors and the institution.

Scope of clinical practice: The extent of an individual practitioner's approved clinical practice within a particular health service organisation based on the individual's credentials, competence, performance and professional suitability and the needs and capability of the health service organisation.[22]

Terms and definitions (continued)

Senior level of governance: The most senior committee or individual with the delegated authority to act or influence change to bring about improvement in care or processes.

Single use: The medical device is intended to be used on an individual patient during a single procedure and then discarded. It is not intended to be reprocessed and used on another patient. Some single-use devices are marketed as non-sterile which require processing to make them sterile and ready for use. The manufacture of the device will include appropriate processing instructions to make it ready for use.[25]

Spaulding classification: Strategy for reprocessing contaminated medical devices. The system classifies a medical device as critical, semicritical, or noncritical on the basis of risk to patient safety from contamination on a device. The system also establishes three levels of germicidal activity (sterilisation, high-level disinfection, and low-level disinfection) for strategies with the three classes of medical devices (critical, semicritical, and noncritical).[42]

System: The resources, policies, procedures and protocols that are organised, integrated, regulated and administered to accomplish the objective of the Standard. The system:

- interfaces risk management, governance, operational processes and procedures, including education, training and orientation
- deploys an active implementation plan and feedback mechanisms
- includes agreed protocols and guidelines, decision support tools and other resource material
- employs a range of incentives and sanctions to influence behaviours and encourage compliance with policy, protocol, and procedures, and regulation.

Tall Man lettering: Enhancement of unique letter characters of medicines names by use of upper case characters to improve differentiation of look-alike medicines names. Australia has nationally standardised application of Tall Man lettering to those medicines names pairs and groups which are at high risk of confusion and are likely to cause serious or catastrophic patient harm if confused.[43]

Training: The development of knowledge and skills.

Transfer of care: Any instance where the responsibility for care of a patient passes from one individual or team to another. This includes nursing and medical change of shift, transfer of care to another medical officer or primary care practitioner and transfer of a patient to another healthcare facility.[38]

Transmission-based precautions: Extra work practices in situations where standard precautions alone may be insufficient to prevent infection (for example for patients known or suspected to infected or colonised with infectious agents that may not be contained with standard precautions alone).[25]

Treatment-limiting orders: Orders, instructions or decisions that involve the reduction, withdrawal or withholding of life-sustaining treatment. These may include ‘no cardiopulmonary resuscitation’ or ‘not for resuscitation’.[5]

Workforce: All those people employed by a health service organisation.

This Standard provides the safety and quality governance framework for health service organisations and its intention is to create integrated governance systems that maintain and improve the reliability and quality of patient care, as well as to promote improved patient outcomes. This Standard and *Standard 2: Partnering with Consumers* link directly to each of the other clinical Standards 3 to 10. Systems are required to be established and maintained to ensure accountability and responsibility for delivery of safe and high quality care. This guide does not specify how a health service organisation should develop or implement its governance system. Rather, it suggests an approach that small hospitals may take. It also recognises that small hospitals are often part of a network of health services, receiving direction and oversight from a district, cluster or group owner, and responsibilities for actions are often divided between different parts of the organisation.

Governance and quality improvement systems

Action	Overview of what is required	Suggested approach in small hospitals
1.1 Implementing a governance system that sets out the policies, procedures and/or protocols for: • **establishing and maintaining a clinical governance framework** • **identifying safety and quality risks** • **collecting and reviewing performance data** • **implementing prevention strategies based on data analysis** • **analysing reported incidents** • **implementing performance management procedures** • **ensuring compliance with legislative requirements and relevant industry standards** • **communicating with and informing the clinical and non-clinical workforce** • **undertaking regular clinical audits**		
1.1.1 An organisation-wide management system is in place for the development, implementation and regular review of policies, procedures and/or protocols	• This action relates to all policies, procedures and/or protocols in the 10 *NSQHS Standards*, which are listed in Table 5 of the *Hospital Accreditation Workbook* (ACSQHC 2012). • Hospitals need to ensure that their policies, procedures and/or protocols: – are based on evidence and good practice – are reviewed periodically to keep them up to date – incorporate any legislative requirements the hospital is required to meet.	• If your hospital is part of a local health network or private hospital group: – Identify if there is a system in place at the network level for the development, implementation and regular review of policies, procedures and/or protocols that apply to your hospital – if there is such a system in place, ensure that local procedures or work instructions are consistent with network policies, procedures and/or protocols. • If your hospital is not part of a local health network or private hospital group, or there is no such system in place at that level, policies, procedures and/or protocols will need to be developed that specify: – the roles, responsibilities and accountabilities for each of the local managers – the position(s) with delegations for implementing, amending or endorsing policies.

Governance and quality improvement systems

Action	Overview of what is required	Suggested approach in small hospitals
1.1 Implementing a governance system that sets out the policies, procedures and/or protocols for: • establishing and maintaining a clinical governance framework • identifying safety and quality risks • collecting and reviewing performance data • implementing prevention strategies based on data analysis • analysing reported incidents		• implementing performance management procedures • ensuring compliance with legislative requirements and relevant industry standards • communicating with and informing the clinical and non-clinical workforce • undertaking regular clinical audits (continued)
1.1.1 (continued)		• Irrespective of where governance for your policy framework sits, you should also ensure that the health service has: – procedures in place that comply with the health service's policy – mechanisms to monitor the use of procedures by the workforce – mechanisms to be used to report to the senior executive.
1.1.2 The impact on patient safety and quality of care is considered in business decision-making	• Strategic planning should include consideration of safety and quality strategies, initiatives and performance. • Templates for developing a business proposal to the organisation's senior executive should include consideration of the impact of the proposal on safety and quality.	• If your hospital is responsible for developing its own strategic plan, then the plan needs to include safety and quality strategies, objectives and goals. • If your hospital is implementing a strategic plan that was developed by your local health network or private hospital group, then: – consider the allocation of resources for safety and quality – identify safety and quality risks and opportunities. • Educate managers, clinicians and corporate services to take into consideration safety and quality when developing a business proposal.
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		
1.2.1 Regular reports on safety and quality indicators and other safety and quality performance data are monitored by the executive level of governance	• Map out the safety and quality indicators and other data you will provide to the senior executive and set a calendar for reporting this information. • Periodically review the safety and quality data submitted to ensure it covers all services provided, all major risks, and provides a comprehensive picture of your hospital's safety and quality performance.	• Identify to whom safety and quality performance information should be reported. This should include the highest level of governance locally, and may also include individuals or governance bodies in your local hospital network, private hospital group, state or territory. • Develop reporting templates and deadlines for reporting data. • Consider the format, scope and data quality of the information provided to the senior executive. For example, information could be reported through meeting minutes, newsletters and memos. Committee reporting requirements could also be documented in the terms of reference for each committee.

Governance and quality improvement systems

Action	Overview of what is required	Suggested approach in small hospitals
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 (continued)		
1.2.2 Action is taken to improve the safety and quality of patient care	• Review the: – program of audit for safety and quality data to ensure it is providing you with information that is useful for measuring the impact of safety and quality improvement activities – information collected on safety and quality, including that provided to the senior executive, to see if it covers all aspects of quality, major risks in your service and all services that are provided. • Feedback should be provided to the workforce on the actions taken to improve safety and quality performance.	• Identify local manager(s) with responsibility for oversight of clinical safety and quality risk management. • Allocate time for quality audits. • Table the results in staff meetings and implement an action plan. • Identify the resources required to address safety and quality risks locally. • Allocate time to review safety and quality systems, delegations, and information provided on safety and quality performance.
1.3 Assigning workforce roles, responsibilities and accountabilities to individuals for: • **patient safety and quality in their delivery of health care** • **the management of safety and quality specified in each of these Standards**		
1.3.1 Workforce are aware of their delegated safety and quality roles and responsibilities	• Your hospital should have a clearly described governance structure and workforce accountabilities should be reflected in the organisational structure. • Position descriptions and contract templates should define the roles and responsibilities for safety and quality for all members of the workforce.	• If your hospital is part of a local health network or private hospital group that has specified the governance structure and accountabilities in your hospital, ensure that these are put in place. • If you are responsible for implementing delegated roles and responsibilities, then: – review the position descriptions for the workforce – discuss safety and quality responsibilities in routine performance management processes – provide information to the workforce on their safety and quality roles and responsibilities.

Action	Overview of what is required	Suggested approach in small hospitals
1.3 Assigning workforce roles, responsibilities and accountabilities to individuals for: • **patient safety and quality in their delivery of health care** • **the management of safety and quality specified in each of these Standards** (continued)		
1.3.2 Individuals with delegated responsibilities are supported to understand and perform their roles and responsibilities, in particular to meet the requirements of these Standards	• There is an induction and training program in place for local board members, local executives and managers to understand their roles and responsibilities for safety and quality. • The workforce is provided with induction and ongoing training to understand their roles and responsibilities in safety and quality and to develop skills in providing safe and high quality care.	• Educate and train members of the workforce in their governance roles, responsibilities and accountabilities. • Schedule training in clinical governance for managers and senior clinicians. • Identify professional development opportunities in clinical safety, quality, leadership and risk for managers and senior clinicians. • This training may be delivered locally, or by your local health network, private hospital group or external provider. • Ensure members of the workforce read and sign their position description annually when doing their performance appraisals.
1.3.3 Agency or locum workforce are aware of their designated roles and responsibilities	• The contract for services with locum, agency and other contracted members of the clinical workforce includes requirements for safety, quality and clinical governance and identifies the skills and experience required of staff categories by the health service organisation. • Provide an effective orientation to safety, quality and clinical governance systems for clinicians engaged via agency and locum arrangements. • Ensure policies and procedures clearly describe the responsibilities for the agency and locum workforce to comply with safety, quality and clinical governance and make these available to locum and agency staff on or before commencement.	• If your hospital is part of a local health network or private hospital group that has responsibility for contract management of the agency and locum workforce, ensure the contractual arrangements are put in place locally. • If you are responsible for informing agency and locum staff of their safety and quality roles and responsibilities, then: – verify that credentialing and scope of clinical practice is undertaken prior to or on commencement – provide agency and locum staff with an orientation to safety, quality and clinical governance that includes access to policies and procedures that outline roles and responsibilities. Provide support material to assist permanent staff members orientate agency and locum staff.

Governance and quality improvement systems

Action	Overview of what is required	Suggested approach in small hospitals
1.4 Implementing training in the assigned safety and quality roles and responsibilities		
1.4.1 Orientation and ongoing training programs provide the workforce with the skill and information needed to fulfil their safety and quality roles and responsibilities	• Review your education and training policies and programs so the workforce can access appropriate orientation, education and training in safety, quality and clinical governance. • A summary of the training that may be required as a result of implementing the *NSQHS Standards* is listed in Table 6 of the *Hospital Accreditation Workbook* (ACSQHC 2012).	• Implement an orientation program for all new members of the workforce. While this may be conducted at a local health network or private hospital group level, local orientation is also needed to ensure that new members of the workforce understand local systems. • Provide education and training for members of the workforce based on a review of your hospital's local safety and quality risks, the requirements set out in operational and strategic plans, and the training needs of the workforce. • Managers and senior members of the workforce assist junior staff to identify individual training needs.
1.4.2 Annual mandatory training programs to meet the requirements of these Standards	• The *NSQHS Standards* mandate that the clinical workforce is: – competent in aseptic technique (see Action 3.10.1) – trained and proficient in basic life support (see Action 9.6.1). • Further training for the workforce, including agency and locum workforce, will depend on the needs and risks identified in your hospital.	• Education and training may involve: – tutorial sessions that may be combined with general administrative meetings – dedicated time for teaching, supervision and assessment of new skills – locally managed and run professional development sessions – formal training provided by the workforce or external providers. • Maintain a register of training or records of attendance and achievement at mandatory training programs by the workforce.
1.4.3 Locum and agency workforce have the necessary information, training and orientation to the workplace to fulfil their safety and quality roles and responsibilities	See overview of what is required for Action 1.4.2.	• Collect information on induction and provide regular training in safety, quality, leadership and risk to the agency and locum workforce.
1.4.4 Competency-based training is provided to the clinical workforce to improve safety and quality		• Identify opportunities to provide access to competency-based training for the workforce.

Governance and quality improvement systems

Action	Overview of what is required	Suggested approach in small hospitals
1.5 Establishing an organisation-wide risk management system that incorporates identification, assessment, rating, controls and monitoring for patient safety and quality		
1.5.1 An organisation-wide risk register is used and regularly monitored	• Implement and monitor a risk register. • Use of the risk register should be regularly reviewed to ensure: – it is kept up to date – it includes all the relevant information – members of the workforce with roles and responsibilities in its use maintain the register and are accountable – the risk management system is effective.	• Document, and keep up-to-date, policies, procedures and protocols about the use of a local risk register. • Record all clinical and non-clinical risks and strategies for the management these risks. • Identify local managers with responsibility for managing each of the risks identified.
1.5.2 Actions are taken to minimise risks to patient safety and quality of care		• Regularly audit the risk management system and review results locally, and also submit them to the senior executive. • Engage the workforce (in meetings, forums or committees) to involve clinicians and others in identifying, assessing and managing risks. • Measure performance of your hospital against key safety and quality risks. • Develop a way to respond to risks identified by external organisations, such as coroners, health complaints commissions, safety and quality commissions.

Governance and quality improvement systems

Action	Overview of what is required	Suggested approach in small hospitals
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		
1.6.1 An organisation-wide quality management system is used and regularly monitored	• Your hospital will need to: – determine how to define 'good quality' for your hospital, and put in place plans to achieve this – develop a schedule of audits of clinical and organisational systems to monitor performance – implement strategies to improve performance – determine what reports your organisation needs in order to understand its performance and the reports needed by your senior executive to understand the performance of the health service (see Action 1.2.1) – involve the workforce in the development, monitoring and improvement of these systems.	• If your hospital is part of a local health network or private hospital group that has an organisation-wide quality management system, then identify the strategies needed to put this in place locally. • If your health service is developing and implementing an organisation-wide quality management system locally: – include senior executives, clinicians, consumers (see *Standard 2: Partnering with Consumers*) and other key stakeholders in the process – set organisational quality and clinical services objectives and identify how these will be met – monitor consumer satisfaction and measure quality on an ongoing basis – develop a small set of safety and quality measures to monitor trends in performance.
1.6.2 Actions are taken to maximise patient quality of care		• Provide reports to the clinical workforce and support their involvement in improvement actions.

Action	Overview of what is required	Suggested approach in small hospitals
1.7 Developing and/or applying clinical guidelines or pathways that are supported by the best available evidence		
1.7.1 Agreed and documented clinical guidelines and/or pathways are available to the clinical workforce	• Your hospital should adopt those clinical guidelines and pathways relevant to the services being provided.	• If your hospital is part of a local health network or private hospital group that has specified the clinical guidelines and pathways to be implemented, engage the clinical workforce to put these in place locally. • If you need to agree and document guidelines and clinical pathways to be used locally, then: – identify, in collaboration with the clinical workforce, the evidence-based clinical guidelines and pathways to be used – resource and support the use of the clinical guidelines and pathways – facilitate easy access by the workforce to guideline and pathway documents.
1.7.2 The use of agreed clinical guidelines by the clinical workforce is monitored	• You will need to review: – the clinical guidelines and pathways being used to ensure they are current and reflect current best evidence and good practice – practices that vary from the guidelines or pathways. • Using a risk-based approach, high volume and high risk conditions need to be reviewed more frequently.	• Monitor the use of clinical guidelines and pathways and provide the clinical workforce with information on variations in practice. • Support the clinical workforce to undertake peer review of feedback.

Clinical practice

Action	Overview of what is required	Suggested approach in small hospitals
1.8 Adopting processes to support the early identification, early intervention and appropriate management of patients at increased risk of harm		
1.8.1 Mechanisms are in place to identify patients at increased risk of harm	• You need to implement mechanisms to identify and protect patients at high risk of harm. • This action relates to other actions in the *NSQHS Standards* about screening and early identification of risk.	• Use patient screening tools to identify factors that contribute to patients being at risk. • Use screening tools for risk areas specific to your hospital, such as those for pressure injuries or falls. • Undertake risk assessment for patients, procedures or locations of treatments known to be high risk. • Undertake risk assessment within 24 hours of admission and implement a prevention or management plan.
1.8.2 Early action is taken to reduce the risks for at-risk patients	• The audit program should include routine auditing of the system for identifying patients at a high risk of harm.	• Monitor the clinical outcomes for patient groups at higher risk of harm. • Provide the workforce with information on the management and outcomes of patients and patient groups at high risk of harm.
1.8.3 Systems exist to escalate the level of care when there is an unexpected deterioration in health status	• You will need to systematically review the organisation's policies, procedures and/or protocols to recognise and respond to patients whose condition is deteriorating to ensure these are operating effectively. • If your organisation complies with *Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care* your organisation will meet this action.	• If your organisation does not need to comply with Standard 9, you will need to have in place: – policies, procedures and/or protocols for recording physiological observations and escalating care when a patient deteriorates – processes to communicate with patients and carers about the possibility of a patient's condition deteriorating.

Clinical practice

Action	Overview of what is required	Suggested approach in small hospitals
1.9 Using an integrated patient clinical record that identifies all aspects of the patient's care		
1.9.1 Accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point of care	• Your hospital should have in place a patient clinical records system that is accessible to the clinical workforce when they are providing care. This will require a clinical record that allows documentation of all clinical events.	• If your hospital is part of a local health network or private hospital group that has specified the policy, procedures and/or protocols for use of the patient clinical records, engage the clinical workforce to put these requirements in place. • If you are required to implement a patient clinical records system locally, then: – identify a local manager(s) with responsibility for and skills in clinical records management – adopt standardised processes for management of clinical records for retention, access at point of care, consent and disposal of records – develop policies and process that authorise documentation in clinical records – ensure all legislative requirements for the management of records are met – include in orientation of new members of the workforce processes for accessing and documenting in the patient clinical record.
1.9.2 The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards	• For a number of requirements in the *NSQHS Standards*, information will need to be obtained from the patient clinical record. Therefore the design of the record should allow for efficient auditing and data collection.	• Review the design of the patient clinical record to enable the collection of patient clinical data.

Performance and skills management

Action	Overview of what is required	Suggested approach in small hospitals
1.10 Implementing a system that determines and regularly reviews the roles, responsibilities, accountabilities and scope of practice for the clinical workforce		
1.10.1 A system is in place to define and regularly review the scope of practice for the clinical workforce	• Your hospital should have an evidence-based policy and procedure for credentialing and defining scope of clinical practice for all members of the clinical workforce.	• If your hospital is part of a local health network or private hospital group that has specified the policy, procedures and protocols for defining and reviewing scope of practice for the clinical workforce, then your hospital should engage the clinical workforce to put these requirements in place. • If your hospital is required to implement a scope of practice procedure, then: – verify each clinician's professional credentials – periodically review this information to ensure it is still current and in line with the policy – establish processes for reviewing clinicians' competency and performance if concerns are raised. • If a health service organisation has contracts for the delivery of health services, mechanisms must be in place to ensure the scope of practice and credentialing requirements are met.
1.10.2 Mechanisms are in place to monitor that the clinical workforce are working within their agreed scope of practice	• Senior executive and local managers need to be confident that the clinical workforce is operating within their approved scope of practice, so the system will need to be maintained and monitored.	• Monitor clinical practice by implementing protocols for the: – routine observation and recording of clinical practice – review complaints or concerns about clinicians working outside their scope of practice.
1.10.3 Organisational clinical service capability, planning and, scope of practice is directly linked to the clinical service roles of the organisation	• Planning for clinical services needs to consider the skills and availability of the workforce, the education, training, support and supervision that may be required by the workforce.	• Keep a register of workforce qualifications and areas of credentialed practice for consideration in planning processes.

Action	Overview of what is required	Suggested approach in small hospitals
1.10 Implementing a system that determines and regularly reviews the roles, responsibilities, accountabilities and scope of practice for the clinical workforce (continued)		
1.10.4 The system for defining the scope of practice is used whenever a new clinical service, procedure or other technology is introduced	• Your hospital should have a process for assessing and monitoring the safety and quality of any new service, procedure or technology before and after it is introduced.	• Adopt, adapt or develop an evidence-based process for assessing safety and quality. This may come from a local health network or private hospital group, a peer hospital or professional group. • Monitor performance following the introduction of this process.
1.10.5 Supervision of the clinical workforce is provided whenever it is necessary for individuals to fulfil their designated role	• Members of the clinical workforce who are developing their skills or during an assessment phase may need to be supervised. Your hospital should have documented procedures for identifying which members of the workforce are to be supervised, who can provide supervision and how long supervision is required. • Reports on supervised workshops should be required routinely in line with the documented procedure.	• Requirements for supervision can be included in: – policies and procedures – position descriptions – professional registration requirements – requirements for periods of training or re-entry to the workforce.

Performance and skills management

Action	Overview of what is required	Suggested approach in small hospitals
1.11 Implementing a performance development system for the clinical workforce that supports performance improvement within their scope of practice		
1.11.1 A valid and reliable performance review process is in place for the clinical workforce	• Your hospital should implement and maintain a robust system of performance development for all members of the clinical workforce. • This system should be reviewed periodically to ensure its design, resourcing, and monitoring supports the adoption of safe and good quality clinical practices, clinical engagement and good patient outcomes.	• If your hospital is part of a local health network or private hospital group that has a performance review process, then your hospital should engage the workforce to put these requirements in place. • If you are required to implement a performance review process, then: – identify a local manager with responsibility for ensuring that the workforce complies with performance review processes – engage clinicians in formalised audit and peer review of their practice – support and encourage completion of continuing professional development requirements of the clinician's professional organisation and registration body.
1.11.2 The clinical workforce participates in regular performance reviews that support individual development and improvement		• Monitor participation in performance review by the clinical workforce. • Review and report on the performance of locum and agency staff. This may include input from local staff. • Report data about participation of the workforce in performance review to the senior executive.

Performance and skills management

Action	Overview of what is required	Suggested approach in small hospitals
1.12 Ensuring that systems are in place for ongoing safety and quality education and training		
1.12.1 The clinical and relevant non-clinical workforce have access to ongoing safety and quality education and training for identified professional and personal development	• Your hospital should have a program of education and training of the workforce that aligns: – the safety and quality risks of providing clinical services – the skills and knowledge gaps of the workforce – requirements for professional development of the workforce. • Education is provided at orientation, induction, during supervised delivery of care, during informal tutorial and training sessions, in courses and external programs of education. • This action is linked to Actions 1.3.2, 1.4.1, 1.4.2, 1.4.3, 1.4.4, 1.5.1, 1.11.2, 1.13.1, 1.14.1, 1.16.2 and 1.18.4.	• If your hospital is part of a local health network or private hospital group that has a program of safety and quality education and training, then your hospital should identify which components meet the requirements of your hospital and what additional education and training may be required. • If you are required to provide access to education and training, then your hospital should: – review training requirements identified during professional review processes – review feedback from the workforce on safety and quality, incident and complaints management processes and from analysis of issues recorded in the risk register – consider training provided in meeting Action 1.4.2 – record training undertaken by the workforce and include this in reports to the senior executive.
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		
1.13.1 Analyse feedback from the workforce on their understanding and use of safety and quality systems	• Your hospital should identify ways to collect information from the workforce on their understanding, use and perceptions of the effectiveness of the organisation's safety and quality systems. • This action links to Actions 1.11.1 and 1.11.2.	• If your hospital is part of a local health network or private hospital group that has a process for the routine collection of feedback from the workforce, then your hospital should engage the workforce to put these requirements in place. • If you are required to collect feedback on safety and quality, then your hospital could consider using: – de-identified data from the performance review system – audit data from clinical and administrative systems – surveys of the workforce – informal advice from the workforce on safety and quality.
1.13.2 Action is taken to increase workforce understanding and use of safety and quality systems	• Information on safety and quality systems in your hospital should be periodically analysed to inform the organisation's education and training program.	• Provide reports to the workforce on trends in safety and quality and analysis of feedback from the workforce. • Seek workforce input on how to improve safety and quality performance.

Incident and complaints management

Action	Overview of what is required	Suggested approach in small hospitals
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		
1.14.1 Processes are in place to support the workforce recognition and reporting of incidents and near misses	• Implement a comprehensive incident management and investigation system in your hospital and identify a local manager with responsibility for maintaining the system.	• If your hospital is part of a local health network or private hospital group that specifies a process for incident management and reporting, then your hospital should put these requirements in place. • If you are required to implement an incident management system, then your hospital should: – define the key elements of the incident reporting and management system in policy and procedures, including confidentiality of information – identify local manager(s) and/or committees with responsibility for managing and maintaining the system – train the clinical workforce in the use of the system and support and encourage reporting of incidents and near misses – allocate responsibility for communicating with the organisation's professional indemnity insurers, if that process is undertaken locally.
1.14.2 Systems are in place to analyse and report on incidents	• A group or individual will need to be identified with the skills and responsibility to analyse data and report on incidents.	
1.14.3 Feedback on the analysis of reported incidents is provided to the workforce	• Provide feedback to the workforce on the analysis of incidents, including number, scope, trends, severity and root cause as appropriate.	• Provide reports to the workforce on incident trends. • Provide feedback during staff meetings.
1.14.4 Action is taken to reduce risks to patients identified through the incident management system	• Information from the incident management system should be routinely analysed to inform the organisation's: – induction, education and training program (see Actions 1.1.1 to 1.4.4) – safety and quality strategies (see Action 1.2.2) – strategic and operational planning.	• Seek workforce input on how to reduce incidents in your hospital. • Incorporate information from the analysis of incidents into the induction, education and training program. • Consider resource and systems changes in strategic and operational planning.
1.14.5 Incidents and analysis of incidents are reviewed at the highest level of governance in the organisation	• Information from incident management processes should be reported to the senior executive in line with the policy and timeframes for reporting. • This links with Action 1.2.1.	• Provide reports to the senior executive on incident trends.

Action	Overview of what is required	Suggested approach in small hospitals
1.15 Implementing a complaints management system that includes partnership with patients and carers		
1.15.1 Processes are in place to support the workforce to recognise and report complaints **1.15.2** Systems are in place to analyse and implement improvements in response to complaints	• Your hospital should implement a complaints management and investigation system and identify a local manager with responsibility for managing and monitoring this process. • A group or individual will need to be identified with responsibility for responding and reporting on complaints and improvements to the complaints system. • Information from complaints should be routinely analysed to inform the organisation's: – induction, education and training program (see Actions 1.1.1 to 1.4.4) – safety and quality strategies (see Action 1.2.2).	• If your hospital is part of a local health network or private hospital group that specifies a process for complaints management and reporting, then your hospital should put these requirements in place. • If your hospital is required to implement a complaints management system, then your hospital should: – align your systems to comply with jurisdictional requirements – describe the elements of the complaints management system in policies, procedures and protocols – identify local manager(s) and/or committees with responsibility for managing the integrity of the system and receiving and responding to complaints – inform the workforce in the use of the system – support and encourage reporting of complaints – support and encourage patients and carers to report complaints and provide them with feedback on the management and outcome of their complaint.
1.15.3 Feedback is provided to the workforce on the analysis of reported complaints	• Feedback should be provided to the workforce on the analysis of complaints including number, scope and trends, as appropriate.	• Provide reports to the workforce from the analysis of complaints.
1.15.4 Patient feedback and complaints are reviewed at the highest level of governance in the organisation	• Information from this process should be reported to the senior executive in line with the policy and timeframes for reporting. • This links with Action 1.2.1.	• Provide reports to the senior executive on patient feedback and complaint trends.

Incident and complaints management

Action	Overview of what is required	Suggested approach in small hospitals
1.16 Implementing an open disclosure process based on the national open disclosure standard		
1.16.1 An open disclosure program is in place and is consistent with the national open disclosure standard	• Your hospital should adopt and implement the national open disclosure standard, or a program that is consistent with this standard. • Implementation of the hospital's open disclosure program should be periodically audited to ensure it is consistent with the national standard and that clinicians are participating when appropriate.	• If your hospital is part of a local health network or private hospital group that specifies a process for open disclosure, then put these requirements in place. • If you are required to implement an open disclosure program, then: – adopt, adapt or develop policies, procedures and/or protocols that are consistent with the national open disclosure standard – implement a monitoring and reporting system for open disclosure events – review open disclosure events to determine how the program could be improved.
1.16.2 The clinical workforce are trained in open disclosure processes	• Your hospital should review the need to include open disclosure in its induction, education and training program. • You will need to monitor participation in training by the workforce.	• Incorporate open disclosure into the induction, education and training program. • Record participation in training.

Patient rights and engagement

Action	Overview of what is required	Suggested approach in small hospitals
1.17 Implementing through organisational policies and practices a patient charter of rights that is consistent with the current national charter of healthcare rights		
1.17.1 The organisation has a charter of patient rights that is consistent with the current national charter of healthcare rights	• Your hospital should adopt the *Australian Charter of Healthcare Rights* or a charter that is consistent with the *Australian Charter of Healthcare Rights*.	• If your hospital is part of a local health network or private hospital group that has developed a charter of healthcare rights, then ensure the requirements of this charter are being met. • If you are required to implement a charter of healthcare rights then: – identify local manager(s) with responsibility for implementing the charter – display the charter prominently in your hospital – include information about the charter in your community communications – include information on the charter in the orientation program for new members of the workforce.
1.17.2 Information on patient rights is provided and explained to patients and carers **1.17.3** Systems are in place to support patients who are at risk of not understanding their healthcare rights	• Copies of the charter are provided to patients and they are given an opportunity to obtain additional information and/or an explanation from members of the workforce. • Provide the charter in languages and formats relevant to people unable to use the written charter and suited to the patient population of your hospital.	• Provide access to copies of the charter to all patients, in a variety of formats and languages relevant to your patient population. These may be available from your local health network, private hospital group or the Commission. • Include training for the workforce on their responsibilities for the implementation of the charter.
1.18 Implementing processes to enable partnership with patients in decisions about their care, including informed consent to treatment		
1.18.1 Patients and carers are partners in the planning for their treatment	• Your hospital should empower patients and carers to be involved in the process of planning their own treatment. Information to support their involvement needs to be provided in a timely and culturally appropriate way. • This links to Actions 1.17.1 to 1.17.3.	• Include in workforce orientation programs information on the – principles of patient autonomy and respect for the individual's right to bodily integrity – importance of continuous open communication – the rights of patients – disclosure of all material risks – involvement of patients and their carers in handover reports and care.

Patient rights and engagement

Action	Overview of what is required	Suggested approach in small hospitals
1.18 Implementing processes to enable partnership with patients in decisions about their care, including informed consent to treatment (continued)		
1.18.2 Mechanisms are in place to monitor and improve documentation of informed consent	• Your hospital should implement policies, procedures and protocols for documenting patient consent to treatment. Documentation for the workforce should meet legal and ethical requirements.	• If your hospital is part of a local health network or private hospital group that specifies processes for informed consent, then put these requirements in place. • If your hospital is required to implement a patient consent process, then: – implement policies, procedures and protocols for informed consent – identify local manager(s) with responsibility for maintaining the integrity of the consent system and its continuous improvement – audit the patient clinical record to assess the effectiveness of the patient consent process – include in workforce orientation, training and education programs information on the common law and legislative requirements in your jurisdiction about consent and obtaining consent to treatment.
1.18.3 Mechanisms are in place to align the information provided to patients with their capacity to understand	• Your hospital should provide the workforce with patient information and resources that have been developed to meet the needs of their target audience. • See also Item 2.4.	• If you use publications that have been externally developed, for example by state or territory health departments or other external providers, try to source information that has been developed with input from consumers. • If you are developing patient information publications locally, obtain and document feedback from consumers about information publications by: – discussing publications with consumers in waiting rooms – holding a focus group or workshop with consumers – making follow-up phone calls to consumers who have been provided with information publications – conducting a survey (electronic, mail or phone) of consumers who have been provided with information publications.

Action	Overview of what is required	Suggested approach in small hospitals
1.18 Implementing processes to enable partnership with patients in decisions about their care, including informed consent to treatment (continued)		
1.18.4 Patients and carers are supported to document clear advance care directives and/or treatment-limiting orders	• Your hospital should put in place mechanisms to inform and support patients and carers and treatment-limiting orders. • The workforce will need to be trained to understand the legal and ethical issues associated with drafting and implementing advance care directives and treatment-limiting orders. • See also Item 9.8.	• If your hospital is part of a local hospital or private hospital group that specifies processes for documenting advance care directives and/or treatment-limiting orders, then put these requirements in place. • If your hospital is required to implement a process, then: – implement policy and processes for receiving, preparing and documenting advance care directives – document information about the legal status of advance care directives – adopt simple forms and other tools to facilitate completion of advance care directives – provide clear directions to the workforce on their role in assisting patients to consider and complete advance care directives – provide training for members of the clinical workforce.
1.19 Implementing procedures that protect the confidentiality of patient clinical records without compromising appropriate clinical workforce access to patient clinical information		
1.19.1 Patient clinical records are available at the point of care	• Your hospital should ensure clinical records can be accessed by the workforce at the point of care. • Policies, procedures and/or protocols will need to be developed to access personally-controlled electronic health records, including emergency access when a patient is unable to provide consent.	• If your hospital is part of a local health network or private hospital group that specifies the patient clinical records system, then put these requirements in place. • If your hospital is required to implement a patient clinical records system, then you should: – adopt policies, procedures and/or protocols designed to ensure access at point of care and determine storage and transport requirements that provide prompt access – train the workforce in record keeping.

Patient rights and engagement

Action	Overview of what is required	Suggested approach in small hospitals
1.19 Implementing procedures that protect the confidentiality of patient clinical records without compromising appropriate clinical workforce access to patient clinical information (continued)		
1.19.2 Systems are in place to restrict inappropriate access to and dissemination of patient clinical information	• Policies, procedures and protocols will need to be developed to support confidentiality and privacy of patient information. These will need to address the use of paper-based and electronic records to ensure they are consistent with the law and good practice. • Systems will need to be periodically audited to ensure processes are being followed and identify areas for improvement.	• Adopt policies, procedures and/or protocols designed to ensure confidentiality of patient information. • Inform the workforce of their responsibilities to protect patient privacy and confidentiality and the consequences of intentional and unintentional breaches of these obligations. • Periodically undertake reviews of access and dissemination of patient clinical information and implement strategies to improve.
1.20 Implementing well-designed, valid and reliable patient experience feedback mechanisms and using these to evaluate the health service performance		
1.20.1 Data collected from patient feedback systems are used to measure and improve health services in the organisation	• Your hospital should adopt and implement a comprehensive patient feedback system. • You will need to consider where and how this information is reported to make the most effective use of the information obtained. • The feedback system will periodically need to be reviewed to ensure it is providing the information being sought.	• If your organisation, local health network or private hospital group specifies the patient feedback mechanisms to be used, then your hospital should put the specified requirements in place. • If your hospital is required to implement patient feedback mechanisms, then: – implement a validated and reliable mechanism for systematically obtaining feedback from patients and carers – identify local manager(s) who is responsible for maintaining, analysing and reporting on patient feedback systems – systematically and regularly seek patient feedback that covers the range of services and patients necessary to provide reliable information about patient experience – provide patients and carers with information about what has been learnt from patient feedback, and how it has been used to generate improvements in the health service.

Key resource

Australian Commission on Safety and Quality in Health Care. *Safety and Quality Improvement Guide Standard 1: Governance for Safety and Quality in Health Service Organisations*. Sydney. ACSQHC, 2012.
www.safetyandquality.gov.au/our-work/accreditation/nsqhss/safety-and-quality-improvement-guides-and-accreditation-workbooks/

Notes

This Standard provides the framework for health services to actively partner with consumers. Its intention is to create a health service that is responsive to patient, carer and consumer input and needs. It applies, in conjunction with Standard 1, to the implementation of all other Standards. In considering implementation of Standard 2 in small rural hospitals, there may be a number of informal consultation mechanisms that already exist that could be formalised in order to meet the requirements of this Standard. Meeting this Standard does not necessarily require consumers as committee members, but may involve many other forms of partnership as outlined below.

Consumer partnership in service planning

Action	Overview of what is required	Suggested approach in small hospitals
2.1 Establishing governance structures to facilitate partnerships with consumers and/or carers		
2.1.1 Consumers and/or carers are involved in the governance of the health service organisation	• This action is the core of Standard 2. It relates to the development of an overarching governance and policy framework that sets out the requirements for involving consumers and carers in the governance processes of the hospital. This is an important platform for the specific policies, procedures and/or protocols that are needed to establish and maintain partnerships in practice. • The items and actions in Standard 2 cover a range of specific activities that relate to the establishment, maintenance and use of partnerships to improve care. These actions should all be linked to, or align with the overarching governance and policy framework required in Action 2.1.1. There are three broad types of actions that are included in the Standard: – actions related to processes for partnering with consumers to improve decision-making, planning and evaluation (Actions 2.2.1, 2.2.2, 2.5.1, 2.8.1, 2.8.2, 2.9.1, 2.9.2). Although the topic areas that are covered by these actions vary, the systems that can be used to address them are similar and may be useful for a number of different actions.	• Identify whether your local health network or private hospital group has a policy and governance framework on partnering with consumers. • If there is a policy, you should make sure it is enacted in your hospital. • If there is no policy, you should create one at a local level for your needs. A first step in this process should be to examine the existing local governance arrangements and to consider whether these could be used or modified to support the establishment of partnerships and involvement of consumers in the governance of your hospital. • Options for involving consumers in the governance of your organisation include: – involving consumers as representatives on the board or existing committees – creating or reviewing an existing consumer advisory committee – these can be ongoing or for specific topics – using less formal mechanisms, such as a ‘critical friends’ group – seeking feedback on governance issues by speaking with consumers in waiting rooms, doing informal surveys or speaking with local consumer and community groups. • Contact your state-based consumer group or local community groups for advice on how to engage with consumers and carers.

Action	Overview of what is required	Suggested approach in small hospitals
2.1 Establishing governance structures to facilitate partnerships with consumers and/or carers (continued)		
2.1.1 (continued)	– actions that relate to the provision of training (Actions 2.3.1, 2.6.1, 2.6.2). These include training for consumers and the clinical workforce. – actions that relate to information for consumers (Actions 2.4.1, 2.4.2, 2.7.1). These include the development and use of patient information publications, and the dissemination of information about the safety and quality of the hospital.	
2.1.2 Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people who do not usually provide feedback	• This action builds on Action 2.1.1 and relates to the need to ensure that governance partnerships are reflective of the diversity of the population served by your hospital. • Hospitals need to demonstrate an understanding of the population of people who use their service and the broader community. • Where there are specific diverse or hard-to-reach groups within this population, strategies to involve them should be included in the overarching policy framework (Action 2.1.1).	• Identify whether your local health network or private hospital group has undertaken a community profile or similar project to identify the types of consumers who access your services. • If this has not been done at a regional level you can identify these groups by working with others within your community (such as community groups, Medicare Locals, local government and professional associations) to share knowledge about community needs. • If diverse and hard-to-reach consumers use your services and are not involved in your hospital's governance, you should adapt your governance arrangements. You could: – seek out members of these groups to be committee or board members – hold informal meetings for diverse and hard-to-reach consumers and carers to talk about governance issues – work with local community groups which represent consumers from diverse and hard-to-reach groups to provide input on governance issues.

Consumer partnership in service planning

Action	Overview of what is required	Suggested approach in small hospitals
2.2 Implementing policies, procedures and/or protocols for partnering with patients, carers and consumers in: • **strategic and operational/services planning** • **decision-making about safety and quality initiatives** • **quality improvement activities**		
2.2.1 The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation	• This action is the first of a series of actions that relate to the formation of partnerships with consumers for the purpose of safety and quality improvement. • Action 2.2.1 relates to the establishment of systematic processes for involving consumers in strategic and/or operational planning.	• If your strategic and operational planning is done at a local health network or private hospital group level, you should encourage and support people who receive care in your hospital to participate in these processes. • If you are responsible for your local strategic and operational planning locally, and consumers are not actively involved, you should adapt your local processes. This could be done by: – inviting consumers onto relevant committees – talking with consumers in waiting rooms or at informal meetings – using data about consumer experiences (such as state-based patient-experience surveys or local surveys) to help identify key issues and opportunities for improvement – creating a 'critical friends' group to provide input on issues and decision-making – meeting with community and consumer organisations to identify key issues and opportunities for improvement – holding a workshop with staff and consumers to discuss key issues and opportunities for improvement – consulting with long stay residents.
2.2.2 Consumers and/or carers are actively involved in decision-making about safety and quality	• Action 2.2.2 relates to the establishment of systematic processes for involving consumers in decision-making about safety and quality. • This action also relates to the formation of partnerships with consumers for the purpose of improvement.	• If your safety and quality decision-making is done at a local health network or private hospital group level, you should encourage and support people who receive care in your hospital to participate in these processes. • If you are responsible for your safety and quality decision-making locally, and consumers are not actively involved, you should adapt your processes. • See Action 2.2.1 for strategies that could be used to involve consumers at a local level.

Action	Overview of what is required	Suggested approach in small hospitals
2.3 Facilitating access to relevant orientation and training for consumers and/or carers partnering with the organisation		
2.3.1 Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role	• Action 2.3.1 relates to the provision of training for consumers. • Ensuring that consumers have the necessary skills and capacity to engage with the health workforce as equal partners is essential for effective and sustainable partnerships. Facilitating access to relevant orientation and training for consumers is an important component of this process. • The provision of education and training may be more applicable for consumers who are involved in formal partnerships with your hospital (such as members of committees). • If consumers are involved in informal partnerships (such as waiting room discussions or forums), you still need to ensure that they: – are aware that the information that they provide is separate to the process of providing or receiving care and will not affect their treatment – have an understanding of the process in which they are participating and how the information they provide will be used – have an opportunity to provide further comment at a later time if they wish – have an opportunity to raise concerns about the process if they wish.	• Identify whether there is a process for orienting and training consumer representatives at the local health network, private hospital group level. • If there is a process, then ensure that it is in place in your hospital and functioning effectively. • If there is not, ensure that consumers who are engaged with your hospital in formal governance roles are provided with orientation and training. This can done be by: – facilitating access to online training and support materials developed by other organisations (such as consumer organisations) – providing a tour of the facility, introducing the consumer to key staff and providing an explanation of the role and expectations of their involvement – having a key staff member meet with the consumer regularly to touch base and identify any information required or skills which the consumer would like to develop as part of their role.

Consumer partnership in service planning

Action	Overview of what is required	Suggested approach in small hospitals
2.4 Consulting consumers on patient information distributed by the organisation		
2.4.1 Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for distribution to patients)	• These actions relate to the preparation of patient information publications that are developed within the hospital. • The provision of information is one of the key principles that underpins effective partnerships. The intent of these actions is to ensure that information is presented in a way that is suitable for and can be understood by the target audience. • Patient information publications are publications that are provided to patients and are directly relevant to their health care. These may include information sheets on a condition or medication, forms provided to patients, information on services and healthcare options.	• If you use publications that have been developed externally, for example by state or territory health departments or other external providers, try to source information that has been developed with input from consumers. • If you are developing patient information publications locally, obtain and document feedback from consumers about information publications by: – discussing publications with consumers in waiting rooms – holding a focus group or workshop with consumers – making follow-up phone calls to consumers who have been provided with information publications – conducting a survey (electronic, mail or phone) of consumers who have been provided with information publications.
2.4.2 Action is taken to incorporate consumer and/or carers' feedback into publications prepared by the health service organisation for distribution to patients.	• When patient information publications are developed within the hospital, consumers and/or carers should provide feedback on them (Action 2.4.1) and this feedback should be included into the final publications (Action 2.4.2).	• Use the feedback received from consumers to: – modify or improve existing patient information publications developed locally – identify areas of need for new information publications.

Consumer partnership in designing care

Action	Overview of what is required	Suggested approach in small hospitals
2.5 Partnering with consumers and/or carers to design the way care is delivered to better meet patient needs and preferences		
2.5.1 Consumers and/or carers participate in the design and redesign of health services	• This action also relates to the formation of partnerships with consumers to improve health services. • Action 2.5.1 relates to the specific processes associated with partnering with consumers in the design and redesign of health services. • Design and redesign activities include improvement initiatives that change the way a process is undertaken to increase its efficiency, continuity, appropriateness, effectiveness, consumer focus and/or safety. These activities can range in scope from designing new units such as emergency departments, to making changes to patient flow processes in outpatient clinics, to reviewing issues associated with patients not arriving for appointments.	• If your design and redesign activities occur at a local health network or private hospital group level, you should encourage and support people who receive care in your hospital to participate in these processes. • If responsibility for design and redesign activities rests with your hospital, and consumers are not actively involved, you should adapt your processes. This could be done by: – having consumers participate in working groups or steering groups – involving state-based consumer organisations throughout design projects – gathering information about the views of consumers on the design of the environment and services, by using surveys or feedback forms and using information from complaints.

Consumer partnership in designing care

Action	Overview of what is required	Suggested approach in small hospitals
2.6 Implementing training for clinical leaders, senior management and the workforce on the value of and ways to facilitate consumer engagement and how to create and sustain partnerships		
2.6.1 Clinical leaders, senior managers and the workforce access training on patient-centred care and the engagement of individuals in their own care	• These actions relate to training of the clinical workforce. • Action 2.6.1 relates to training for the clinical workforce about partnerships that exist between a consumer or patient and a clinician when care is provided. These types of partnerships can be commonly called 'patient-centred care', 'consumer-centred care' or 'patient engagement'. • There are many issues that can be included in training about these kinds of partnerships, including: – sharing treatment decisions – guiding patients to appropriate sources of information on health and health care – eliciting and taking account of patients' preferences – communicating information on risk and probability – providing support for self-care and self-management. • Action 2.6.2 builds on Action 2.6.1 and relates to the involvement of consumers in training of the clinical workforce about these kinds of partnerships.	• Offer training for the clinical workforce on partnerships with consumers. This could involve: – facilitating access to external training courses about partnering with consumers. Options may include state or territory consumer organisations or health departments, local health networks, Medicare Locals and local consumer organisations – adapting training materials on partnerships with consumers developed by other organisations into existing orientation and training. Your local health network, consumer organisations, state health department or other hospitals in your area may have developed these materials – inviting consumers or your local consumer organisation to speak to the clinical workforce.
2.6.2 Consumers and/or carers are involved in training the clinical workforce		• If training about partnerships with consumers is delivered by an external provider, try and use a provider that involves consumers. • If you deliver training to the clinical workforce locally, you could: – invite consumers or your local consumer organisation to speak to staff – talk to consumers and carers in waiting areas about what they think is important to include in training about partnerships for the clinical workforce – hold workshops or focus groups with consumers to seek their advice on key information, resources and strategies for training the clinical workforce in partnerships – invite consumers to attend and review training sessions to ensure the training reflects their needs and perspectives.

Consumer partnership in service measurement and evaluation

Action	Overview of what is required	Suggested approach in small hospitals
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		
2.7.1 The community and consumers are provided with information that is meaningful and relevant on the organisation's safety and quality performance	• There is an increasing focus in the health system on public reporting of information as a way of providing a comprehensive picture of safety and quality, monitoring trends and driving changes to the system. • While the focus of these activities is often at a system level, hospitals can use equivalent strategies to provide information that will support the development of partnerships with consumers and the local community. • Action 2.7.1 relates to the provision of information about safety and quality performance to the community, consumers and carers.	• Contribute safety and quality performance information into communication and dissemination processes carried out by your local health network or private hospital group. This could also include contributing safety and quality performance data that is provided to state or territory health departments and published in reports and the My Hospitals web site: www.myhospitals.gov.au. • Examples of how to provide information to your consumers and community include: – developing information sheets/posters on safety and quality performance for consumers and/or carers to read within waiting areas – attending and presenting information about your hospital, including safety and quality performance information, at local community meetings, business meetings or community events.
2.8 Consumers and/or carers participating in the analysis of safety and quality performance information and data, and the development and implementation of action plans		
2.8.1 Consumers and/or carers participate in the analysis of organisational safety and quality performance **2.8.2** Consumers and/or carers participate in the planning and implementation of quality improvements	• These actions relate to the formation of partnerships with consumers for the purpose of improvement, with a particular focus on safety and quality performance. • These actions relate to the involvement of consumers in both the review of organisational safety and quality performance information (Action 2.8.1), and the development of improvements based on this information (Action 2.8.2). • These actions relate to the processes for involving consumers in safety and quality decision-making (Action 2.2.2).	• If the review of safety and quality performance information and development of quality improvements for your hospital is done at a local health network or private hospital group level, you should encourage and support people who receive care in your hospital to participate in these processes. • If your hospital is responsible for the review of safety and quality performance information and development of quality improvements, and consumers are not actively involved, you should develop a process that suits your needs. • See Action 2.2.1 for strategies that could be used to involve consumers at a local level.

Consumer partnership in service measurement and evaluation

Action	Overview of what is required	Suggested approach in small hospitals
2.9 Consumers and/or carers participating in the evaluation of patient feedback data and development of action plans		
2.9.1 Consumers and/or carers participate in the evaluation of patient feedback data	• These actions relate to the formation of partnerships with consumers for the purpose of improvement, with a particular focus on the experience of patients. • These actions relate to the involvement of consumers in both the review of patient feedback data (such as from surveys) (Action 2.9.1), and the development of improvements based on this information (Action 2.9.2).	• If the review of patient feedback data and development of quality improvements is done at a local health network or private hospital group level, you should encourage and support people who receive care in your hospital to participate in these processes. • If your hospital is responsible for the review of patient feedback data and development of quality improvements locally, and consumers are not actively involved, you should develop a process that suits your needs. • See Action 2.2.1 for strategies that could be used to involve consumers at a local level.
2.9.2 Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data		

Key resources

Australian Commission on Safety and Quality in Health Care. *Safety and Quality Improvement Guide Standard 2: Partnering with Consumers*. Sydney. ACSQHC, 2012. www.safetyandquality.gov.au/our-work/accreditation/nsqhss/safety-and-quality-improvement-guides-and-accreditation-workbooks/

Consumer Focus Collaboration. *Improving health services through consumer participation: A resource guide for organisations*. Canberra. Commonwealth Department of Health and Aged Care, 2000 www.healthissuescentre.org.au/documents/detail.chtml?filename_num=226531

Consumers' Health Forum of Australia. *Online training module: Guidelines for consumer representatives*. www.ourhealth.org.au/consumer-rep-support/online-training-and-education

US Institute for Patient- and Family-Centered Care. *Advancing the Practice of Patient- and Family-Centered Care: How to Get Started*. Bethesda. IPFCC, 2008:1-28. www.ipfcc.org/pdf/getting_started.pdf

US Institute for Patient- and Family-Centered Care. *Advancing the Practice of Patient- and Family-Centered Care in Primary Care and Other Ambulatory Settings: How to Get Started*. Bethesda. IPFCC, 2008. www.ipfcc.org/pdf/GettingStarted-AmbulatoryCare.pdf

US Institute for Patient- and Family-Centered Care. Johnson B, Abraham M. *Partnering with patients, residents, and families: A resource for leaders of hospitals, ambulatory care settings, and long-term care communities*. Bethesda. IPFCC, 2012. www.ipfcc.org/resources/pinwheel/index.html

Victorian Quality Council. *Enabling the consumer role in clinical governance: A guide for health services*. Melbourne. VQC, 2005. www.health.vic.gov.au/qualitycouncil/downloads/clingov_cons.pdf

Notes

The intention of Standard 3 is to prevent patients from acquiring preventable healthcare associated infections and to use evidence-based strategies to effectively manage infections when they occur. In small hospitals, it is expected that all of the elements of an infection prevention and control program would be present, but application of the strategies and the monitoring processes will be less complex than in larger health services.

Governance and systems for infection prevention, control and surveillance

Action	Overview of what is required	Suggested approach in small hospitals
3.1 Developing and implementing governance systems for effective infection prevention and control to minimise the risks to patients of healthcare associated infections		
3.1.1 A risk management approach is taken when implementing policies, procedures and/or protocols for: • standard infection control precautions • transmission-based precautions • aseptic non-touch technique • safe handling and disposal of sharps • prevention and management of occupational exposure to blood and body substances • environmental cleaning and disinfection • antimicrobial prescribing • outbreaks or unusual clusters of communicable infection	• These actions are at the core of Standard 3. They describe the risk management approach that needs to be taken to understand and evaluate the risks associated with the services provided by the hospital and the patients treated in the hospital. To critically review these risks, a process of identification and prioritisation needs to occur. This should include: – undertaking a gap analysis and review of the effectiveness of governance arrangements, systems, processes and practices – identifying where the hospital is performing well and meets the intent of Standard 3 – identifying those areas where there may be gaps or further work to be undertaken to meet the intent of Standard 3 – using the findings to develop an action plan that prioritises how to respond to the gaps identified using available resources. • There are strong links between other *NSQHS Standards* and Standard 3, and these should be considered as part of the risk management process. Of particular importance are: *Standard 1: Governance for Safety and Quality in Health Service Organisations, Standard 2: Partnering with Consumers, Standard 4: Medication Safety,* and *Standard 6: Clinical Handover.*	• Identify where the governance and policy framework sits for infection prevention and control systems in your hospital. • If governance sits externally (e.g. with your local health network, private hospital group, state or territory), you will need to: – have an understanding of infection risks that exist within your hospital – ensure that infection risks for your hospital are addressed in the external governance and policy framework, and/or put in place additional systems locally as needed – ensure that infection prevention and control systems are operating effectively in your hospital – identify at least one suitable person to coordinate the effective governance of the different aspects of infection prevention and control in your hospital – routinely provide information about the performance of the infection prevention and control systems to this person. • If governance of the infection prevention and control system sits internally within your hospital, you will need to develop a governance and policy framework that meets the requirements of Standard 3. • Irrespective of whether the governance for infection prevention and control sits internally or externally, you still need to have a local risk management plan in place.

Governance and systems for infection prevention, control and surveillance

Action	Overview of what is required	Suggested approach in small hospitals
3.1 Developing and implementing governance systems for effective infection prevention and control to minimise the risks to patients of healthcare associated infections (continued)		
3.1.1 (continued) • processing of reusable medical devices • single-use devices • surveillance and reporting of data where relevant • reporting of communicable and notifiable diseases • provision of risk assessment guidelines to workforce • exposure-prone procedures	• This risk management approach is relevant for most of the components of Standard 3, including: – infection prevention and control strategies (Items 3.5 to 3.10) – managing patients with infections and colonisations (Items 3.11 to 3.13) – antimicrobial stewardship (Item 3.14) – cleaning, disinfection and sterilisation (Items 3.15 to 3.18).	
3.1.2 The use of policies, procedures and/or protocols is regularly monitored		• Policies need to include requirements for evaluating utilisation and compliance with policies, procedures and/or protocols. Monitoring processes may include: – conducting local audits, or participating in audits conducted by your local health network, private hospital group, state or territory – reviewing audit data and incidence of healthcare associated infections to identify where improvements are needed. • Examples of monitoring processes include auditing of hand hygiene, environmental cleaning, waste management and cleaning, disinfection and sterilising activities.

Governance and systems for infection prevention, control and surveillance

Action	Overview of what is required	Suggested approach in small hospitals
3.1 Developing and implementing governance systems for effective infection prevention and control to minimise the risks to patients of healthcare associated infections (continued)		
3.1.3 The effectiveness of the infection prevention and control systems is regularly reviewed at the highest level of governance in the organisation	See overview of what is required for Actions 3.1.1 and 3.1.2.	• Identify an individual, or small team, responsible for the governance arrangements regarding infection prevention and control in your hospital. This role needs to be identified locally, even if overall responsibility for governance regarding infection prevention and control sits with your local health network or private hospital group. • Routinely provide the results from audits, surveillance and incident reviews to the local governance body, and any relevant governance bodies within your a local health network, private hospital group, state or territory. • Include infection prevention and control on agendas, minutes and reports of the governing body.
3.1.4 Action is taken to improve the effectiveness of infection prevention and control policies, procedures and/or protocols		• Establish a review process to ensure currency of policies, procedures and protocols that meet the risks identified for your organisation. This may require feeding information from your hospital into reviews that are conducted by your local health network or private hospital group. • Use data to guide the development of improvement strategies such as: – using protocols from the local health network, private hospital group, state, territory or other external group (such as Hand Hygiene Australia) – including infection prevention and control as part of appraisal processes for the clinical workforce – ensuring that technological changes in products and equipment are reflected in local infection prevention and control practices – resolving any systems issues that may be identified (for example, timely access to necessary equipment) – making amendments to local policies, procedures and/or protocols or making recommendations to the local health network or private hospital group for policies that sit at that level – including infection prevention and control in local orientation programs

Action	Overview of what is required	Suggested approach in small hospitals
3.1 Developing and implementing governance systems for effective infection prevention and control to minimise the risks to patients of healthcare associated infections (continued)		
3.1.4 (continued)		(continued) – providing additional infection prevention education and training for clinicians and antibiotic prescribers (this may be done by your local health network, private hospital group, state or territory or other external organisations) – providing the results of audit, monitoring and evaluation activities to the workforce to encourage the development of local improvements – engaging the workforce to report and use the risk management system – improving or developing communication material and information resources for clinicians, patients and carers.
3.2 Undertaking surveillance of healthcare associated infections		
3.2.1 Surveillance systems for healthcare associated infections are in place	• Surveillance systems play an essential role in providing data and reliable information on the incidence and costs of infection. This can support good decision-making about the prevention of healthcare associated infections. • Surveillance activities include data collection, data analysis, interpretation and dissemination of results. • The type and scope of surveillance of healthcare associated infections will be determined by the complexity of services provided by the hospital and the requirements of state and territory departments of health.	• Participate in surveillance activities conducted by your local health network, private hospital group, state, territory or other external organisation. These surveillance activities may include the collection of data from other health and general practitioners. • Where available and appropriate, use nationally agreed definitions for surveillance activities.
3.2.2 Healthcare associated infections surveillance data are regularly monitored by the delegated workforce and/or committees		• Report surveillance data to the executive of your hospital, jurisdictional or other organisational bodies, any relevant committees and the clinical workforce for review, recommendations and feedback.

Governance and systems for infection prevention, control and surveillance

Action	Overview of what is required	Suggested approach in small hospitals
3.3 Developing and implementing systems and processes for reporting, investigating and analysing healthcare associated infections, and aligning these systems to the organisation's risk management strategy		
3.3.1 Mechanisms to regularly assess the healthcare associated infection risks are in place **3.3.2** Action is taken to reduce the risks of healthcare associated infection	• These actions are linked to Action 3.1.1 regarding the need to take a risk management approach to infection control and prevention policies, procedures and/or protocols. • Risk assessment can incorporate a range of data and information sources, including surveillance data, antimicrobial usage, surveys of the workforce, focus groups, incidents reports and results of other monitoring processes that are in place.	• Participate in risk assessment and data collection activities conducted by your local health network, private hospital group, state or territory. • Use risk assessment frameworks provided by your local health network, private hospital group, state or territory or other external organisations (such as Standards Australia) to undertake a local risk assessment process. • Ensure a process is in place in your hospital to consider how risks identified externally (such as an outbreak of influenza or viral gastroenteritis) are managed. • See Action 3.1.4 regarding improvement actions that can be undertaken locally.
3.4 Undertaking quality improvement activities to reduce healthcare associated infections through changes to practice		
3.4.1 Quality improvement activities are implemented to reduce and prevent healthcare associated infections **3.4.2** Compliance with changes in practice are monitored **3.4.3** The effectiveness of changes to practice are evaluated	• These actions relate to the overarching quality improvement approach that is needed to prevent and control infections and improve their management. • Activities undertaken as part of Actions 3.1.4, 3.5.3, 3.8.1, 3.10.2, 3.10.3, 3.11.2 to 3.11.5, 3.14.3, and 3.14.4 can be used to demonstrate compliance with these actions.	• Where relevant, participate in quality improvement activities that are conducted by your local health network, private hospital group, state or territory e.g. Antibiotic Awareness week. • When conducting quality improvement activities locally, use a standardised quality improvement methodology to bring about change. This methodology may be determined by your local health network, private hospital group, state or territory. • Undertake local audits, evaluations and reviews, or participate in external audits and evaluations of the impact of quality improvement activities. • See Action 3.1.4 regarding improvement actions that can be taken at a local level.

Action	Overview of what is required	Suggested approach in small hospitals
3.5 Developing, implementing and auditing a hand hygiene program consistent with the current national hand hygiene initiative		
3.5.1 Workforce compliance with current national hand hygiene guidelines is regularly audited	• These actions relate to the need for hospitals to implement and support a hand hygiene program that is consistent with the National Hand Hygiene Initiative. Further information can be found at Hand Hygiene Australia: www.hha.org.au. • The main components of this item are to; – audit compliance with the current national hand hygiene guidelines (Action 3.5.1) – report compliance rates (Action 3.5.2 – take action to improve compliance rates if needed (Action 3.5.3). • The frequency of compliance audits will be determined by the National Hand Hygiene Initiative, state and territory health departments, the local health network or private hospital group. • Some very small hospitals are not required to undertake direct observational auditing, and if unsure, should check with their state or territory health department, local health network, private hospital group or Hand Hygiene Australia.	• Identify whether or not your hospital needs to conduct direct observation auditing of hand hygiene compliance (less than 20 acute beds). • If so, undertake these audits in accordance with guidelines provided by Hand Hygiene Australia, your local health network, private hospital group, state or territory. • If not, use other methods to determine compliance of the workforce with hand hygiene requirements. Alternative methods include: – audit and evaluate the types of product available to the workforce – audit and evaluate the amount of hand hygiene products utilised – record the number of members of the workforce who have completed hand hygiene education and training.
3.5.2 Compliance rates from hand hygiene audits are regularly reported to the highest level of governance in the organisation		• See Action 3.1.3 regarding reporting of information to the highest level of governance. • In addition to reporting information to the executive of the hospital, information about hand hygiene compliance should be fed back to audited areas and specific workforce groups.
3.5.3 Action is taken to address non-compliance, or the inability to comply, with the requirements of the current national hand hygiene guidelines		• Review local work practices, equipment supplied and products used to identify opportunities to reduce risk of non-compliance or the inability to comply with hand hygiene requirements. • Include in the local risk assessment how non-compliance and the inability to comply with hand hygiene requirements will be managed in the organisation. • See Action 3.1.4 regarding improvement actions that can be taken at a local level.

Infection prevention and control strategies

Action	Overview of what is required	Suggested approach in small hospitals
3.6 Developing, implementing and monitoring a risk-based workforce immunisation program in accordance with the current National Health and Medical Research Council Australian immunisation guidelines		
3.6.1 A workforce immunisation program that complies with current national guidelines is in use	• The intent of this item is to ensure that hospitals have an immunisation program in place that meets the requirements of the *Australian Immunisation Handbook* (NHMRC, current edition), requirements of state and territory departments of health and the identified risks of the organisation. • Hospitals need to ensure that their policies, procedures and/or protocols address employer and employee responsibilities for management of occupational risks for vaccine preventable diseases and infections. • The risk assessment for the hospital (Action 3.1.1) will assist with identifying high risk areas and members of the workforce for immunisation.	• Identify whether there is an immunisation program for the workforce in your hospital that is conducted by your local health network, private hospital group, state or territory. • If there is, your hospital should participate in this program. You need to ensure that this program addresses the specific risks that have been identified locally for your hospital (Action 3.1.1). • If there is not, your hospital could: – manage a program locally to immunise your workforce – outsource immunisation services to an external provider – collaborate with another hospital or health service organisation to provide the program. • Develop or review policies, procedures and protocols (or contracts) to reflect the process the organisation is using. • Where relevant, review local recruitment requirements to ensure new employees, contractors and students are compliant with immunisation policies prior to working in the hospital.

Action	Overview of what is required	Suggested approach in small hospitals
3.7 Promoting collaboration with occupational health and safety programs to decrease the risk of infection or injury to healthcare workers		
3.7.1 Infection prevention and control consultation related to occupational health and safety policies, procedures and/or protocols are implemented to address: • communicable disease status • occupational management and prophylaxis • work restrictions • personal protective equipment • assessment of risk to healthcare workers for occupational allergies • evaluation of new products and procedures	• The intent of this action is to ensure that the workforce has access to appropriate information, testing, training, counselling and vaccination programs. • The key task required for this action is to ensure that workplace health and safety policies, procedures and/or protocols include the priority areas specified in this action where the risk of injury or infection can be reduced for the health workforce. • Issues that need to be addressed will be informed by the organisation's risk assessment (Action 3.1.1) and may include: – occupational allergies such as skin conditions related to dermatitis or allergies related to gloves, skin antiseptics or hand hygiene products – finger nail status or wearing of jewellery in clinical settings – new product reviews or evaluations – exposure-prone procedures – management of members of the workforce with current infections. • Workplace health and safety policies, procedures and/or protocols should be based on legislation within each state and territory.	• Identify whether there are workplace health and safety policies, procedures and/or protocols within your local health network, private hospital group, state or territory that apply to your organisation. • If there are, these need to be effectively applied in your hospital. As part of this process, examine whether the priority areas identified in this action are included in these policies, procedures and/or protocols. • If there are not, you should already have in place policies, procedures and/or protocols for workplace health and safety as required by the legislation in your state or territory. Review these to ensure that they include the priority areas identified in this action. • Ensure that local processes are in place for dealing with incidents such as occupational exposures.

Infection prevention and control strategies

Action	Overview of what is required	Suggested approach in small hospitals
3.8 Developing and implementing a system for use and management of invasive devices based on the current national guidelines for preventing and controlling infections in health care		
3.8.1 Compliance with the system for the use and management of invasive devices is monitored	• The intent of this action is to ensure that there is aseptic insertion and safe maintenance of devices, which is critical to reducing infection risk. • The types of surgical and medical invasive devices used in your hospital will be determined by the scope of activity. Invasive devices are used in both procedural environments, such as operating theatres as well as wards and clinics. • The key task for this action is to review compliance with relevant regulations covering invasive devices. If necessary, systems that address the introduction, use and management of invasive devices in the hospital may need to be developed and implemented. • Issues that need to be addressed will be informed by the organisational risk assessment (Action 3.1.1) and may include: – criteria for the insertion of an invasive device (such as venous access devices and urinary catheters), and the time that the device is left in place – assessment of aseptic technique for insertion of devices – processes for maintenance of invasive devices – choice of appropriate devices by clinicians – monitoring patients for infection – incident reports regarding invasive devices.	• Identify whether there are policies, procedures and/or protocols regarding the use of invasive devices in your local health network, private hospital group, state or territory. • If there are, ensure that these are in place in your hospital and functioning effectively. These policies need to address the specific risks that have been identified locally for your hospital. • If not, you need to develop and implement a policy framework for invasive devices. The policy framework needs to cover supply and procurement, introduction, use, reuse, disposal, storage, fault management, recall, and evaluation of invasive devices. As part of the development of these policies, procedures and/or protocols, focus on invasive devices that are frequently used and where there is a risk of a healthcare associated infection as a result of their use. Incident reports and surveillance data can be used to identify risk areas.

Action	Overview of what is required	Suggested approach in small hospitals
3.9 Implementing protocols for invasive device procedures regularly performed within the organisation		
3.9.1 Education and competency-based training in invasive devices protocols and use is provided for the workforce who perform procedures with invasive devices	• This action is linked to Action 3.8.1 and aims to ensure that there are protocols in place for invasive device procedures. • This action requires consideration of the education needs of the clinical workforce to ensure that members of the workforce who perform procedures are competent in the skills required for safe insertion, use and maintenance of the device.	• Identify whether there are programs for education and competency assessment about safe use, insertion and maintenance of invasive devices that are required and/or delivered by your local health network, private hospital group, state or territory. • If this is the case, then use these programs to provide training to the clinical workforce. • If training is not available through your local health network, private hospital group, state or territory, examine options for using external training agencies to provide the required education. Alternatively, a group of hospitals could work together to develop and provide this education locally. • Policies need to be standardised to enable members of the clinical workforce who rotate between hospitals, including doctors and allied health staff, to be able to transfer training records for the devices used across multiple facilities. • Identify areas where usage of invasive devices is high, and prioritise education and training to these areas based on risk.

Infection prevention and control strategies

Action	Overview of what is required	Suggested approach in small hospitals
3.10 Developing and implementing protocols for aseptic technique		
3.10.1 The clinical workforce is trained in aseptic technique	• Aseptic technique protects patients during invasive clinical procedures by employing infection prevention and control measures that minimise, as far as practically possible, the presence of infectious agents. • The risk assessment for the hospital (Action 3.1.1) should be used to identify areas where aseptic technique is required. Compliance auditing should be conducted in areas of highest risk and highest use. Procedures where aseptic technique may be relevant include, but are not limited to: – intravenous therapy maintenance – simple dressings – complex or large dressings of wounds – urinary catheterisation – insertion and maintenance of vascular access devices including peripheral and central lines – surgical procedures. • These actions require providing training to the clinical workforce on: – aseptic technique (Action 3.10.1 and linked to Action 3.9.1) – auditing of compliance with aseptic technique (Action 3.10.2) – taking action for improvement as needed (Action 3.10.3).	• Aseptic technique can be included in orientation and induction programs, appraisal processes and performance reviews. • See Action 3.9.1 regarding provision of education and training to the clinical workforce.
3.10.2 Compliance with aseptic technique is regularly audited		• Conduct local audits, or participate in audits of compliance with aseptic technique conducted by your local health network, private hospital group, state or territory. • The extent and frequency of auditing of compliance with aseptic technique will be influenced by: – the clinical context where care is provided, such as emergency department, operating theatre or ward – the frequency with which aseptic technique is required – the treatment provided, such as the insertion of a peripheral venous access device or a dressing – when aseptic technique was last assessed – results of previous compliance audits.
3.10.3 Action is taken to increase compliance with the aseptic technique protocols		• See Action 3.1.4 for improvement actions that can be taken locally.

Managing patients with infections and colonisations

Action	Overview of what is required	Suggested approach in small hospitals
3.11 Implementing systems for using standard precautions and transmission-based precautions		
3.11.1 Standard precautions and transmission-based precautions consistent with the current national guidelines are in use	• 'Standard precautions' refers to work practices that ensure a basic level of infection prevention and control that apply to everyone, regardless of their perceived or confirmed infection status. • Transmission-based precautions are required when there is an increased risk of transmission, with patients suspected or confirmed to be infected with agents transmitted by contact, droplet or airborne routes. • Details of standard and transmission-based precautions are available in the *Australian Guidelines for the Prevention and Control of Infections in Health Care* (NHMRC 2010). • These actions require the use of standard and transmission-based precautions consistent with national guidelines (Action 3.11.1), monitoring of compliance with these precautions (Actions 3.11.2 and 3.11.4) and taking action to improve compliance with these precautions (Action 3.11.3 and 3.11.5). • The organisational risk assessment (Action 3.1.1) will identify gaps and assist with prioritising areas where improvements can be made.	• Ensure that information on standard and transmission-based precautions that is consistent with current national guidelines is available locally. • Where they are available and relevant, use resources that have been developed by your local health network, private hospital group, state or territory.
3.11.2 Compliance with standard precautions is monitored		• Conduct local audits, or participate in audits of compliance with standard precautions conducted by your local health network, private hospital group, state or territory.
3.11.3 Action is taken to improve compliance with standard precautions		• See Action 3.1.4 for improvement actions that can be taken at a local level.
3.11.4 Compliance with transmission-based precautions is monitored		• Conduct local audits, or participate in audits of compliance with transmission-based precautions conducted by your local health network, private hospital group, state or territory.
3.11.5 Action is taken to improve compliance with transmission-based precautions		• See Action 3.1.4 for improvement actions that can be taken at a local level.

Managing patients with infections and colonisations

Action	Overview of what is required	Suggested approach in small hospitals
3.12 Assessing the need for patient placement based on the risk of infection transmission		
3.12.1 A risk analysis is undertaken to consider the need for transmission-based precautions including: • accommodation based on the mode of transmission • environmental controls through air flow • transportation within and outside the facility • cleaning procedures • equipment requirements	• The intent of this action is to minimise exposure of patients and the workforce to infectious agents such as gastroenteritis, seasonal influenza or multi-resistant organisms. This action builds on Item 3.11, with a particular focus on transmission-based precautions. • Placing colonised or infectious patients in single rooms, cohort rooms or cohort areas as a component of a multifaceted infection control policy can reduce acquisition rate and infection. • The organisational risk assessment (Action 3.1.1) will provide information about risk areas and gaps for improvement.	• Review what systems your hospital has in place to manage patients who may require transmission-based precautions. Focus on the high priority areas identified in the organisational risk assessment. • Develop strategies to transfer patients who cannot be safely placed in your organisation. • See Action 3.1.1 regarding the organisational risk assessment and policies, procedures and/or protocols for infection control and prevention.
3.13 Developing and implementing protocols relating to the admission, receipt and transfer of patients with an infection		
3.13.1 Mechanisms are in use for checking for pre-existing healthcare associated infections or communicable disease on presentation for care **3.13.2** A process for communicating a patient's infectious status is in place whenever responsibility for care is transferred between service providers or facilities	• The intent of these actions is to minimise exposure of other patients and the workforce to infectious agents from admitted or transferred patients. • The main tasks for these actions are to; – check a patient's pre-existing healthcare associated infection or communicable disease status (Action 3.13.1) – communicate this information whenever responsibility for care is transferred (Action 3.13.2). • Key times when a patient's infectious status should be evaluated and documented include: – on admission and presentation – at every handover – during clinical review and consultation – on transfer and discharge. • This action is linked to the requirements of *Standard 6: Clinical Handover*.	• Ensure that a patient's infectious status is included in the structured handover systems that are required in *Standard 6: Clinical Handover*. The handover system may be developed and implemented through your local health network, private hospital group, state or territory. • The organisational risk assessment (Action 3.1.1) will help to identify areas of high priority for action. • Options for action include: – identifying admission and entry points to your hospital – reviewing how healthcare associated infection risk is assessed and responded to by members of the workforce responsible for admission and bed management, and by medical officers – identifying whether there is an alert or flagging system for infectious patients – working with referral points such as clinics, domiciliary care, aged care facilities, emergency admissions and doctor's rooms regarding opportunities for risk assessment.

Antimicrobial stewardship

Action	Overview of what is required	Suggested approach in small hospitals
3.14 Developing, implementing and regularly reviewing the effectiveness of the antimicrobial stewardship system		
3.14.1 An antimicrobial stewardship program is in place	• The intent of these actions is to encourage appropriate prescribing of antimicrobials as part of the broader systems within a hospital to prevent and manage healthcare associated infections. • This guide should be read in conjunction with the information provided in the *Safety and Quality Improvement Guide for Standard 3: Preventing and Controlling Healthcare Associated Infections* (ACSQHC 2012), Item 3.14, and with the guidance provided for *Standard 4: Medication Safety*. • An antimicrobial stewardship program (AMS) is a combination of a range of complementary strategies and interventions that work together to optimise antimicrobial use. • An overarching antimicrobial stewardship program is a requirement of Action 3.14.1. The organisation should have a program plan for antimicrobial stewardship that includes actions and timelines for implementation. The program should include: – the necessary governance structure to support antimicrobial stewardship activity, with the explicit support of the facility leadership – a team to co-ordinate the program activities relevant to the facility size and complexity (this could be at network or facility level) – a prescribing policy consistent with the current endorsed *Therapeutic Guidelines: Antibiotic* – an antimicrobial formulary and guidelines for treatment and prophylaxis that align with the current endorsed *Therapeutic Guidelines: Antibiotic* – access to current endorsed *Therapeutic Guidelines: Antibiotic* (Action 3.14.2)	• Antimicrobial stewardship programs need to be tailored to each hospital, based on factors such as its complexity, size and resources. • Your hospital may need to manage the implementation of this criterion through visiting clinicians, networks and/or contracts for professional clinical services. • Identify whether there are policies, procedures and/or protocols regarding antimicrobial stewardship in your local health network, private hospital group, state or territory. • If there are, ensure that these are in place in your hospital and functioning effectively. These policies need to address the specific risks that have been identified locally for your hospital. • Irrespective of where the governance for antimicrobial stewardship sits, review or establish a local antimicrobial plan and implementation strategy based on the priorities identified in your organisational risk assessment (Action 3.1.1). As part of this process, you need to identify: – what governance will be required locally to support the program – how, and by whom, the program will be coordinated – what resources will be needed locally to maintain the program, and what resources can be obtained externally (such as specialist advice for complex clinical conditions). • Engaging local prescribers in the AMS team and development of the AMS policy and plan is a useful way to obtain prescriber buy-in to the AMS program. • Ensure the antimicrobial prescribing policy clearly outlines the process for seeking specialist infectious diseases or medical microbiology advice, and the indications for seeking this advice. • Inform prescribers about the policy and how to access it. • The antimicrobial formulary should take into account the clinical needs of the hospital and be informed by local microbiologic information. It should list antimicrobials with restrictions on their use and the conditions of these restrictions.

Antimicrobial stewardship

Action	Overview of what is required	Suggested approach in small hospitals
3.14 Developing, implementing and regularly reviewing the effectiveness of the antimicrobial stewardship system (continued)		
3.14.1 (continued)	– monitoring of antimicrobial usage and resistance (Action 3.14.3) – systems and processes for evaluating and improving effectiveness of AMS activities (Action 3.14.4).	• The committee responsible for drugs and therapeutics should develop and maintain the prescribing policy and formulary, with advice from microbiology and infectious diseases services in the hospital, or from the local health network, private hospital group, state or territory (for example an approved state-wide formulary or antibiogram).
3.14.2 The clinical workforce prescribing antimicrobials have access to current endorsed therapeutic guidelines on antibiotic usage		• Ensure that clinicians have access to current endorsed *Therapeutic Guidelines: Antibiotic* or state based endorsed guidelines on antibiotic usage. • Where they are available and relevant, use resources that have been developed by your local health network, private hospital group, state or territory. • Ensure there is version control of prescribing guidelines. See also Action 3.1.1 as well as *Standard 1: Governance for Safety and Quality in Health Service Organisations* and *Standard 4: Medication Safety*.
3.14.3 Monitoring of antimicrobial usage and resistance is undertaken	See overview of what is required for Actions 3.14.1 and 3.14.2.	• Conduct local audits and reviews as part of the local antimicrobial stewardship program, or participate in reviews and monitoring processes regarding antimicrobial usage and resistance conducted by your local health network, private hospital group, state or territory. • Monitor antibiotic usage appropriate to the scope of services provided by your hospital. High use or high expenditure can provide a 'flag' for facilities to undertake a more detailed analysis of usage. See *Safety and Quality Improvement Guide for Standard 3: Preventing and Controlling Healthcare Associated Infections* (ACSQHC 2012), Action 3.14.3. • Monitoring usage activities might include: – reviewing the list of stock ordered and used each month, as well as reviewing monthly expenditure on antimicrobials – reviewing antimicrobial use in high risk areas in relation to specific procedures, clinical condition, or identified high risk antimicrobials – auditing medical records regarding surgical prophylaxis antibiotic utilisation and prophylaxis extending beyond 24 hours.

Action	Overview of what is required	Suggested approach in small hospitals
3.14 Developing, implementing and regularly reviewing the effectiveness of the antimicrobial stewardship system (continued)		
3.14.3 (continued)		• Monitoring resistance activities might include: – monitoring infection rates for surgery, and the insertion of medical devices – conducting targeted surveillance for multiresistant organisms where appropriate – using surveillance where appropriate.
3.14.4 Action is taken to improve the effectiveness of antimicrobial stewardship		• As well as the monitoring activities suggested in Action 3.14.3, actions that can be taken include: – reviewing adverse events related to antimicrobial prescribing – using audit tools to assess effectiveness of antimicrobial use, such as quality use of medicines (QUM) indicators – reviewing the duration of use of antimicrobials – implementing an 'IV to oral' policy – auditing prescribing compliance against recommendations in current endorsed *Therapeutic Guidelines: Antibiotic*, or stated-based endorsed guidelines – auditing documentation of 'indication to prescribe' and 'stop or review date' for antimicrobial use in the medical record/medication chart – providing regular feedback to prescribers, pharmacists and clinicians on outcomes of audit and monitoring activity – providing education for those who prescribe, administer or dispense antimicrobials on antimicrobial resistance and the appropriate prescribing and use of antimicrobials (consider available on-line programs such as antimicrobial prescribing modules: www.nps.org.au/health_professionals/online_learning) – providing patient education on safe and appropriate use of antibiotics. • See also Action 3.1.4 for improvement actions that can be taken locally. In addition, further examples are provided in the *Safety and Quality Improvement Guide for Standard 3: Preventing and Controlling Healthcare Associated Infections* (ACSQHC 2012), particularly Items 3.14 and Table 2 • Detailed information about antimicrobial stewardship interventions is available in *Antimicrobial Stewardship in Australian Hospitals* (ACSQHC 2011), and a range of resources can be accessed at http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/antimicrobial-stewardship/

Cleaning, disinfection and sterilisation

3.15 Using risk management principles to implement systems that maintain a clean and hygienic environment for patients and healthcare workers

Action	Overview of what is required	Suggested approach in small hospitals
3.15.1 Policies, procedures and/or protocols for environmental cleaning that address the principles of infection prevention and control are implemented, including: • maintenance of building facilities • cleaning resources and services • risk assessment for cleaning and disinfection based on transmission-based precautions and the infectious agent involved • waste management within the clinical environment • laundry and linen transportation, cleaning and storage • appropriate use of personal protective equipment	• The intent of these actions is to provide a clean and hygienic environment for patients and the workforce to minimise infection risk to patients and the workforce. • The scope of these actions includes: – maintenance and cleaning of buildings and infrastructure – waste and linen handling and management – cleaning, disinfection and sterilisation activities for reusable equipment. • These actions require: – development, implementation and review of policies, procedures and/or protocols for environmental cleaning that address infection prevention and control (Actions 3.15.1 and 3.15.2) – establishment of an environmental cleaning schedule and associated audits (Action 3.15.3). • Where services are provided by an external service or contractor, the hospital is responsible for ensuring that these actions are met, including the development and review of its environmental cleaning schedule.	• Ensure that the environmental cleaning services in your hospital include principles of infection prevention and control and meet the requirements of this Standard. • Where services are provided by an external contractor, and coordinated by a local health network or private hospital group, ensure that these services address the specific risks that have been identified locally for your hospital (Action 3.1.1). • If problems occur with the environmental cleaning services locally, ensure that action is taken to raise these concerns and to ensure that they are addressed as part of your risk management system.
3.15.2 Policies, procedures and/or protocols for environmental cleaning are regularly reviewed		
3.15.3 An established environmental cleaning schedule is in place and environmental cleaning audits are undertaken regularly		

Action	Overview of what is required	Suggested approach in small hospitals
3.16 Reprocessing reusable medical equipment, instruments and devices in accordance with relevant national or international standards and manufacturers' instructions		
3.16.1 Compliance with relevant national or international standards and manufacturer's instructions for cleaning, disinfection and sterilisation of reusable instruments and devices is regularly monitored	• The intent of this action is to minimise infection risk to patients and the workforce from reusable equipment, instruments and devices. • The organisational risk assessment (Action 3.1.1) will identify gaps and areas of improvement to be addressed. Issues to be considered in this risk assessment include: – the requirements of the hospital for reprocessing reusable equipment or instruments – the equipment and consumables required to meet the reprocessing standards – outsourcing of this service to an external provider – purchase of sterile stock – services to external providers. • The standards for cleaning, disinfection and sterilisation of reusable instruments and devices are available in the *Australian Guidelines for the Prevention and Control of Infections in Health Care* (NHMRC 2010).	• Ensure that the processes for cleaning, disinfection and sterilisation of reusable instruments and devices in your hospital are carried out in accordance with national or international standards. • These services may be provided by an external contractor, and if your hospital is part of a local health network or private hospital group, this function may be coordinated at that level. Ensure that these services address the specific risks identified for your hospital (Action 3.1.1). • Review the hospital's scope of activity and the need to use reusable instruments and equipment, especially for invasive procedures. • Consider whether reusable instruments and equipment can be purchased as sterile or single use items. • Consider single use items in areas where there is infrequent use or the hospital does not have the resources to meet the national or international standards and manufacturer instructions for reusable items.

Cleaning, disinfection and sterilisation

Action	Overview of what is required	Suggested approach in small hospitals
3.17 Implementing systems to enable the identification of patients on whom the reusable medical devices have been used		
3.17.1 A traceability system that identifies patients who have a procedure using sterile reusable medical instruments and devices is in place	• The intent of this action is to minimise the risk of infection to patients from reusable medical devices. The ability to trace what items were used on which patients helps to manage the risks associated with the use of these devices. • This action builds on Action 3.16.1. You should consider what additional systems are needed to trace reusable devices and instruments. This may include identification of: – batch numbers – individual items or sets of items – patients that the items are used on – dates – steriliser identification – cycles – operators responsible for release of the item for use – sterile stock from external providers.	• See Action 3.16.1 regarding the need to comply with national and international standards for cleaning, disinfection and sterilisation of reusable instruments and devices. • If your hospital is part of a local health network or private hospital group that has a traceability system, ensure that this in place in your hospital. • As part of your organisational risk assessment (Action 3.1.1), review whether a traceability system is required. Some small hospitals will not need this type of system because they: – do not perform procedures where reusable instruments and equipment are used – only use single use or disposable instruments and equipment for procedures.
3.18 Ensuring workforce who decontaminate reusable medical devices undertake competency-based training in these practices		
3.18.1 Action is taken to maximise coverage of the relevant workforce trained in a competency-based program to decontaminate reusable medical devices	• The intent of this action is to minimise risks from reusable medical devices. This action builds on Actions 3.16.1 and 3.17.1. • Tasks required for this action include provision of competency-based training to the clinical workforce who use reusable medical devices. • Training should be provided to members of the workforce who decontaminate reusable medical devices in areas such as clinics and emergency departments, as well as operating theatres.	• See Action 3.9.1 regarding the provision of training to the clinical workforce.

Communicating with patients and carers

Action	Overview of what is required	Suggested approach in small hospitals
3.19 Ensuring consumer-specific information on the management and reduction of healthcare associated infections is available at the point of care		
3.19.1 Information on the organisation's corporate and clinical infection risks and initiatives implemented to minimise patient infection risks is provided to patients and/or carers **3.19.2** Patient infection prevention and control information is evaluated to determine if it meets the needs of the target audience	• The provision of information is one of the key principles that underpins effective partnerships. The intent of these actions is to ensure that information is provided to patients and carers and presented in a way that is suitable for, and can be understood by, the target audience. • Information needs to be provided to patients and/or carers about the infection risks in the hospital and the steps that are being taken to address these (Action 3.19.1). This information also needs to be evaluated to determine if it meets the needs of the target audience (Action 3.19.2). • Further information about consulting with patients and carers about patient information publications is available in *Standard 2: Partnering with Consumers* (Action 2.4.1).	• If you provide information about infection prevention and control that has been developed externally for example by your local health network or private hospital group, or other external organisation, try to use information that has been developed with input from patients and carers. • If you are developing information about infection risks and strategies locally, options for obtaining feedback include: – discussing infection prevention and control information with patients and carers in waiting rooms – holding a focus group or workshop with patients and carers – making follow-up phone calls to patients and carers who have been provided with information – conducting a survey (electronic, mail or phone) of people who have been provided with infection prevention and control information. • Use the information received from the feedback to: – modify or improve existing patient infection prevention and control documents developed locally – identify areas of need for new publications.

Key resources

Antimicrobial Stewardship in Australian Hospitals (ACSQHC 2011)
http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/antimicrobial-stewardship/

Australian Commission on Safety and Quality in Health Care – Healthcare Associated Infection Program web site.
http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/

Australian Commission on Safety and Quality in Health Care. *OSSIE toolkit for the Implementation of the Australian Guidelines for the Prevention of Infection in Health Care*. Sydney, ACSQHC, 2010.
http://www.safetyandquality.gov.au/publications/the-ossie-toolkit-for-the-implementation-of-the-australian-guidelines-for-the-prevention-of-infection-in-health-care-2010/

Australian Commission on Safety and Quality in Health Care. *Safety and Quality Improvement Guide Standard 3: Preventing and Controlling Healthcare Associated Infections*. Sydney, ACSQHC, 2012.
http://www.safetyandquality.gov.au/our-work/accreditation/nsqhss/safety-and-quality-improvement-guides-and-accreditation-workbooks/

Australian Commission on Safety and Quality in Health Care. *Safety and Quality Improvement Guide Standard 4: Medication Safety*. Sydney, ACSQHC, 2012.
http://www.safetyandquality.gov.au/our-work/accreditation/nsqhss/safety-and-quality-improvement-guides-and-accreditation-workbooks/

Duguid M, Cruickshank M (eds). Antimicrobial Stewardship in Australian Hospitals, Sydney, ACSQHC, 2011.
http://www.safetyandquality.gov.au/publications/antimicrobial-stewardship/

Hand Hygiene Australia
http://www.hha.org.au

National Health and Medical Research Council. *Australian Guidelines for the Prevention and Control of Infection in Health Care*. Canberra, NHMRC, 2010.
http://www.nhmrc.gov.au/guidelines/publications/cd33

Therapeutic Guidelines Antibiotic available at:
http://www.tg.org.au

Notes

The intention of this Standard is to ensure that competent clinicians safely prescribe, dispense and administer the appropriate medicines to patients who are informed about their medicines. Small hospitals may need to manage the implementation of this Standard through visiting clinicians, networks and/or contracts for professional clinical services because these health services are too small to engage clinicians in their own right.

As with Standard 3, all of the elements of a comprehensive medication safety management system are to be in place. However, the strategies and the monitoring processes will be less complex than in larger health services.

Governance and systems for medication safety

Action	Overview of what is required	Suggested approach in small hospitals
4.1 Developing and implementing governance arrangements and organisational policies, procedures and/or protocols for medication safety, which are consistent with national and jurisdictional legislative requirements, policies and guidelines		
4.1.1 Governance arrangements are in place to support the development, implementation and maintenance of organisation-wide medication safety systems	• The organisation-wide medication safety system brings together the policies, procedures and/or protocols that ensure: – appropriate medication governance and systems – patient information processes including medication history, previous adverse drug reactions and medication reconciliation – medication management processes supported by information, appropriate storage and risk management – medication management continuity through current information – involving patients and carers in decision-making. • The main components of the organisation-wide medication safety system included in this Standard concern processes for safe: – prescribing – dispensing – supplying – administering – reconciling – storing	• Identify whether there is a medication safety governance framework within your hospital that includes: – the governance group/committee with responsibility for the medication management system – reporting lines – specific roles and responsibilities – communication processes – training requirements – evaluation, audit and feedback processes – arrangements with external organisations where services are contracted for all or part of the medication management system. • If there is, then you should ensure that it is functioning effectively, and regularly review the roles, responsibilities and accountabilities described in the framework. • If there is not, then you should identify a suitable individual or group to take responsibility for medication safety, and to establish a governance framework, and consider participation in a local health network or private hospital group governance. • Ensure that the responsibility for implementing decisions about medication management is clear, and that there are mechanisms for communicating decisions and medication safety alerts.

Action	Overview of what is required	Suggested approach in small hospitals
4.1 Developing and implementing governance arrangements and organisational policies, procedures and/or protocols for medication safety, which are consistent with national and jurisdictional legislative requirements, policies and guidelines (continued)		
4.1.1 (continued)	– manufacturing – compounding – monitoring of the effects of medicines. • The medication safety system that is put in place must reflect legal and other national, state/territory and local requirements.	• Provide education and training to members of the workforce who are involved in medication safety. This training may be delivered locally or externally. Training should include orientation for new staff, and ongoing education on medication safety risks and strategies to address the risks. • Ensure contracts and agreements for the provision of services by health practitioners meet the health service organisation's governance requirements. For example, the service provider has in place mechanisms to ensure their agent (clinical practitioner) is operating within their scope of practice, qualifications and professional credentials specified in the contract or agreement.
4.1.2 Policies, procedures and/or protocols are in place that are consistent with legislative requirements, national, jurisdictional and professional guidelines		
4.2 Undertaking a regular, comprehensive assessment of medication use systems to identify risks to patient safety and implementing system changes to address the identified risks		
4.2.1 The medication management system is regularly assessed	• Action 4.2.1 relates to the monitoring part of the quality improvement cycle. It concerns two important sources of information about the medication safety system: – safety self-assessments of the system – auditing use of the National Inpatient Medication Chart (NIMC).	• Assess the safety of the medication management system using existing tools such as the *Medication Safety Self Assessment® for Australian Hospitals*, selecting the elements that are relevant to your hospital. • Use a multidisciplinary team that includes frontline workforce to conduct the assessment and review the results of the assessment to identify opportunities for improvement. This may involve using staff from other hospitals within your local health network or private hospital group. • Include actions required to address any problems identified in the hospital's quality improvement plan (or equivalent for the local health network or private hospital group) and assign responsibilities. • Participate in national NIMC auditing, with the results considered by the medication safety governance group and identified areas for improvement and actions agreed.

Governance and systems for medication safety

Action	Overview of what is required	Suggested approach in small hospitals
4.2 Undertaking a regular, comprehensive assessment of medication use systems to identify risks to patient safety and implementing system changes to address the identified risks (continued)		
4.2.2 Action is taken to reduce the risks identified in the medication management system	• Action 4.2.2 relates to the improvement part of the quality improvement cycle. It requires corrective actions to be taken as a result of information obtained through medication safety self-assessment and NIMC auditing.	• Report on the medication safety self-assessment and audits to the medication safety governance group. • Identify actions required to improve the system, and include these in a quality improvement plan that assigns responsibilities and time frames for completion. • Submit the plan, and reports of actions, to the clinical governance committee and/or executive committee. • Add risks identified to the organisational risk register along with actions identified to address them. • Communicate assessment results and actions taken to clinical workforce.
4.3 Authorising the relevant clinical workforce to prescribe, dispense and administer medications		
4.3.1 A system is in place to verify that the clinical workforce have medication authorities appropriate to their scope of practice	• A critical part of the medication management system is that appropriate systems and checks are in place for ensuring the clinical workforce are authorised to participate in medication management. • Actions 4.3.1 to 4.3.3 relate to the implementation, monitoring and improvement parts of the quality improvement cycle. • The main tasks for these actions are: – identifying or implementing a medication authorisation system (4.3.1) – monitoring the medication authorisation system (4.3.2) – improving the performance of the medication authorisation system (4.3.3).	• Identify all areas where specific authorisation is required to prescribe, dispense, or administer medicines. • Identify, or develop and maintain, a log or register for individual professions and/or positions where an authority is required to prescribe, administer, or dispense medicines. • Ensure that qualifications and competencies are assessed when workforce is recruited. This may include: – sighting qualifications or registration certificates – checking if registered practitioners have conditions placed on their registration – assessing the practitioner's competency. • Ensure contracts for services specify the medication authorities in the scope of practice of the contractor.

Action	Overview of what is required	Suggested approach in small hospitals
4.3 Authorising the relevant clinical workforce to prescribe, dispense and administer medications (continued)		
4.3.2 The use of the medication authorisation system is regularly monitored	• A critical part of the medication management system is that appropriate systems and checks are in place for ensuring the clinical workforce are authorised to participate in medication management. • Actions 4.3.1 to 4.3.3 relate to the implementation, monitoring and improvement parts of the quality improvement cycle. • The main tasks for these actions are: – identifying or implementing a medication authorisation system (4.3.1) – monitoring the medication authorisation system (4.3.2) – improving the performance of the medication authorisation system (4.3.3).	• Implement a process for regular review and updating of the logs/registers of authorities to prescribe, administer or dispense medicines. • Review medication incidents in which unauthorised practitioners have prescribed, supplied or administered medicines. • Implement a system for revalidating authorities. This may include reassessment of competencies. • Ensure contracts for services require compliance with the medication authorisation system.
4.3.3 Action is taken to increase the effectiveness of the medication authority system		• Use information from Action 4.3.2 to identify when the system has been breached and implement changes to prevent further breaches.
4.4 Using a robust organisation-wide system of reporting, investigating and managing change to respond to medication incidents		
4.4.1 Medication incidents are regularly monitored, reported and investigated	• These actions relate to processes for recording, reporting and responding to medication incidents when they occur in hospitals. • Actions 4.4.1 and 4.4.2 relate to the monitoring and improvement parts of the quality improvement cycle. • The main tasks for these actions are ensuring that: – incident reporting occurs (Action 4.4.1) – outcomes are reviewed and reported (Action 4.4.1) – results inform medication safety system quality improvement (Action 4.4.2).	• Review all medication incidents, adverse events and near misses reported in the incident monitoring system. • Identify any trends in the type and causes of errors, particular areas in the medication management pathway where incidents are occurring, or specific medicines are involved. • Investigate incidents causing, or having the potential to cause, serious patient harm. This may involve in-depth analysis, and might be done externally. • Provide regular reports on medication incidents, adverse events, investigations and near misses to the medication safety governance group to consider and recommend actions to reduce the recurrence of incidents. • Identify whether there is a policy on reporting adverse drug reactions to the Therapeutic Goods Administration. If there is not, you need to have a policy about reporting and documenting adverse drug reactions (see Action 4.7.3).

Governance and systems for medication safety

Action	Overview of what is required	Suggested approach in small hospitals
4.4 Using a robust organisation-wide system of reporting, investigating and managing change to respond to medication incidents (continued)		
4.4.1 (continued)	• The quality improvement requirements of this item (Action 4.4.2) are linked to the strategies implemented as part of the organisation-wide medication safety system. These strategies may include: – reviewing reports – encouraging reports from staff – providing information back to staff on incident reporting outcomes and consequent actions.	• Ensure that the orientation program for healthcare professionals includes education and training on how to report medication incidents, near misses and adverse drug reactions, and encourage reporting. • Provide regular feedback to the workforce on incidents reported and actions required to prevent recurrence. • Implement systems with service contractors to retrieve information on patient medicines and medicine-related problems and make it available in the health service organisation patient clinical records.
4.4.2 Action is taken to reduce the risk of an adverse medication incidents	See overview of what is required for Action 4.4.1.	• Implement recommendations from incident investigations. • Encourage the clinical workforce to identify and report errors, and to develop potential solutions to reduce the risk of similar errors occurring. • Present solutions to the medication safety governance group for consideration and agreement on actions. • Include actions in the quality improvement plan along with timeframes for implementation and responsible personnel. • Include identified risks in the organisational risk register, with actions to address the risks. • Communicate to the workforce and students about medication incidents and actions and proposed practice changes to reduce occurrence.

Action	Overview of what is required	Suggested approach in small hospitals
4.5 Undertaking quality improvement activities to enhance the safety of medicines use		
4.5.1 The performance of the medication management system is regularly assessed	• These actions relate to processes for measuring, reporting and improving performance within the medication management system and responses to outcomes when obtained. • Actions 4.5.1 and 4.5.2 relate to the monitoring and improvement parts of the quality improvement cycle. • The main tasks for these actions are: – identify and implement suitable performance measures (Action 4.5.1) – quality improvement processes based on outcomes from performance measure auditing (Action 4.5.2). • Your hospital may already have tools to measure performance or be required to use tools that are developed by the local health network or private hospital group or adopt national tools.	• Select suitable performance measures that are relevant to the organisation's resources, medication safety strategies and initiatives, to monitor the safety and quality of the medication management system, and the effect of quality improvement activities. • Guidance can be found in *Indicators for Quality Use of Medicines in Australian Hospitals*. • Audit compliance with national and relevant state or territory medication safety recommendations, alerts and notices. Examples could include (but are not limited to): – auditing against the *National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines* – auditing the storage location and use of safety controls on storage of potassium ampoules – participating in the national NIMC audit (see Action 4.2.1).
4.5.2 Quality improvement activities are undertaken to reduce the risk of patient harm and increase the quality and effectiveness of medicines use	• Performance measures and/or indicators will identify areas for quality improvement and guide quality improvement activities.	**Note: the following strategies are mandatory requirements.** • Implement national recommendations and safety alerts including: – *National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines* – national medication safety alerts for intravenous potassium chloride, and vincristine – *Recommendations for Terminology, Abbreviations and Symbols used in Prescribing and Administering of Medicines.* • Implement the NIMC and related specialist and ancillary charts for hospitals. • Implement patient identification processes consistent with *Standard 5: Patient Identification and Procedure Matching* throughout the medication management cycle. • An extensive list of examples of other quality improvement activities can be found in the corresponding Action 4.5.2 of the *Safety and Quality Improvement Guide for Standard 4: Medication Safety* (ACSQHC 2012).

Documentation of patient information

Action	Overview of what is required	Suggested approach in small hospitals
4.6 The clinical workforce taking an accurate medication history when a patient presents to a health service organisation, or as early as possible in the episode of care, which is then available at the point of care		
4.6.1 A best possible medication history is documented for each patient	• A patient medication history is an essential basis for medication decision-making during the episode of care. Hospitals must ensure that a patient medication history is obtained and made available to all relevant health professionals. • Actions 4.6.1 and 4.6.2 relate to the implementation and monitoring parts of the quality improvement cycle. • The main tasks for these actions are: – identifying or developing and implementing a policy or procedure (Action 4.6.1) – monitoring the policy for use and the medication history for availability (Action 4.6.2).	• Review current procedures for obtaining a history of medicines taken prior to admission. • Identify, adapt and implement a policy, procedure or guideline on obtaining and documenting a best possible medication history (BPMH), including: – the use of a standard form for recording the BPMH, for example the NIMC, the national Medication Management Plan (MMP) or an electronic or paper-based equivalent – the practice of keeping the MMP together with the current NIMC and ancillary medication charts throughout the episode of care. • Provide education and training to members of the workforce who are involved in obtaining BPMH. This training may be delivered locally or through the local health network, and may include competency assessment. • Collect information on a patient's medication history from service contractors e.g. community pharmacist, where relevant and include this in the patient clinical record.
4.6.2 The medication history and current clinical information is available at the point of care		• Review current processes to ensure the BPMH and current clinical information are available when medicines are prescribed, i.e. at the point of care. • Implement procedures requiring changes to medicines during the patient's stay, or any issues identified through the process of medication reconciliation or medication review, to be documented on the MMP (or equivalent) or in the electronic health record. • Ensure that your hospital is included in the medication management information technology planning for your local health network or hospital group, and provide representation on relevant expert committees.

Documentation of patient information

Action	Overview of what is required	Suggested approach in small hospitals
4.7 The clinical workforce documenting the patient's previously known adverse drug reactions on initial presentation and updating this if an adverse reaction to a medicine occurs during the episode of care		
4.7.1 Known medication allergies and adverse drug reactions are documented in the patient clinical record	• Recording known medication allergies and adverse drug reactions reduces the risk of represcribing medicines which caused earlier incidents. • Actions 4.7.1 to 4.7.3 relate to the policy development, implementation, reporting and improvement parts of the quality improvement cycle. • The main tasks required for these actions are: – ensuring a process for obtaining and recording known medication allergies and previous adverse drug reactions (4.7.1) – ensuring a process for reporting adverse drug reactions are reported to the Therapeutic Goods Administration (4.7.3) – monitoring compliance with both policies (4.7.2).	• Identify whether there is a policy or procedure for documenting medication allergies and adverse drug reactions. • If there is, ensure that the processes include: – recording known allergies and adverse drug reactions in the patient record, and adverse drug reactions occurring during the episode of care in the patient notes – informing the patient about the adverse drug reaction and the importance of informing other prescribers and members of their healthcare team – informing the patient's general practitioner and other members of the patient's healthcare team (e.g. community pharmacist) of the adverse drug reaction in the patient's discharge summary – reporting adverse drug reactions occurring in the health service organisation internally and to the Therapeutic Goods Administration (TGA) (see Action 4.7.3). • If a policy or procedure is not in place, identify a suitable model and associated work practices that could be adapted and implemented for your hospital. • Ensure that education programs on medication safety that are available to the workforce include training on identifying, documenting and reporting of adverse drug reactions. • Include information on known adverse events and medication allergies from service contractors e.g. community pharmacist, in the patient clinical record.

Documentation of patient information

Action	Overview of what is required	Suggested approach in small hospitals
4.7 The clinical workforce documenting the patient's previously known adverse drug reactions on initial presentation and updating this if an adverse reaction to a medicine occurs during the episode of care (continued)		
4.7.2 Action is taken to reduce the risk of adverse reactions	See overview of what is required for Action 4.7.1.	• Use medication chart audits and process indicator data collection to monitor adverse drug reaction documentation (see Action 4.2.1). • Use the results of audits to identify actions to improve documentation, reduce risks and guide education needs, and ensure these are included in the relevant quality improvement plan and risk register. • Consider using an adverse drug reaction summary sheet at the front of the patient's notes, and allergy alert stickers on paper-based records. • Where electronic health records are used, ensure that adverse drug reactions are recorded in electronic medicines management systems and visible when medicines are prescribed, dispensed and administered.
4.7.3 Adverse drug reactions are reported within the organisation and to the Therapeutic Goods Administration		• Include the reporting of adverse drug reactions within the medication safety governance framework and reporting to the TGA in the adverse drug reaction policy, procedure or guideline. • Review adverse drug reactions reported and feed back information to the workforce through bulletins and in-service sessions. • Encourage clinicians to report adverse drug reactions through adverse drug reaction campaigns and access to online reporting. • Ensure that orientation, training and education programs available to clinicians include reporting adverse drug reactions to the TGA.

Documentation of patient information

Action	Overview of what is required	Suggested approach in small hospitals
4.8 The clinical workforce reviewing the patient's current medication orders against their medication history and prescriber's medication plan, and reconciling any discrepancies		
4.8.1 Current medicines are documented and reconciled at admission and transfer of care between healthcare settings	• Medication reconciliation improves patient safety by mitigating the risk of medication error. • Action 4.8.1 relates to the policy development, implementation, reporting and improvement parts of the quality improvement cycle. • The main tasks required for this action are: – ensuring a process for a formal, structured process of medication reconciliation – integrating the process into existing work flows – monitoring compliance with the process – improving the process.	• Identify a suitable procedure, protocol or guideline for a formal, structured process on reconciling medicines. • Develop an implementation plan to integrate the process into existing work flow, using a multidisciplinary, quality improvement approach. • The plan might include: – using the national Medication Management Plan or equivalent (paper or electronic) document to support the reconciliation process – a process that involves patients and carers in the medication reconciliation process – giving priority to reconciling medicines in patients with a higher risk of experiencing medication-related adverse events.

Medication management process

Action	Overview of what is required	Suggested approach in small hospitals
4.9 Ensuring that current and accurate medicines information and decision support tools are readily available to the clinical workforce when making clinical decisions related to medicines use		
4.9.1 Information and decision support tools for medicines are available to the clinical workforce at the point of care	• Hospital policies or procedures must make available decision support tools at decision-making points to assist health professionals to make evidence-based therapeutic decisions. These can be in hard copy, electronic versions or other formats. • Actions 4.9.1 to 4.9.3 relate to the policy development, monitoring and improvement parts of the quality improvement cycle. • The main tasks are: – identifying and making available required decision support materials (Action 4.9.1) – monitoring availability and use (Action 4.9.2) – improving the appropriateness, use and availability of decision support materials (Action 4.9.3).	• Identify existing medicines information resources and other clinical decision support materials available to the clinical workforce, and review to ensure content is: – current and consistent with evidence-based prescribing – accessible at the decision-making points of clinical workflow – consistent with local organisational policies. • Ensure that medicines information resources mandated by legislation are available and accessible. • Ensure that current versions of standard medicines information reference materials are accessible (in hard copy or online) in clinical areas where medicines are prescribed, dispensed or administered. Examples can be found in the corresponding Action 4.9.1 of the *Safety and Quality Improvement Guide for Standard 4: Medication Safety* (ACSQHC 2012). • Establish communication links with medicines information services (local, state/territory or national). • Identify methods to promote the use of information sources and decision support tools that are effective for your hospital. This may involve using communication strategies that have been implemented in your local health network or hospital group, such as newsletters, presentations, in service education sessions, awareness campaigns and desktop icons. • Identify whether processes exist for maintaining electronic and hard copy resources. • If resources are accessed through and maintained by another hospital in your local network, or by an external provider, ensure that maintenance of resources incorporates the needs of your hospital.

Action	Overview of what is required	Suggested approach in small hospitals
4.9 Ensuring that current and accurate medicines information and decision support tools are readily available to the clinical workforce when making clinical decisions related to medicines use (continued)		
4.9.2 The use of the information and decision support tools is regularly reviewed	• Hospital policies or procedures must make available decision support tools at decision-making points to assist health professionals to make evidence-based therapeutic decisions. These can be in hard copy, electronic versions or other formats. • Actions 4.9.1 to 4.9.3 relate to the policy development, monitoring and improvement parts of the quality improvement cycle. • The main tasks are: – identifying and making available required decision support materials (Action 4.9.1) – monitoring availability and use (Action 4.9.2) – improving the appropriateness, use and availability of decision support materials (Action 4.9.3).	• Review the appropriateness of resources for relevance and currency in parallel with changes to organisational policies, services provided, work practices and emerging clinical evidence. • Audit the availability and currency of medicines information resources and other decision support tools in clinical areas. • Where electronic medicines management systems are in place, ensure that there is monitoring of the decision support tools by your hospital or as part of a network process, e.g. overrides of active alerts for drug interactions, contra-indications, patient allergy alerts in prescribing and dispensing systems. • Obtain clinician feedback about the content and usefulness of resources, using methods such as targeted surveys, discussion groups, or existing communication infrastructure. This strategy should be multidisciplinary.
4.9.3 Action is taken to improve the availability and effectiveness of information and decision support tools		• Determine the strategies for improvement to be used based on issues identified through your hospital's regular review processes (see Action 4.9.2). • Document information and decision support issues and risks in the organisational medication safety risk register and the quality improvement plan. • Provide ongoing opportunity for clinicians to have input to content and selection of resources. • Provide access to training for the workforce on resources available and how to use them (see Item 4.1). Training may be delivered locally or through the local health network or private hospital group.

Medication management process

Action	Overview of what is required	Suggested approach in small hospitals
4.10 Ensuring that medicines are distributed and stored securely, safely and in accordance with the manufacturer's directions, legislation, jurisdictional orders and operational directives		
4.10.1 Risks associated with secure storage and safe distribution of medicines are regularly reviewed	• Distributing, storing and disposing of medicines safety and securely is an essential part of a safe medication system. • Actions 4.10.1 to 4.10.6 relate to the implementation, monitoring and improving parts of the quality improvement cycle. • The main tasks for this action are to ensure that: – local policies consistent with requirements for medicines distribution, storage and disposal are identified or developed and implemented (Actions 4.10.1 and 4.10.4) – medicines storage and distribution is monitored (Actions 4.10.3 and 4.10.5) – the distribution, storage and disposal systems are improved (Actions 4.10.2 and 4.10.6).	• Identify, implement and review policies, procedures and/or protocols for safe distribution and storage of medicines that meet with legislative requirements, jurisdictional directives and professional guidelines. This includes the storage and management of anaesthetic medicines if used within the hospital. • Monitor compliance with the above policies. • Review security and levels of workforce access, and approval processes for access to medicines storage areas. • Identify risks associated with distribution and storage of medicines, through: – use of standardised risk assessment tools – conducting observation audits and 'walk rounds' – review of incident reports – review of the potential for increased risk of error when changes to product labelling, packaging or storage requirements occur, and/or changes to purchasing arrangements and contracts, product shortages, recalls or substitution occur.
4.10.2 Action is taken to reduce the risks associated with storage and distribution of medicines	See overview of what is required for Action 4.10.1.	• Identify and implement risk reduction strategies. These could include: – safe and effective medicines distribution systems (e.g. bedside locked drawers) – regular review of ward/unit stock lists to ensure that products and stock levels are aligned to clinical needs – standardised labelling of storage areas, physical separation of products (e.g. look-alike, sound-alike products), use of National Tall Man Lettering – inspection of ward/unit medicines storage areas to monitor appropriateness of products stocked, levels of stock, expiry dates, and sustained compliance with medication safety strategies.

Action	Overview of what is required	Suggested approach in small hospitals
4.10 Ensuring that medicines are distributed and stored securely, safely and in accordance with the manufacturer's directions, legislation, jurisdictional orders and operational directives (continued)		
4.10.3 The storage of temperature-sensitive medicines is monitored	See overview of what is required for Action 4.10.1.	• Small hospitals may not have dedicated facilities for temperature-sensitive medicines. However, and if available, hospitals should monitor temperature controlled storage facilities, including temperature, refrigeration and storage. • Implement regular testing and maintenance schedules for temperature alarms and temperature recording devices where available. This may be achieved by participating in multi-site tests with other hospitals.
4.10.4 A system that is consistent with legislative and jurisdictional requirements for the disposal of unused, unwanted or expired medications is in place		• Ensure staff are familiar with the disposal procedure requirements including for Schedule 8 medicines and hazardous products.
4.10.5 The system for disposal of unused, unwanted or expired medications is regularly monitored		• Report and investigate incidents related to unwanted or expired medicines.
4.10.6 Action is taken to increase compliance with the system for storage, distribution and disposal of medications	See overview of what is required for Action 4.10.1.	• Respond to reported incidents, adverse events or near misses. • Use team meetings and notices to promote awareness of medication errors that can result from unsafe medicines storage and distribution.

Medication management process

Action	Overview of what is required	Suggested approach in small hospitals
4.11 Identifying high-risk medicines in the organisation and ensuring they are stored, prescribed, dispensed and administered safely		
4.11.1 The risks for storing, prescribing, dispensing and administration of high-risk medicines are regularly reviewed	• High-risk medicines require special management to mitigate patient safety risks. • Actions 4.11.1 and 4.11.2 relate to implementation, monitoring and improvement parts of the quality management cycle. • The main tasks for these activities are: – identifying or establishing and implementing a list of high-risk medicines and an associated policy or procedure (Action 4.11.2) – monitor and review the policy or procedure (Action 4.11.2) – improve the high risk medicines policy and procedure by reviewing regularly (Action 4.11.1).	• Identify the specific high-risk medicines used in your hospital, and establish or adapt an existing list as a reference for staff. • Identify whether there are policies, procedures and protocols in place that cover these high-risk medicines (refer to Action 4.1.2). • Review work practices related to high-risk medicines. • Identify and undertake relevant monitoring and review activities for high-risk medicines and ensure that these are regularly reported to the medication safety governance group. This could include: – monitoring and analysis of incident reports and logs – reports of risk assessments and audits, and actions taken on recommendations from alerts, incident reports and audits. • Ensure that factors that contribute to safer use of high-risk medicines are considered and incorporated into medication management processes, for example: – introduction of new medicines – contract specification and procurement processes for products and services – availability of medications (prescribing restrictions, products stocked, stock levels, storage) – design, layout and labelling of storage areas – selection of drug distribution system. • Undertake audit and risk assessment of high-risk medicines as a mechanism for review and to demonstrate that improvements and changes have been sustained (this is linked to Action 4.5.1). This may be achieved by participating in multi-site audits with other hospitals in your local health network or hospital group. • Use established communication processes for obtaining workforce feedback and suggestions for improvements to the management of high-risk medicines.

Action	Overview of what is required	Suggested approach in small hospitals
4.11 Identifying high-risk medicines in the organisation and ensuring they are stored, prescribed, dispensed and administered safely (continued)		
4.11.2 Action is taken to reduce the risks of storing, prescribing, dispensing and administering high-risk medicines	See overview of what is required for Action 4.11.1.	• Refer also to Action 4.5.2. • Identify whether specific policies, procedures, protocols or guidelines are in place for the safe purchasing, storing, prescribing, dispensing, and administering of the high-risk medicines identified in Action 4.11.1. If there are not, then you need to identify policies, procedures, protocols and guidelines that can be adapted and implemented with approval by the medication safety governance group. • Communicate and regularly update the list of high-risk medicines for your hospital (Action 4.11.1). • Investigate incidents involving high-risk medicines and use the recommendations from these to make system changes that include risk-minimisation strategies. • Implement authorisation processes for access to medicines storage areas, appropriate to individual roles within the organisation and consistent with legislative requirements. • Implement standardisation of medication management processes, for example: – medication ordering: implement the applicable NIMC, and related specialist and ancillary charts; standardise dosing protocols – work practices and products: remove concentrated electrolyte injectables from ward stock areas; use pre-mixed solutions or preloaded syringes for injectable high-risk medicines; use standardised single concentrations of infusions of high-risk medicines – standardise medication checking procedures for high-risk medicines – use devices (oral dispensers) for measuring and administering oral liquid doses to avoid wrong route errors. • Implement recommendations from national safety alerts and state or territory alerts and directives where applicable.

Medication management process

Action	Overview of what is required	Suggested approach in small hospitals
4.11 Identifying high-risk medicines in the organisation and ensuring they are stored, prescribed, dispensed and administered safely (continued)		
4.11.2 (continued)		• Identify and implement materials to support medication safety strategies, for example: – prescribing guidelines for high-risk medicines available at the end of the bed, or in electronic form accessible from clinical work stations – guidelines for safe administration of high-risk medicines – the *National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines* for preparing and administering injectable medicines. • Ensure that high-risk medicines and risk awareness components for medication management are available in workforce orientation and education programs (see Action 4.1.1). • Promote medication safety awareness of high-risk medicines (see Action 4.4.2).

Continuity of medication management

Action	Overview of what is required	Suggested approach in small hospitals
4.12 Ensuring a current comprehensive list of medicines, and the reason(s) for any change, is provided to the receiving clinician and the patient during clinical handovers		
4.12.1 A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in medicines	• Safe and high quality medication management is enhanced when current patient medication information is available to successive health professionals and passed on during clinical handover. In addition, patient medicines information should be made available to the patient and carer in an appropriate format. • Actions 4.12.1 to 4.12.4 relate to the planning, implementing, monitoring and improving parts of the quality improvement cycle. • The main tasks in this section require hospitals to: – develop policies or procedures for clinical handover and patient transfers which include medicines information (Action 4.12.1) – develop current medicines lists for patients and carers (Action 4.12.2) – develop current patient medicines lists for successive health professionals (Action 4.12.3) – increase availability of current patient medicines lists (Action 4.12.4).	• Identify whether policy, procedures and/or protocols for clinical handover and patient transfers are in place that include: – requirement for inclusion of current medicines in transfer information – roles, responsibilities and accountabilities of the clinical workforce in the process. • Introduce a system (paper-based or electronic) for recording and generating a record of patients' current medicines (medicines list) in a standard format. • Ensure that the implementation includes a process to document any changes made to medicines as a result of medication reconciliation, prescription review and dispensing. The desired outcome is to achieve consistency between the medicines list, discharge summary and the patient clinical record. • When implementing electronic medicines list systems, introduce work practices and service delivery models that link the production of medicines lists with prescribing processes, medication supply systems, the discharge summary system and patient identification system (if a comprehensive integrated electronic medication management system is not in place), and the personally controlled electronic health record (PCEHR) for when patients are discharged. • Establish a plan for implementing the practice of reconciling medicines when care is transferred, particularly on discharge to other healthcare service providers (see Action 4.8.1). • If patient medication lists and explanatory information is to be generated by a service contractor, the requirements of the health service organisation are to be included in their contract for service.

Continuity of medication management

Action	Overview of what is required	Suggested approach in small hospitals
4.12 Ensuring a current comprehensive list of medicines, and the reason(s) for any change, is provided to the receiving clinician and the patient during clinical handovers (continued)		
4.12.2 A current and comprehensive list of medicines is provided to the patient and/or carer when concluding an episode of care	See overview of what is required for Action 4.12.1.	• Implement a policy that requires a complete and accurate discharge medication list and information about any changes to medicines to be provided to patients at discharge. The policy should outline who is responsible for preparing the lists and patients who should receive a list. • Review work practices, and introduce processes that include: – development of the medicines list from the record of medication prescribed and dispensed for discharge after the medicines have been reviewed and reconciled. (See also criterion on documentation of patient information, Action 4.6.2.) – multidisciplinary planning for transfer or discharge – encouraging the workforce to prepare the list in partnership with the patient or their carer – timely production of medicines lists so that the list can be provided to the patient at the time of transfer/discharge – a clinician (where possible a pharmacist) providing the medicines list to the patient and carer, and discussing with the patient and carer their current medicines, any changes made to their medicines, the purpose and use of the list, and other relevant written materials provided (such as consumer medicines information [CMI] for new medicines). • Encourage patients to keep a current list of their medicines and take it to their healthcare professionals each visit and when they go into hospital. Patient education could be done through use of brochures, posters, or inclusion in patient information handbook.

Action	Overview of what is required	Suggested approach in small hospitals
4.12 Ensuring a current comprehensive list of medicines, and the reason(s) for any change, is provided to the receiving clinician and the patient during clinical handovers (continued)		
4.12.3 A current comprehensive list of medicines is provided to the receiving clinician during clinical handover	See overview of what is required for Action 4.12.1.	• Identify the points at which transfer of care occurs within your hospital, and include medication management information and the communication of an accurate and comprehensive list of medicines into work practices. For example: – clinical handover within your hospital, e.g. change of shift – on discharge to community healthcare services, e.g. general practitioner, community pharmacy – on transfer to another institution, e.g. current NIMC and Medication Management Plan (or equivalent record) – on transfer to residential care facilities, e.g. use of an interim medication chart.
4.12.4 Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover		• Identify whether monitoring of the provision of medication lists is included in the relevant quality improvement plan and governance framework. • If it is not, then establish a means of monitoring and reporting on transfer of medicines information for clinical handover. • Examples of activities to achieve this: – conduct audits, or obtain data from electronic systems used to generate medication lists, to report on quality indicators, e.g. the continuity of care indicators in *Indicators for Quality Use of Medicines in Australian Hospitals* – review and audit of clinical handover incidents related to inaccurate medicines lists, discharge summaries with inaccurate or incomplete medicines information, and medicines information provided electronically that has been stored in the Personally Controlled Electronic Health Record – obtain feedback from clinicians and/or patients on the quality, clarity and timeliness of medicines lists – participate in collaborative projects with community providers and Medicare Locals.

Communicating with patients and carers

Action	Overview of what is required	Suggested approach in small hospitals
4.13 The clinical workforce informing patients and carers about medication treatment options, benefits and associated risks		
4.13.1 The clinical workforce provides patients with patient specific medicine information, including medication treatment options, benefits and associated risks	• Providing patients and carers with medicine information will assist informed choices and achieve adherence with agreed treatment plans. • Actions 4.13.1 and 4.13.2 relate to the implementing and monitoring parts of the quality improvement cycle. • The main tasks are: – ensuring a supply of appropriate medicines information designed for patients and carers (Action 4.13.1) – monitoring availability of the patient material to the relevant clinical workforce (Action 4.13.2).	• Include in policies or procedures a requirement to: – provide medicines information to patients and carers – document the action in the clinical record. • Identify written resources that are suitable to provide to patients and carers.
4.13.2 Information that is designed for distribution to patients is readily available to the clinical workforce		• Make patient and consumer medicine information resources available in clinical areas. • Check that the materials are available as required.
4.14 Developing a medication management plan in partnership with patients and carers		
4.14.1 An agreed medication management plan is documented and available in the patient's clinical record	• Developing a medication management (action) plan for patients at risk of medication related adverse events can reduce the risk of error and patient harm. • Action 4.14.1 relates to the planning and implementing parts of the quality improvement cycle. • Tasks include: – identifying and using a standard template and procedure that will assist small hospitals develop medication management (action) plans for those patients that require them – working with patients and carers to develop the plans – retaining a copy of the plan in the patient record.	• Ensure staff are aware of the standard procedure and template for developing medication management (action) plans. • Staff should be aware of patients for whom medication management (action) plans are to be developed. These are patients with one or more risk factors known to predispose people to medication-related adverse events (see *Safety and Quality Improvement Guide for Standard 4: Medication Safety* (ACSQHC 2012) page 5).

Communicating with patients and carers

Action	Overview of what is required	Suggested approach in small hospitals
4.15 Providing current medicines information to patients in a format that meets their needs whenever new medicines are prescribed or dispensed		
4.15.1 Information on medicines is provided to patients and carers in a format that is understood and meaningful	• Patients and carers need to be provided with information in a form they understand and can use if they are to use their medicines safely and effectively. They should also be encouraged to provide feedback on the materials. • Actions 4.15.1 and 4.15.2 relate to the implementing, monitoring and improving parts of the quality improvement cycle. • The main tasks are: – identifying suitable written resources – providing a mechanism for patients to give feedback about the medicines information provided during the episode of care.	• Strategies may include those provided in Actions 4.12.2 and 4.13.1. • Identify written resources that are suitable to provide to patients and carers and make these available in clinical areas.
4.15.2 Action is taken in response to patient feedback to improve medicines information distributed by the health service organisation to patients		• Invite feedback from patients and carers on the quality and suitability of medicine information provided during the episode of care. • Provide formal or informal feedback to those responsible for maintaining the resources.

Key resources

Australian Commission on Safety and Quality in Health Care. *Safety and Quality Improvement Guide Standard 2: Partnering with Consumers*. Sydney. ACSQHC, 2012. www.safetyandquality.gov.au/our-work/accreditation/nsqhss/safety-and-quality-improvement-guides-and-accreditation-workbooks/

Australian Commission on Safety and Quality in Health Care. *National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines*. Sydney. ACSQHC, 2010. www.safetyandquality.gov.au/our-work/medication-safety/user-applied-labelling/

Clinical Excellence Commission, NSW Therapeutic Advisory Group Inc. *Medication Safety Self Assessment® for Australian Hospitals*, 2007 http://mssa.cec.health.nsw.gov.au/MSSA_introduction.html

NSW Therapeutic Advisory Group. *Indicators for Quality Use of Medicines in Australian Hospitals*, 2007 http://www.ciap.health.nsw.gov.au/nswtag/reviews/indicators.html

Notes

Notes

The intention of this Standard is to ensure that patients are correctly identified whenever care is provided and correctly matched to their intended treatments. Implementation of this Standard in small hospitals with long-stay beds may vary from acute services. However, the principles of implementation will be unchanged.

Identification of individual patients

Action	Overview of what is required	Suggested approach in small hospitals
5.1 Developing, implementing and regularly reviewing the effectiveness of a patient identification system including the associated policies, procedures and/or protocols that: • **define approved patient identifiers** • **require at least three approved patient identifiers on registration or admission** • **require at least three approved patient identifiers when care, therapy or other services are provided** • **require at least three approved patient identifiers whenever clinical handover, patient transfer or discharge documentation is generated**		
5.1.1 Use of an organisation-wide patient identification system is regularly monitored	• These actions are at the core of Standard 5. The organisation-wide patient identification system brings together the policies, procedures and/or protocols that are needed to establish and maintain the identity of the patient when they are receiving care, therapy or services. • These actions, and others within this Standard, are based on a quality improvement cycle where: – policies, procedures and/or protocols about patient identification and procedure matching are developed (either locally or centrally) – the patient identification system is implemented locally – compliance with, and performance of the patient identification system is monitored (locally and/or centrally) – local action is taken to improve performance.	• In a small hospital you may not need to develop an organisation-wide patient identification system locally. • Identify whether there is a policy framework about patient identification that applies to your hospital from your local health network, private hospital group, state or territory. • If there is, then ensure that this policy framework is in place in your hospital and functioning effectively. • If there is not, put in place policies, procedures and/or protocols about establishing, maintaining and checking identity. These should include activities such as patient registration, generating and checking identification bands. • Conduct local audits of the patient identification system, or participate in audits conducted by your local health network, private hospital group, state or territory.

Identification of individual patients

Action	Overview of what is required	Suggested approach in small hospitals
5.1 Developing, implementing and regularly reviewing the effectiveness of a patient identification system including the associated policies, procedures and/or protocols that: • **define approved patient identifiers** • **require at least three approved patient identifiers on registration or admission** • **require at least three approved patient identifiers when care, therapy or other services are provided** • **require at least three approved patient identifiers whenever clinical handover, patient transfer or discharge documentation is generated** (continued)		
5.1.2 Action is taken to improve compliance with the patient identification matching system	• These actions are at the core of Standard 5. The organisation-wide patient identification system brings together the policies, procedures and/or protocols that are needed to establish and maintain the identity of the patient when they are receiving care, therapy or services. • These actions, and others within this Standard, are based on a quality improvement cycle where: – policies, procedures and/or protocols about patient identification and procedure matching are developed (either locally or centrally) – the patient identification system is implemented locally – compliance with, and performance of the patient identification system is monitored (locally and/or centrally) – local action is taken to improve performance.	• Audit data, patient mismatching incidents, adverse events and near misses from your hospital should be used to identify where improvements are needed. • Use checklists or protocols from the local health network, private hospital group, state, territory or other external group (such as the Royal Australasian College of Surgeons or the Commission) to improve compliance with the patient identification system. • Provide education and training to members of the workforce who are involved in patient identification and matching. This training may be delivered locally or through the local health network or private hospital group.

Identification of individual patients

Action	Overview of what is required	Suggested approach in small hospitals
5.2 Implementing a robust organisation-wide system of reporting, investigation and change management to respond to any patient care mismatching events		
5.2.1 The system for reporting, investigating and analysis of patient care mismatching events is regularly monitored	• Patient safety incidents and near misses that involve a mismatch between a patient and their care are an important source of information about gaps in systems and where improvements can be made. • These actions require local review of such incidents, and action to reduce the likelihood of their occurrence in the future.	• Ensure that patient identification is included in the incident reporting system that is required under Item 1.14 of *Standard 1: Governance for Safety and Quality in Health Service Organisations*. • If part of a local health network or private hospital group, the incident reporting system may sit at this level. • Review patient mismatching incidents, adverse events and near misses from your hospital to identify where improvements are needed.
5.2.2 Action is taken to reduce mismatching events		• See Action 5.1.2 regarding improvement actions that can be taken by your hospital.
5.3 Ensuring that when a patient identification band is used, it meets the national specifications for patient identification bands		
5.3.1 Inpatient bands are used that meet the national specifications for patient identification bands	• Identification bands are one component of the organisation-wide patient identification system (Action 5.1.1). • Identification bands need to meet the Specifications for a Standard Patient Identification Band: http://www.safetyandquality.gov.au/our-work/patient-identification/a-national-standard-for-patient-identification-bands-in-australia/	• Identify whether there is a procurement process in place for purchasing identification bands that applies to your hospital from your local health network, private hospital group, state or territory. • If there is, then use this process to purchase identification bands. • If there is not, then obtain identification bands through your local purchasing arrangements. • All identification bands, whether purchased locally or through external arrangements, need to comply with the Specifications for a Standard Patient Identification Band.

Action	Overview of what is required	Suggested approach in small hospitals
5.4 Developing, implementing and regularly reviewing the effectiveness of the patient identification and matching system at patient handover, transfer and discharge		
5.4.1 A patient identification and matching system is implemented and regularly reviewed as part of structured clinical handover, transfer and discharge processes	• The organisation-wide patient identification system (Action 5.1.1) also needs to include processes for patient identification and procedure matching at handover, transfer and discharge. • It is not necessary to put in place separate policies, procedures and/or protocols for patient identification and procedure matching as it relates to handover, transfer and discharge. • The policies and protocols required to meet *Standard 6: Clinical Handover* should include elements about patient identification and the need to use three identifiers. There should be links and references between these handover, transfer and discharge policies and the organisation-wide patient identification system required in Action 5.1.1.	• Ensure that patient identification is included in the structured handover systems that are required in *Standard 6: Clinical Handover*. • Include patient identification and procedure matching during handover, transfer and discharge into the monitoring and evaluation processes required for Standard 6.

Processes to match patients and their care

Action	Overview of what is required	Suggested approach in small hospitals
5.5 Developing and implementing a documented process to match patients to their intended procedure, treatment or investigation and implementing the consistent national guidelines for patient procedure matching protocol or other relevant protocols		
5.5.1 A documented process to match patients and their intended treatment is in use	• The final element of the organisation-wide patient identification system described in Action 5.1.1 relates to the use of processes to match patients to their intended care. • These processes include the use of protocols and checklists such as the WHO Surgical Safety Checklist and Ensuring Correct Patient, Correct Site, Correct Procedure Protocol. • The main tasks required for these actions are to – put in place protocols for matching patients to their care (Action 5.5.1) – monitor how these protocols are being used (Action 5.5.2) – take action to improve use of the protocols if needed (Action 5.5.3).	• Use checklists or protocols from the local health network, private hospital group, state, territory or other external group (such as the Royal Australasian College of Surgeons and the Commission) to match patients with their intended care.
5.5.2 The process to match patients to any intended procedure, treatment or investigation is regularly monitored		• Conduct local audits of the use of protocols and checklists, or participate in audits conducted by your local health network, private hospital group, state or territory.
5.5.3 Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation		• See Action 5.1.2 regarding improvement actions that can be taken at a local level.

Key resources

Australian Commission on Safety and Quality in Health Care. *Safety and Quality Improvement Guide Standard 5: Patient Identification and Procedure Matching*. Sydney. ACSQHC, 2012.
www.safetyandquality.gov.au/our-work/accreditation/nsqhss/safety-and-quality-improvement-guides-and-accreditation-workbooks/

Specifications for a Standard Patient Identification Band
www.safetyandquality.gov.au/our-work/patient-identification/a-national-standard-for-patient-identification-bands-in-australia/

Surgical Safety Checklist
Australia and New Zealand edition:
www.surgeons.org/media/12661/LST_2009_Surgical_Safety_Check_List_(Australia_and_New_Zealand).pdf

World Health Organization. Surgical Safety Checklist and Implementation Manual:
www.who.int/patientsafety/safesurgery/ss_checklist/en/

Notes

The intention of this Standard is to ensure that there is timely, relevant and structured clinical handover to support safe patient care. Key to successful implementation of this Standard in small hospitals will be identifying the critical points for patient care where structured handover is required.

Governance and leadership for effective clinical handover

Action	Overview of what is required	Suggested approach in small hospitals
6.1 Developing and implementing an organisational system for structured clinical handover that is relevant to the healthcare setting and specialties, including: • **documented policy, procedures and/or protocols** • **agreed tools and guides**		
6.1.1 Clinical handover policies, procedures and/or protocols are used by the workforce and regularly monitored	• These actions are at the core of Standard 6. The organisation-wide system for structured clinical handover brings together the policies, procedures and/or protocols that are needed to ensure there is timely, relevant and structured clinical handover that supports safe patient care. • Clinical handover policies and procedures should outline: – structure and minimum data sets (information) for different clinical handover situations – governance structure for management, monitoring, evaluation, reporting and improvement processes for clinical handover – mechanisms to feed back and report the results and actions of clinical handover reviews to your relevant local or local network level executive. • Action 6.1.1 relates to the policy development part of the quality improvement cycle that underpins Standard 6. • Actions 6.1.2 and 6.1.3 relate to the improvement part of this cycle.	• Identify situations where clinical handover should take place in your hospital. • Identify whether there is a policy framework about clinical handover that applies to your hospital from your local health network, private hospital group, state or territory. • If there is, then ensure that this policy framework is in place in your hospital and functioning effectively. • If there is not, put in place a policy, procedure and/or protocol about management, structure and minimum data sets for different clinical handover situations. • Identify an individual, or project team to monitor clinical handover policy, procedure and/or protocol locally. • Conduct local audits of the clinical handover policies, procedures and/or protocols, or participate in audits conducted by your local health network, private hospital group, state or territory.

Action	Overview of what is required	Suggested approach in small hospitals
6.1 Developing and implementing an organisational system for structured clinical handover that is relevant to the healthcare setting and specialties, including: • **documented policy, procedures and/or protocols** • **agreed tools and guides** (continued)		
6.1.2 Action is taken to maximise the effectiveness of clinical handover policies, procedures and/or protocols	See overview of what is required for Action 6.1.1.	• Identify an individual, or small team to evaluate clinical handover policy, procedures and/or protocols locally. • Engage stakeholders to ensure all relevant people are involved in the evaluation of clinical handover policy, procedures and/or protocols. • Use data to guide the development of improvement strategies such as: – reviewing audit data, clinical handover incidents, adverse events and near misses from your hospital to identify where improvements are needed – making amendments to local policy, procedures and/or protocols or making recommendations to the local health network or private hospital group for policies that sit at that level – providing education and training to members of the workforce who are involved in clinical handover. This training may be delivered locally or through the local health network or private hospital group. • Use checklists, tools, guides or protocols from the local health network, private hospital group, state, territory or other external group (such as the Commission) to maximise the effectiveness of clinical handover policies, procedures and/or protocols and tools. • Where relevant, feed information to your local health network, private hospital group, state or territory.
6.1.3 Tools and guides are periodically reviewed		• See Actions 6.1.2 regarding improvement actions that can be taken at the local level.

Clinical handover processes

Action	Overview of what is required	Suggested approach in small hospitals
6.2 Establishing and maintaining structured and documented processes for clinical handover		
6.2.1 The workforce has access to documented structured processes for clinical handover that include: • preparing for handover, including setting the location and time while maintaining continuity of patient care • organising relevant workforce members to participate • being aware of the clinical context and patient needs • participating in effective handover resulting in transfer of responsibility and accountability for care	• The main tasks required for these actions are to implement and maintain the structured clinical handover processes described in your policy (Action 6.1.1) to ensure timely and relevant handover for the local context. • Policies, procedures and protocols should be fit for the local context and include: – identifying the situations where clinical handover should occur such as during shift changes, when patients are transferred within and between hospitals, and at patient discharge – documenting structured clinical handover processes to convey the relevant minimum data set of information to transfer responsibility and accountability between members of the clinical workforce – considering time management strategies to ensure relevant members of the workforce are present, organised, educated and prepared for handover – understanding that handover results in transfer of responsibility and accountability.	• Your local process may already be outlined in the clinical handover policy framework that sits at the level of the local health network, private hospital group, state or territory. • If it is, your hospital will not require a separate policy for your local context. • If not, your hospital will require policy for local clinical handover procedure and/or protocol. • See Action 6.1.1 relating to policy development.
6.3 Monitoring and evaluating the agreed structured clinical handover processes, including: • **regularly reviewing local processes based on current best practice in collaboration with clinicians, patients and carers** • **undertaking quality improvement activities and acting on issues identified from clinical handover reviews** • **reporting the results of clinical handover reviews at executive level of governance**		
6.3.1 Regular evaluation and monitoring processes for clinical handover are in place	• The main task required for these actions is to put in place mechanisms (described in Actions 6.1.1 and 6.1.2) to evaluate and monitor the effectiveness of local processes for clinical handover and to take action to improve clinical handover if needed.	• See Actions 6.1.1, 6.1.2 and 6.1.3 relating to policy development, monitoring and improvement.

Action	Overview of what is required	Suggested approach in small hospitals
6.3 Monitoring and evaluating the agreed structured clinical handover processes, including: • **regularly reviewing local processes based on current best practice in collaboration with clinicians, patients and carers** • **undertaking quality improvement activities and acting on issues identified from clinical handover reviews** • **reporting the results of clinical handover reviews at executive level of governance** (continued)		
6.3.2 Local processes for clinical handover are reviewed in collaboration with clinicians, patients and carers	• The main task required for these actions is to put in place mechanisms (described in Actions 6.1.1 and 6.1.2) to evaluate and monitor the effectiveness of local processes for clinical handover and to take action to improve clinical handover if needed.	• See Actions 6.1.2 and 6.1.3 relating to improvement. • One of the benefits of working in a small hospital is that your hospital can follow up directly with clinicians about how the structured clinical handover system is working locally. Use this information to inform local improvement activities.
6.3.3 Action is taken to increase the effectiveness of clinical handover		• See Actions 6.1.2 and 6.1.3 regarding improvement actions that can be taken by your hospital.
6.3.4 The actions taken and the outcomes of local clinical handover reviews are reported to the executive level of governance		• Assign an individual or small team responsible for the local governance arrangements surrounding clinical handover within your hospital. • Routinely provide the results from audits and incident reviews to the local governance bodies, and any relevant governance bodies within a local health network, private hospital group, state or territory. • See Actions 6.1.1, 6.1.2 and 6.1.3.

Clinical handover processes

Action	Overview of what is required	Suggested approach in small hospitals
6.4 Implementing a robust organisation-wide system of reporting, investigation and change management to respond to any clinical handover incidents		
6.4.1 Regular reporting, investigating and monitoring of clinical handover incidents is in place	• Adverse events that involve clinical handover incidents are an important source of information about gaps in systems where improvements to clinical handover can be made. • These actions require local review of clinical handover incidents and action to reduce the likelihood of their occurrence in the future.	• Identify whether there is an incident reporting system that applies to your hospital from your local health network, private hospital group, state or territory. • If a networked incident reporting system is in place, ensure that it is used in your hospital and functioning effectively. • If there is not, ensure that clinical handover is included in the incident reporting system that is required under Item 1.14 of *Standard 1: Governance for Safety and Quality in Health Service Organisations*. • Review clinical handover incidents, adverse events and near misses from your hospital to identify where improvements are needed. • See Actions 6.1.1 and 6.1.2.
6.4.2 Action is taken to reduce the risk of an adverse clinical handover incidents		• See Actions 6.1.1, 6.1.2 and 6.4.1.

Patient and carer involvement in clinical handover

Action	Overview of what is required	Suggested approach in small hospitals
6.5 Developing and implementing mechanisms to include patients and carers in the clinical handover process that are relevant to the healthcare setting		
6.5.1 Mechanisms to involve a patient and, where relevant, their carer in clinical handover are in use	• Involving patients and carers in planning and improvement processes is one step in improving clinical handover. • Policies, procedures and/or protocols should describe how patients can be involved in clinical handover processes.	• If the policy framework for clinical handover sits at a local health network or private hospital group level, identify whether it includes mechanisms for involving patients in clinical handover. • If this is the case, ensure that this policy framework is in place in hospital and functioning effectively. You should encourage and support people who receive care in your hospital to participate in these processes. • If your hospital has its own local policy for clinical handover, ensure these policies, procedures and/or protocols describe how patients can be involved in clinical handover processes.

Key resources

Australian Commission on Safety and Quality in Health Care. *Safety and Quality Improvement Guide Standard 6: Clinical Handover*. Sydney. ACSQHC, 2012. www.safetyandquality.gov.au/our-work/accreditation/nsqhss/safety-and-quality-improvement-guides-and-accreditation-workbooks/

Australian Commission on Safety and Quality in Health Care. *Implementation Toolkit for Clinical Handover*. Sydney. ACSQHC, 2011. www.safetyandquality.gov.au/our-work/clinical-communications/clinical-handover/implementation-toolkit-for-clinical-handover-improvement-and-resource-portal/

Notes

Notes

The intention of this Standard is to ensure that patients who receive blood and blood products do so appropriately and safely. In small hospitals the use of blood or blood products may be limited and therefore implementation strategies may not be complex. Implementation should consider both the risk to patients, access to information by staff, and skills maintenance by the clinical workforce. If no blood or blood products are used in the hospital then the actions required under Standard 7 are not applicable to the health service organisation.

Governance and systems for blood and blood product prescribing and clinical use

Action	Overview of what is required	Suggested approach in small hospitals
7.1 Developing, governance systems for safe and appropriate prescription, administration and management of blood and blood products		
7.1.1 Blood and blood product policies, procedures and/or protocols are consistent with national evidence-based guidelines for pre-transfusion practices, prescribing and clinical use of blood and blood products	• These actions relate to the need to ensure that policies, procedures and/or protocols are in place that accord with national evidence-based guidelines for: – pre-transfusion practice – prescribing practice and clinical use of blood and blood products – administration of blood and blood products – management of blood and blood products. • Actions 7.1.1, 7.1.2 and 7.1.3 are related to the quality improvement cycle that underpins all of the NSQHS Standards. These actions require: – the existence and use of policies, procedures and/or protocols that are consistent with national evidence-based guidelines (Action 7.1.1) – monitoring that these policies are being used (Action 7.1.2) – taking action to increase their quality and use (Action 7.1.3).	• Identify whether there is a policy framework about the use of blood and blood products from your local health network, private hospital group, state or territory. • If there is, then ensure that this policy framework is in place in your hospital and functioning effectively. • If you are not part of a local health network or private hospital group that has these policies in place, you can: – develop your own set of local policies that are consistent with national evidence-based guidelines – ensure that the clinical workforce has access to national evidence-based guidelines, and make it clear that they are expected to act in accordance with them.

Action	Overview of what is required	Suggested approach in small hospitals
7.1 Developing, governance systems for safe and appropriate prescription, administration and management of blood and blood products		
7.1.2 The use of policies, procedures and/or protocols is regularly monitored	See overview of what is required for Action 7.1.1.	• Policies need to include requirements for monitoring compliance with the policy framework. In small hospitals, choose an appropriate audit strategy that is not burdensome but enables you to pick up problems. Monitoring processes may include: – conducting local audits, or participating in audits conducted by your local health network, private hospital group, state or territory – reviewing audit data, deviations from protocols and incidents involving blood and blood products to identify where improvements are needed. • Audit results should be reviewed by your Transfusion Governance Group (see Action 7.4.1). • Examples of audit tools may be available from jurisdictional blood programs – links to these programs can be found on the National Blood Authority (NBA) web site at: http://www.blood.gov.au/bptools/index.html
7.1.3 Action is taken to increase the safety and appropriateness of prescribing and clinically using blood and blood products		• The level of compliance determined under Action 7.1.2 will determine how much work is required under this Action: – if you identify a high level of compliance, you may only need to reinforce current practice – if you identify a low level of compliance, then you should implement improvement strategies, such as educating and training staff. You may like to develop links with larger health services in your local health network to allow sharing of education and training, or to allow benchmarking.

Governance and systems for blood and blood product prescribing and clinical use

Action	Overview of what is required	Suggested approach in small hospitals
7.2 Undertaking a regular, comprehensive assessment of blood and blood product systems to identify risks to patient safety and taking action to reduce risks		
7.2.1 The risks associated with transfusion practices and clinical use of blood and blood products are regularly assessed	• Risks are activities which have the potential to lead to harm. Actions 7.2.1 and 7.2.2 are related. You need to identify the risks and then implement actions to reduce them. • These actions simply build on Item 1.5 in *Standard 1: Governance for Safety and Quality in Health Service Organisations* that requires an organisation-wide risk register.	• If you are going to use blood and blood products, be aware of the risks. This is particularly important in small hospitals where staff may not undertake these tasks as frequently as in larger hospitals. • Identify risks associated with transfusion practice including procedural risks such as patient mis-identification and blood sampling errors, as well as transfusion risks such as patient adverse reactions. • If part of a local health network or private hospital group, an organisation-wide risk register may sit at this level. You should also have an understanding of the specific risks that face your local hospital. • Reviewing blood-related incidents is one way to identify weak spots.
7.2.2 Action is taken to reduce the risks associated with transfusion practices and the clinical use of blood and blood products		• For each risk identified by your hospital, also identify control and mitigation strategies, and implement the actions to reduce the risk as part of your Transfusion Quality Improvement Program (see Action 7.4.1).
7.3 Ensuring blood and blood product adverse events are included in the incidents management and investigation system		
7.3.1 Reporting on blood and blood product incidents is included in regular incident reports	• Incidents are events that have actually occurred (including adverse events and near misses). • Actions 7.3.1, 7.3.2 and 7.3.3 are related and concern the reporting and reviewing incidents. These actions require: – local reporting of incidents (Action 7.3.1) – executive review of incidents (Action 7.3.2) – state and national reporting of incidents (Action 7.3.3).	• This action builds on *Standard 1: Governance for Safety and Quality in Health Service Organisations* which requires capturing of incidents in an incident management system (Item 1.14). • It requires that you input blood related incidents in this system, and can identify them in reports from this system. • If your hospital is part of a local health network or private hospital group, the incident reporting system may sit at this level. • Incidents can be used to identify areas of risk (Action 7.2.1). It is important to consider whether there are patterns of incidents, so that action can be taken to reduce risks in those areas (Action 7.2.2)

Governance and systems for blood and blood product prescribing and clinical use

Action	Overview of what is required	Suggested approach in small hospitals
7.3 Ensuring blood and blood product adverse events are included in the incidents management and investigation system		
7.3.2 Adverse blood and blood product incidents are reported to and reviewed by the highest level of governance in the health service organisation	• Incidents are events that have actually occurred (including adverse events and near misses). • Actions 7.3.1, 7.3.2 and 7.3.3 are related and concern the reporting and reviewing incidents. These actions require: – local reporting of incidents (Action 7.3.1) – executive review of incidents (Action 7.3.2) – state and national reporting of incidents (Action 7.3.3).	• This Action builds on Action 1.14.5 which requires the review and analysis of incidents at the highest governance level. • To meeting Action 1.14.5, your hospital should include blood-related incidents on the reports to the highest level of governance (as per Action 7.3.1.)
7.3.3 Health service organisations participate in relevant haemovigilance activities conducted by the organisation or at state or national level		• The method for providing data to state and national haemovigilance systems differs from state to state. Your local health network, private hospital, state or territory department of health will be able to provide information about how this occurs.
7.4 Undertaking quality improvement activities to improve the safe management of blood and blood products		
7.4.1 Quality improvement activities are undertaken to reduce the risks of patient harm from transfusion practices and the clinical use of blood and blood products	• This action is the basis of Standard 7, and brings all activities together to form a Transfusion Quality Improvement Program. These activities include: – improving the quality and use of policies (Action 7.1.3) – reducing systems risks (Action 7.2.2) – reducing incidents (Action 7.3.1) – improving documentation of transfusion (Action 7.5.3) – reducing risks to individual patients (Action 7.6.2) – managing storage and handling risks (Action 7.7.2) – reducing wastage (Action 7.8.2) – improving the provision of information to patients (Action 7.10.1) – improving documentation of consent (Action 7.11.1) • A Transfusion Governance Group should have oversight of the Program.	• In small hospitals, the Transfusion Quality Improvement Program may be incorporated into a broader quality management system (see Item 1.6 of Standard 1). You need to document that part of the scope of that broader program is to improve quality relating to blood and blood products. • If your hospital is part of a local health network or private hospital group, your hospital may also be part of a Transfusion Quality Improvement Program that sits at that level. • In small hospitals, it is likely that the role of the Transfusion Governance Group will be undertaken by a broader governance group, and will not be called a Transfusion Governance Group. You need to document that the terms of reference of a group for your hospital includes the oversight of quality improvement activities relating to blood and blood products. • If your hospital is part of a local health network or private hospital group, the Transfusion Governance Group may sit at this level. However you still need to have in place arrangements for governance of these activities locally.

Documenting patient information

Action	Overview of what is required	Suggested approach in small hospitals
7.5 As part of the patient treatment plan, the clinical workforce accurately documenting: • **relevant medical conditions** • **indications for transfusion** • **any special product or transfusion requirements** • **known patient transfusion history** • **type and volume of product transfusion** • **patient response to transfusion**		
7.5.1 A best possible history of blood product usage and relevant clinical and product information is documented in the patient clinical record	• Actions 7.5.1, 7.5.2 and 7.5.3 are all related and form part of the quality improvement cycle. They require you to document information related to transfusion (Action 7.5.1), check this documentation is occurring (Action 7.5.2) and take action to improve compliance with these documentation requirements (Action 7.5.3). • This is important, as it is a statutory requirement to track product from vein to vein.	• Documentation of comprehensive information regarding transfusion of blood and/or blood products in the patient clinical record is important. If small hospitals use blood and blood products, they need to routinely record all of the core information listed under this action in the *Safety and Quality Improvement Guide for Standard 7: Blood and Blood Products* (ACSQHC 2012).
7.5.2 The patient clinical records of transfused patients are periodically reviewed to assess the proportion of records completed		• Conduct local audits of the contents of patient clinical records, or participate in audits conducted by your local health network, private hospital group, state or territory. • If you meet the requirements of Action 1.9.2 in Standard 1 regarding accessible patient clinical records, then this audit should not be difficult. • In small hospitals, choose an appropriate audit strategy that is not burdensome but would pick up problems.
7.5.3 Action is taken to increase the proportion of patient clinical records of transfused patients with a complete patient clinical record		• The level of compliance determined under Action 7.5.2 will determine how much work is expected under this action: – If you identify a high level of compliance, you may only need to reinforce current practice. – If you identify a low level of compliance, then you should implement improvement strategies, such as educating and training staff. You may choose to identify staff who are non-compliant, and engage directly with them, or undertake benchmarking between staff or departments.

Documenting patient information

Action	Overview of what is required	Suggested approach in small hospitals
7.6 The clinical workforce documenting any adverse reactions to blood or blood products		
7.6.1 Adverse reactions to blood or blood products are documented in the patient clinical record	• Item 7.6 relates to actions regarding individual patients. If a patient has an adverse event, it is important to document this in their clinical record, as it may have implications for further treatment. You may also need to report adverse events to the manufacturer to enable identification of problems with a product.	• The work relating to documentation of adverse reactions in the patient clinical record is already required under Action 7.5.1 and no other work is needed.
7.6.2 Action is taken to reduce the risk of adverse events from administering blood or blood products		• Review the patient clinical record for previous transfusion reactions, or special transfusion requirements prior to transfusion as described in the *Safety and Quality Improvement Guide for Standard 7: Blood and Blood Products* (ACSQHC 2012).
7.6.3 Adverse events are reported internally to the appropriate governance level and externally to the pathology service provider, blood service or product manufacturer whenever appropriate		• Under Action 7.3.2, your hospital will have already reported incidents and adverse events internally. • In addition, ensure they are reported to the pathology service provider to enable reporting to the product manufacturer. To facilitate this process your hospital should have a policy that makes it clear whose role it is to undertake this reporting locally.

Managing blood and blood product safety

In small organisations, blood management may be outsourced or undertaken by a larger health service within the local health network. Where this occurs, contracts or arrangements with providers would need to include requirements to both address the strategies identified, and to provide the health service organisation with sufficient information to confirm they are implemented. Your evidence for Items 7.7 and 7.8 would be the contract requirements and ensuring the outsourced provider meets such requirements.

Action	Overview of what is required	Suggested approach in small hospitals
7.7 Ensuring the receipt, storage, collection and transport of blood and blood products within the organisation are consistent with best practice and/or guidelines		
7.7.1 Regular review of the risks associated with receipt, storage, collection and transport of blood and blood products is undertaken	• Actions 7.7.1 and 7.7.2 are related and require you to identify and review risks associated with blood and blood product management, and to take action to mitigate such risks.	• Regardless of the size of the hospital, ensuring blood and blood products meet defined storage and handling requirements is critical to patient safety. You need to identify risks, as discussed in the *Safety and Quality Improvement Guide for Standard 7: Blood and Blood Products* (ACSQHC 2012).
7.7.2 Action is taken to reduce the risk of incidents arising from the use of blood and blood product control systems		• For each risk identified in Action 7.7.1, you should implement actions to mitigate these risks as part of your Transfusion Quality Improvement Program (refer to Action 7.4.1)

Action	Overview of what is required	Suggested approach in small hospitals
7.8 Minimising unnecessary wastage of blood and blood products		
7.8.1 Blood and blood product wastage is regularly monitored	• Actions 7.8.1 and 7.8.2 are related and require you to monitor and reduce wastage of blood and blood products.	• BloodNet is a national system for ordering and tracking blood and blood products. If you use BloodNet, you can enter product discards, and simply review reports from BloodNet regularly to monitor your wastage. If you do not have BloodNet, contact the National Blood Authority to discuss whether it can be implemented free of charge (13 000 BLOOD, 13 000 25663). Alternatively, you can implement your own internal reporting process. • A local policy may be required that includes: – how and when wastage is reported at your health service organisation – who is responsible for reviewing wastage reports and implementing strategies to reduce wastage.
7.8.2 Action is taken to minimise wastage of blood and blood products		• At all times, blood wastage should be minimised. The *Safety and Quality Improvement Guide for Standard 7: Blood and Blood Products* (ACSQHC 2012) includes examples of how you might achieve this. Also, the National Blood Authority is developing tools to assist health services to improve inventory management practice. These tools will be available at: http://www.blood.gov.au/wastage

Communicating with patients and carers

Action	Overview of what is required	Suggested approach in small hospitals
7.9 The clinical workforce informing patients and carers about blood and blood product treatment options, and the associated risks and benefits		
7.9.1 Patient information relating to blood and blood products, including risks, benefits and alternatives, is available for distribution by the clinical workforce	• You need to identify sources of information about blood and blood products that would be suitable for distribution to patients, and make this information available to the workforce.	• In a small hospital you may not develop local information for patients. However you may use or adapt more generically available information. • Information available for distribution is available from a range of organisations including state and territory health departments, the National Health and Medical Research Council and the Australian Red Cross Blood Service. Links to this information are available in the *Safety and Quality Improvement Guide for Standard 7: Blood and Blood Products* (ACSQHC 2012).
7.9.2 Plans for care that include the use of blood and blood products are developed in partnership with patients and carers	• You should develop plans for care in partnership with the patient and their carer. • Plans for care that relate to the administration of blood products may be specific for an individual patient or may be in accordance with policies, procedures and/or protocols (as per Action 7.1.1).	• A result of providing patients with information about blood and blood products, including risks and benefits and alternatives, is that patients may want to discuss with their clinician the plan for their care. Ensure patients are given the opportunity for this to occur. • A local policy that includes information for patients may be required.
7.10 Providing information to patients about blood and blood product use and possible alternatives in a format that can be understood by patients and carers		
7.10.1 Information on blood and blood products is provided to patients and their carers in a format that is understood and meaningful	• You should provide information to patients and their carers about blood and blood product use and possible alternatives, in a format and level appropriate for the patient.	• This action requires distribution of the information identified at Action 7.9.1 to patients and their carers. • It is expected that you would have the information available, and provide it to patients and their carers. The developmental aspect of this action relates to ensuring it is understood. This is discussed further in the *Safety and Quality Improvement Guide for Standard 7: Blood and Blood Products* (ACSQHC 2012).

Action	Overview of what is required	Suggested approach in small hospitals
7.11 Implementing an informed consent process for all blood and blood product use		
7.11.1 Informed consent is undertaken and documented for all transfusions of blood or blood products in accordance with the informed consent policy of the health service organisation	• This is a developmental action. The reason that it has been designated developmental is that it requires informed consent to be undertaken and documented for 'all' transfusions. This is not possible, due to the emergency nature of some transfusions. You still need to demonstrate work you are doing to work toward meeting this action.	• Ensure your hospital has a policy in place outlining the form of consent for transfusions required at your organisation, based on a risk assessment. If your hospital is part of a local health network or private hospital group, this policy may sit at that level. • Each hospital needs to decide whether this is: – specific to transfusion or more general – signed by the patient or documented by the doctor – perpetual (or a specified time period e.g. six months) or for each transfusion. • In small hospitals, a consent form developed by another organisation may be used. Links to examples are provided in the *Safety and Quality Improvement Guide for Standard 7: Blood and Blood Products* (ACSQHC 2012). • This action also requires monitoring of compliance with the consent documentation policy, and action to improve compliance. • To meet the monitoring and quality improvement actions required under Action 7.11.1, your hospital could: – provide your audit under Action 7.5.2 – check for documentation of consent according to your consent policy – apply strategies to improve your documentation under Action 7.5.3.

Key resources

Australian Commission on Safety and Quality in Health Care. *Safety and Quality Improvement Guide Standard 7: Blood and Blood Products*. Sydney. ACSQHC, 2012.
www.safetyandquality.gov.au/our-work/accreditation/nsqhss/safety-and-quality-improvement-guides-and-accreditation-workbooks/

National Blood Authority
www.nba.gov.au

Notes

Notes

The intention of this Standard is to prevent patients from developing pressure injuries and to effectively manage pressure injuries when they occur. For small hospitals with long-stay patients, the risk of patients developing pressure injuries is high.

Implementation strategies should be comprehensive and address issues of access and maintenance to equipment for prevention and management of pressure injuries.

Governance and systems for the prevention and management of pressure injuries

Action	Overview of what is required	Suggested approach in small hospitals
8.1 Developing and implementing policies, procedures and/or protocols that are based on current best practice guidelines		
8.1.1 Policies, procedures and/or protocols are in use that are consistent with best practice guidelines and incorporate screening and assessment tools	• These actions are at the core of Standard 8. The organisation-wide pressure injury prevention and management system consists of the policies, procedures and/or protocols that are needed to properly screen and assess for pressure injuries and implement prevention and management plans when necessary. • The main components of the organisation-wide pressure injury prevention and management systems that are included in this Standard concern processes for: – pressure injury risk screening – comprehensive skin assessment – preventing pressure injuries – managing pressure injuries when they do occur – monitoring and evaluating the effectiveness of your pressure injury prevention and management system.	• Identify whether there is a policy framework about pressure injuries that applies to your hospital from your local health network, private hospital group, state or territory. • If there is, then ensure that this policy framework is in place in your hospital and functioning effectively. • If there is not, ensure that a policy and procedure about pressure injury prevention and management is put in place. This should include activities such as screening, risk assessment and treatment.
8.1.2 The use of policies, procedures and/or protocols is regularly monitored		• Policies also need to include requirements for monitoring the performance of the pressure injury prevention and management system. Monitoring processes may include: – conducting local audits, or participating in audits conducted by your local health network, private hospital group, state or territory – reviewing audit data and pressure injury incidence to identify where improvements are needed.

Action	Overview of what is required	Suggested approach in small hospitals
8.2 Using a risk assessment framework and reporting systems to identify, investigate and take action to reduce the frequency and severity of pressure injuries		
8.2.1 An organisation-wide system for reporting pressure injuries is in use	• Many of the actions in Standard 8 are based on a quality improvement cycle where: – policies, procedures and/or protocols for pressure injury prevention and management are developed (either locally or centrally) – the pressure injury prevention and management systems are implemented locally – compliance with, and performance of, the pressure injury prevention and management systems is monitored (centrally and/or locally) – local action is taken to improve performance. • Actions 8.1.1 and 8.1.2 relate to the policy development and implementation parts of this cycle. • Actions 8.2.1 and 8.2.2 relate to the monitoring part of the quality improvement cycle. They concern two important sources of information about pressure injury prevention and management systems: – the reporting of pressure injuries when they occur (Action 8.2.1) – data from administrative systems and clinical audit indicating compliance with policy, and incidence and prevalence of pressure injuries (Action 8.2.2). • Actions 8.2.3 and 8.2.4 relate to the improvement part of the quality improvement cycle.	• Ensure that pressure injuries are included in the incident reporting system that is required under Item 1.14 of *Standard 1: Governance for Safety and Quality in Health Service Organisations*. • If your hospital is part of a local health network or private hospital group, the incident reporting system may sit at this level. • The incident reporting system should collect sufficient data to allow the assessment of any factors that contributed to the development of reported pressure injuries.
8.2.2 Administrative and clinical data are used to regularly monitor and investigate the frequency and severity of pressure injuries		• See Action 8.1.2 for methods of monitoring performance regarding pressure injuries.
8.2.3 Information on pressure injuries is regularly reported to the highest level of governance in the health service organisation		• Assign an individual or small team responsible for the local governance arrangements regarding pressure injuries in your hospital. This role needs to be identified locally, even if overall responsibility for governance regarding pressure injuries sits with your local health network or private hospital group. • Routinely provide the results from audits and incident reviews to the local governance bodies, and any relevant governance bodies within a local health network, private hospital group, state or territory.

Governance and systems for the prevention and management of pressure injuries

Action	Overview of what is required	Suggested approach in small hospitals
8.2 Using a risk assessment framework and reporting systems to identify, investigate and take action to reduce the frequency and severity of pressure injuries (continued)		
8.2.4 Action is taken to reduce the frequency and severity of pressure injuries	See overview of what is required for Actions 8.2.1, 8.2.2 and 8.2.3.	• Use data to guide the development of improvement strategies such as: – using protocols from the local health network, private hospital group, state, territory or other external group (such as the Australian Wound Management Association) – resolving any systems issues that may be identified (for example, timely access to necessary equipment) – making amendments to local policies, procedures and/or protocols or making recommendations to the local health network or private hospital group for policies that sit at that level – providing orientation and additional education and training for clinicians (this may be done by your local health network, private hospital group, state or territory or other external organisations) – improving or developing communication material and information resources for clinicians, patients and carers.
8.3 Undertaking quality improvement activities to address safety risks and monitor the systems that prevent and manage pressure injuries		
8.3.1 Quality improvement activities are undertaken to prevent pressure injuries and/or improve the management of pressure injuries	• This action relates to the overarching quality improvement approach that is needed to prevent and pressure injuries and improve their management. • Activities undertaken as part of Actions 8.2.4, 8.5.3, 8.6.3, 8.7.4 and 8.8.4 can be used to demonstrate compliance with this action.	• Where relevant, participate in quality improvement activities that are conducted by your local health network, private hospital group, state or territory. • When conducting quality improvement activities locally, use a standardised quality improvement methodology to bring about change. This methodology may be determined by your local health network, private hospital group, state or territory. • Undertake local evaluation, or participate in external evaluations of the impact of quality improvement activities. • See Action 8.2.4 regarding improvement actions that can be taken at a local level.

Governance and systems for the prevention and management of pressure injuries

Action	Overview of what is required	Suggested approach in small hospitals
8.4 Providing or facilitating access to equipment and devices to implement effective prevention strategies and best practice management plans		
8.4.1 Equipment and devices are available to effectively implement prevention strategies for patients at risk and plans for the management of patients with pressure injuries	• The main task required for this action is to put in place mechanisms for accessing appropriate equipment and devices for preventing and managing pressure injuries.	• Evaluate equipment and device requirements, usage and effectiveness in your hospital. • Determine the type and number of support devices your hospital requires. • Schedule routine maintenance and coordinate ad hoc repairs to maximise the availability of equipment. • Develop guidelines on how to access required equipment (for example, rental options). • If there is a process for accessing and maintaining equipment within your local health network or private hospital group, carry out these activities in accordance with this process.

Preventing pressure injuries

Action	Overview of what is required	Suggested approach in small hospitals
8.5 Identifying risk factors for pressure injuries using an agreed screening tool for all presenting patients within timeframes set by best practice guidelines		
8.5.1 An agreed tool to screen for pressure injury risk is used by the clinical workforce to identify patients at risk of a pressure injury	• The next part of the organisation-wide pressure injury prevention and management system (Action 8.1.1) concerns the processes that are in place for identifying patients who are at risk of developing pressure injuries. • These items require the inclusion of agreed risk assessment criteria for pressure injury in your hospital's admission and ongoing assessment policies, procedures and/or protocols. • As part of your wider quality improvement processes, compliance with the use of risk assessment screening tools should be incorporated into data collection processes. • Use audit and other data to identify gaps in systems for screening patients for pressure injury and target quality improvement activities accordingly.	• Ensure the pressure injury policy framework used locally includes an agreed process and criteria for screening.
8.5.2 The use of the screening tool is monitored to identify the proportion of at-risk patients that are screened for pressure injuries on presentation		• Conduct local audits, or participate in audits conducted by your local health network, private hospital group, state or territory. Monitoring and data collection systems should identify: – the proportion of patients who are screened at admission for their risk of pressure injury – the proportion of patients who are identified as at risk of pressure injury through the initial screening process – the proportion of patients identified as being at risk through the initial screening process that are assessed for any pressure injuries that may already be present.
8.5.3 Action is taken to maximise the proportion of patients who are screened for pressure injury on presentation		• See Actions 8.2.4 regarding improvement actions that can be taken locally.

Action	Overview of what is required	Suggested approach in small hospitals
8.6 Conducting a comprehensive skin inspection in timeframes set by best practice guidelines on patients with a high risk of developing pressure injuries at presentation, regularly as clinically indicated during a patient's admission, and before discharge		
8.6.1 Comprehensive skin inspections are undertaken and documented in the patient clinical record for patients at risk of pressure injuries	• The next part of the organisation-wide pressure injury prevention and management system (Action 8.1.1) concerns the processes that are in place for conducting comprehensive skin assessments on patients who are identified as at risk of developing pressure injuries. • These items require the inclusion of agreed processes for undertaking and documenting comprehensive skin assessment. • As part of your wider quality improvement processes, data collection and audit processes should include documentation of skin assessments on patients who have been identified as being at risk for pressure injuries. • Use audit and other data to identify gaps in systems for conducting comprehensive skin assessments and target quality improvement activities accordingly.	• Ensure the pressure injury policy framework uses a locally-agreed process for conducting and documenting comprehensive skin assessments on patients who are identified as being at risk of pressure injuries.
8.6.2 Patient clinical records, transfer and discharge documentation are periodically audited to identify at-risk patients with documented skin assessments		• Conduct local audits and reviews, or participate in audits conducted by your local health network, private hospital group, state or territory. • Where local reviews are necessary, patient clinical records should be systematically reviewed to provide information on the frequency of documented skin assessments. • The audit should identify: – the proportion of documented skin assessments conducted on patients who are identified as being at risk of pressure injury – compliance with skin assessment and documentation policies, procedures and protocols.
8.6.3 Action is taken to increase the proportion of skin assessments documented on patients at risk of pressure injuries		• See Action 8.2.4 regarding improvement actions that can be undertaken locally.

Preventing pressure injuries

Action	Overview of what is required	Suggested approach in small hospitals
8.7 Implementing and monitoring pressure injury prevention plans and reviewing when clinically indicated		
8.7.1 Prevention plans for all patients at risk of a pressure injury are consistent with best practice guidelines and are documented in the patient clinical record	• The next part of the organisation-wide pressure injury prevention and management system (Action 8.1.1) concerns the processes that are in place for implementing prevention plans for patients who are identified as at risk of developing pressure injuries. • These items require the inclusion of agreed processes for developing, implementing and documenting pressure injury prevention plans. • As part of your wider quality improvement processes, data collection and audit should include processes for identifying the proportion of at-risk patients that have pressure injury prevention plans in place. • Use audit and other data to identify gaps in systems for pressure injury prevention and target quality improvement activities accordingly.	• Ensure the pressure injury policy framework used locally includes an agreed format for prevention plans.
8.7.2 The effectiveness and appropriateness of pressure injury prevention plans are regularly reviewed		• When pressure injuries are reported, information should be gathered about what, if any, prevention plan was in place.
8.7.3 Patient clinical records are monitored to determine the proportion of at-risk patients that have an implemented pressure injury prevention plan		• Conduct local audits, or participate in audits conducted by your local health network, private hospital group, state or territory. • Where necessary, audit patient clinical records and case notes to determine the proportion of at-risk patients who have documented pressure injury prevention plans. • Bedside audits of practice may be useful for determining if at-risk patients are being cared for in accordance with their individualised pressure injury prevention plans.
8.7.4 Action is taken to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan		• See Action 8.2.4 regarding improvement actions that can be undertaken locally.

Action	Overview of what is required	Suggested approach in small hospitals
8.8 Implementing best practice management and ongoing monitoring as clinically indicated		
8.8.1 An evidence-based wound management system is in place within the health service organisation	• The next part of the organisation-wide pressure injury prevention and management system (Action 8.1.1) concerns the processes that are in place for wound management in patients with identified pressure injuries. • These items require the inclusion of agreed processes for developing, implementing and documenting pressure injury wound management plans. • As part of your wider quality improvement processes, data collection and audit should include processes for identifying the proportion of patients with pressure injuries who have appropriate wound management plans in place. • Use audit and other data to identify gaps in systems for pressure injury wound management and target quality improvement activities accordingly.	• Ensure the pressure injury policy framework used locally includes a wound management system. This should address assessment, treatment, monitoring and documentation of pressure injuries. Relevant guidelines can be found at: http://www.awma.com.au/publications/2012_AWMA_Pan_Pacific_Guidelines.pdf
8.8.2 Management plans for patients with pressure injuries are consistent with best practice and documented in the patient clinical record		• Frameworks or formats for management plans may be available from your local health network, private hospital group, state or territory. • Management plans for patients with pressure injuries should be consistent with clinical guidelines and address ongoing skin and wound assessment, patient positioning and the use of pressure relieving devices, allied health involvement and risk reduction strategies.
8.8.3 Patient clinical records are monitored to determine compliance with evidence-based pressure injury management plans		• Conduct local audits, or participate in audits conducted by your local health network, private hospital group, state or territory. • Where necessary, audit the records of patients who develop pressure injuries to identify if management plans are in place and clinical guidelines are being followed.
8.8.4 Action is taken to increase compliance with evidence-based pressure injury management plans		• See Action 8.2.4 regarding improvement actions that can be undertaken locally.

Communicating with patients and carers

Action	Overview of what is required	Suggested approach in small hospitals
8.9 Informing patients with a high risk of pressure injury, and their carers, about the risks, prevention strategies and management of pressure injuries		
8.9.1 Patient information on prevention and management of pressure injuries is provided to patients and carers in a format that is understood and is meaningful	• Patients and carers are part of the clinical team, and opportunities should be identified to improve communication between clinicians, patients and carers about the prevention and management of pressure injuries. This proactive and patient-centred approach to care may help confirm physical assessment findings or obtain additional information to inform the development of a patient's pressure injury prevention and management plan. • Opportunities for communication may include: – on presentation to an acute care area – during risk assessment, skin inspection or the delivery of wound care – at regularly scheduled intervals throughout a patient's hospital admission – daily, during healthcare team rounds – at bedside handover. • Communication can include written information such as brochures, fact sheets, newsletters and posters, and online information and information broadcast on internal hospital media systems.	• Identify if there are resources and frameworks for communication with patients and carers available from your local health network, private hospital group, state or territory. These may be part of the policy framework that is required for *Standard 6: Clinical Handover*. • If so, ensure these are adapted as required and used in your hospital. • If not, develop mechanisms and/or resources for communicating with patients and carers about prevention and management of pressure injuries • The communication processes and information resources required to meet this Action may not need to be developed separately. These could be linked to policies, procedures and/or protocols for activities such as clinical handover (as required under *Standard 6: Clinical Handover*) • As part of this development process it may be useful to review resources for patients and carers that are available from state- and disease-based consumer organisations. See the *Safety and Quality Improvement Guide for Standard 2: Partnering with Consumers* (ACSQHC 2012) for information about how to access these groups.
8.10 Developing a plan of management in partnership with patients and carers		
8.10.1 Pressure injury management plans are developed in partnership with patients and carers	• Inform patients and carers about the purpose and process of developing a pressure injury management plan and invite them to be involved in its development.	• Engage and collaborate with patients and carers in the development of management plans. • Document the involvement of patients and carers in management plans.

Key resources

Australian Commission on Safety and Quality in Health Care. *Safety and Quality Improvement Guide Standard 8: Preventing and Managing Pressure Injuries*. Sydney. ACSQHC, 2012.
www.safetyandquality.gov.au/our-work/accreditation/nsqhss/safety-and-quality-improvement-guides-and-accreditation-workbooks/

Australian Wound Management Association. *Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury*. 2012
http://www.awma.com.au/publications/2012_AWMA_Pan_Pacific_Guidelines.pdf

Notes

The intention of this Standard is to ensure the prompt recognition of patients when their condition deteriorates and for appropriate action to be taken. In small hospitals, the principles of recognising and responding to clinical deterioration will apply; however strategies for response may involve external services and/or clinicians and/or upskilling existing members of the workforce.

Establishing recognition and response systems

Action	Overview of what is required	Suggested approach in small hospitals
9.1 Developing, implementing and regularly reviewing the effectiveness of governance arrangements and the policies, procedures and/or protocols that are consistent with the requirements of the National Consensus Statement		
9.1.1 Governance arrangements are in place to support the development, implementation, and maintenance of organisation-wide recognition and response systems **9.1.2** Policies, procedures and/or protocols for the organisation are implemented in areas such as: • measurement and documentation of observations • escalation of care • establishment of a rapid response system • communication about clinical deterioration	• These actions are at the core of Standard 9. Organisation-wide recognition and response systems consist of the policies, procedures and/or protocols that are needed to properly recognise and respond to patients whose condition is deteriorating in your hospital. • The main components of the organisation-wide recognition and response system that are included in this Standard concern processes for: – recognising clinical deterioration and escalating care (Items 9.3 and 9.4) – responding to clinical deterioration (Items 9.5 and 9.6) – communicating with patients and carers (Items 9.7 to 9.9). • The recognition and response system that is put in place needs to be consistent with the *National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration*.	• Identify where the governance and policy framework for your recognition and response system sits. • If it sits externally with your local health network, private hospital group, state or territory, you will need to: – make sure this governance and policy framework is applied in your hospital – identify a suitable person who is responsible for the recognition and response system at the local level – routinely provide information about the performance of the recognition and response system to this person. • If governance of the recognition and response system sits internally within your hospital, you will need to develop a governance and policy framework that meets the requirements of Actions 9.1.1 and 9.1.2. • Detailed assistance is provided in the *Guide to Support Implementation of the National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration* and associated resources: www.safetyandquality.gov.au/our-work/recognition-and-response-to-clinical-deterioration/implementing-r-and-r-systems/

Action	Overview of what is required	Suggested approach in small hospitals
9.2 Collecting information about the recognition and response systems, providing feedback to the clinical workforce, and tracking outcomes and changes in performance over time		
9.2.1 Feedback is actively sought from the clinical workforce on the responsiveness of the recognition and response systems	• Many of the actions in Standard 9 are based on a quality improvement cycle where: – policies, procedures and/or protocols for recognising and responding to clinical deterioration are developed (either locally or centrally) – the recognition and response systems are implemented locally – compliance with, and performance of the recognition and response systems is monitored (locally and/or centrally) – local action is taken to improve performance. • Actions 9.1.1 and 9.1.2 relate to the policy development and implementation parts of this cycle. • Actions 9.2.1 and 9.2.2 relate to the monitoring part of the quality improvement cycle. They concern two important sources of information about recognition and response systems: – the views of the clinical workforce about how the recognition and response system is performing (Action 9.2.1) – deaths and cardiac arrests for patients without a treatment-limiting order (Action 9.2.2). • Actions 9.2.3 and 9.2.4 relate to the improvement part of the quality improvement cycle.	• Conduct local reviews, or participate in activities such as surveys and focus groups as conducted by your local health network, private hospital group, state or territory, or other external organisation. • One of the benefits of working in a small hospital is that you can also follow up directly with clinicians about how the recognition and response system is working locally. Use this information to inform local quality improvement activities.
9.2.2 Deaths or cardiac arrests for a patient without an agreed treatment-limiting order (such as not for resuscitation or do not resuscitate) are reviewed to identify the use of the recognition and response systems, and any failures in these systems		• Your hospital should systematically review the records of all patients who suffer an unexpected cardiopulmonary arrest or die unexpectedly in your hospital. This should be done locally, even if the policy and governance framework for your recognition and response system sits at a higher level. • Your local health network, private hospital group, state or territory may have frameworks and tools you can use to structure these reviews.

Establishing recognition and response systems

Action	Overview of what is required	Suggested approach in small hospitals
9.2 Collecting information about the recognition and response systems, providing feedback to the clinical workforce, and tracking outcomes and changes in performance over time (continued)		
9.2.3 Data collected about recognition and response systems are provided to the clinical workforce as soon as practicable	See overview of what is required for Actions 9.2.1 and 9.2.2.	• Providing information from the evaluation of your recognition and response system to the clinical workforce can inform clinicians about areas that need improvement and help to motivate them to change practice and participate in improvement activities. • Your hospital should routinely discuss audit data and findings from incident or death reviews with your clinical workforce, including external clinicians who are involved in providing the rapid response (for example, doctors providing on call services from the local general practice). This can be done at team meetings, during education sessions or by providing direct feedback to individuals.
9.2.4 Action is taken to improve the responsiveness and effectiveness of the recognition and response systems		• Use data to guide the development of improvement strategies such as: – resolving any systems issues that may be identified (for example, timely access to necessary equipment) – making amendments to local policies, procedures and/or protocols or making recommendations to the local health network or private hospital group for policies that sit at that level – providing additional education and training for clinicians (this may be done by your local health network, private hospital group, state or territory or other external organisations) – improving or developing communication material and information resources for clinicians, patients and carers.

Action	Overview of what is required	Suggested approach in small hospitals
9.3 Implementing mechanism(s) for recording physiological observations that incorporates triggers to escalate care when deterioration occurs		
9.3.1 When using a general observation chart, ensure that it: • is designed according to human factors principles • includes the capacity to record information about respiratory rate, oxygen saturation, heart rate, blood pressure, temperature and level of consciousness graphically over time • includes thresholds for each physiological parameter or combination of parameters that indicate abnormality • specifies the physiological abnormalities and other factors that trigger the escalation of care • includes actions required when care is escalated	• Observation charts are tools for documenting, monitoring and communicating changes in physiological observations. Observation charts play a key role in recognising and responding to clinical deterioration and in the organisation-wide recognition and response system (Actions 9.1.1 and 9.1.2). • Observation and response charts include features described in Action 9.3.1. They have been specifically designed to support accurate and timely recognition of clinical deterioration, and prompt action when deterioration is observed. The way in which observation charts are designed and used can contribute to both the poor recording of observations and failures to interpret them correctly. • The main tasks required for these actions are to put in place observation charts that meet the requirements described in Action 9.3.1, monitor how these charts are being used (Action 9.3.2) and take action to improve use of the charts if needed (Action 9.3.3).	• Some states, territories, local health networks or private hospital groups and have developed and implemented general observation charts for use in their health service organisations. If this applies to your hospital, use the charts that are required by the state, territory, local health network or private hospital group. • If there is not a general observation chart that applies to your hospital from one of these sources, identify if your local referral hospital has an appropriate observation and response chart that could be used in your hospital. • If your hospital needs to develop a general observation chart for local use, use one of the four observation and response charts that have been developed by the Commission according to human factors principles: http://www.safetyandquality.gov.au/our-work/recognition-and-response-to-clinical-deterioration/observation-and-response-charts/ This web page contains guidance about the use of these charts.
9.3.2 Mechanisms for recording physiological observations are regularly audited to determine the proportion of patients that have complete sets of observations recorded in agreement with their monitoring plan	See overview of what is required for Action 9.3.1.	• Identify whether there is an audit tool that applies to your hospital from your local health network, private hospital group, state or territory. • If there is such a tool, then ensure that it is used in your hospital as required by your local health network, private hospital group, state or territory. • If there is not, a tool for auditing observations, monitoring and escalation is available for download from the Commission's web site: www.safetyandquality.gov.au/wp-content/uploads/2012/10/Final-editable-PDF-Observations-Monitoring-Escalation-audit-tool.pdf

Recognising clinical deterioration and escalating care

Action	Overview of what is required	Suggested approach in small hospitals
9.3 Implementing mechanism(s) for recording physiological observations that incorporates triggers to escalate care when deterioration occurs (continued)		
9.3.3 Action is taken to increase the proportion of patients with complete sets of recorded observations, as specified in the patient's monitoring plan	See overview of what is required for Action 9.3.1.	• See Action 9.2.4 regarding improvement actions that can be taken at a local level.
9.4 Developing and implementing mechanisms to escalate care and call for emergency assistance where there are concerns that a patient's condition is deteriorating		
9.4.1 Mechanisms are in place to escalate care and call for emergency assistance	• The next element of the organisation-wide system for recognising and responding to clinical deterioration (Action 9.1.1) concerns processes for escalating care when a patient's condition is deteriorating. • Processes for escalating care should involve the use of: – a track and trigger system (or early warning system) that provides an objective decision-making process for recognising and responding to altered physiological observations and assessments – an escalation protocol that describes the actions required for different levels of abnormality. • The main tasks required for these actions are to put in place mechanisms for escalating care and – calling for emergency assistance (Action 9.4.1) – monitoring how these escalation processes are being used (Action 9.4.2) – taking action to improve use of the escalation processes if needed (Action 9.4.3).	• Processes for escalating care, including track and trigger systems and escalation protocols, need to be developed with regard to the location of, and resources available at, your hospital. • You may need to develop escalation processes in consultation with external providers such as local general practice or ambulance providers. • Your escalation protocol should specify when care needs to be escalated to another health care organisation such as your local referral hospital. • If there is a policy framework regarding the escalation of care and processes to call for emergency assistance that sits at the level of the local health network, private hospital group, state or territory, then take this into account when local escalation processes are developed. • A tool to help map escalation triggers and responses is available for download from the Commission's web site: www.safetyandquality.gov.au/wp-content/uploads/2012/02/Escalation-mapping-template-editable-PDF.pdf

Action	Overview of what is required	Suggested approach in small hospitals
9.4 Developing and implementing mechanisms to escalate care and call for emergency assistance where there are concerns that a patient's condition is deteriorating (continued)		
9.4.2 Use of escalation processes, including failure to act on triggers for seeking emergency assistance, are regularly audited	See overview of what is required for Action 9.4.1.	• Identify whether there is an audit tool that applies to your hospital from your local health network, private hospital group, state or territory. • If there is such a tool, then ensure that it is used in your hospital as required by your local health network, private hospital group, state or territory. • If there is not, a tool for auditing observations, monitoring and escalation is available for download from the Commission's web site: www.safetyandquality.gov.au/wp-content/uploads/2012/10/Final-editable-PDF-Observations-Monitoring-Escalation-audit-tool.pdf • Information about use of escalation triggers can also come from: – the review of deaths and cardiac arrests (Action 9.2.3) – calls for emergency assistance (Action 9.5.2).
9.4.3 Action is taken to maximise the appropriate use of escalation processes		• See Action 9.2.4 regarding improvement actions that can be taken at a local level.

Responding to clinical deterioration

Action	Overview of what is required	Suggested approach in small hospitals
9.5 Using the system in place to ensure that specialised and timely care is available to patients whose condition is deteriorating		
9.5.1 Criteria for triggering a call for emergency assistance are included in the escalation policies, procedures and/or protocols	• The next part of the organisation-wide recognition and response system (Action 9.1.1) concerns the processes that are in place for responding to clinical deterioration. • These items build on Action 9.4.1 and require the inclusion of criteria to call for emergency assistance to be included in your hospital's escalation policies, procedures and/or protocols (Action 9.5.1). • As part of your wider quality improvement processes, calls for emergency assistance should be reviewed to identify gaps and opportunities for improvement (Action 9.5.2). • The response to these calls for emergency assistance generally comes from some form of rapid response system. A rapid response system is a system for providing emergency assistance to patients whose condition is deteriorating. These responses can include a medical emergency team, intensive care liaison nurse, clinicians from other parts of the hospital who are trained in advanced life support and clinicians who are external to the hospital.	• Identify whether there are criteria for triggering an emergency call that apply to patients in your hospital from your local health network, private hospital group, state or territory. • If there are such criteria, then ensure that these triggers are used in your hospital as required by your local health network, private hospital group, state or territory. • If there are not, then you need to agree on the criteria for triggering an emergency call in your hospital. A tool to help map escalation triggers and responses is available for download from the Commission's web site: www.safetyandquality.gov.au/wp-content/uploads/2012/02/Escalation-mapping-template-editable-PDF.pdf • You may need to develop your rapid response system in consultation with external providers such as local general practitioners, ambulance providers or the retrieval service. • Include details of how the rapid response system operates as part of your hospital's escalation policy.
9.5.2 The circumstances and outcome of calls for emergency assistance are regularly reviewed		• You should systematically review the circumstances and outcome of all emergency calls in your hospital. This should be done locally, even if the policy and governance framework for your recognition and response system sits at a higher level. • Your local health network, private hospital group, state or territory may have frameworks and tools you can use to structure these reviews. • If not, you could consider adapting the case review form developed by the Commission to suit your local system. This is available for download from the Commission's web site: http://www.safetyandquality.gov.au/wp-content/uploads/2012/02/Rapid-Response-System-Case-Report-Low-Res3.pdf

Action	Overview of what is required	Suggested approach in small hospitals
9.6 Having a clinical workforce that is able to respond appropriately when a patient's condition is deteriorating		
9.6.1 The clinical workforce is trained and proficient in basic life support	• As part of the organisation-wide recognition and response system (Action 9.1.1), all clinicians, including those who are casual, from an agency or locums, need to able to implement basic life support measures while awaiting emergency assistance. • The Australian Resuscitation Council defines basic life support as 'the preservation of life by the initial establishment of, and/or maintenance of, airway, breathing, circulation and related emergency care, including use of an automated external defibrillator.'	• Identify whether there are training programs in basic life support that are required and/or delivered by your local health network, private hospital group, state or territory. • If this is the case, then these should be used to provide training to the clinical workforce. • If training is not available through your local health network, private hospital group, state or territory, use external training agencies who offer certification in basic life support skills. This training should be compliant with guidelines from the Australian Resuscitation Council. • Records should be kept about basic life support certification for the clinical workforce.
9.6.2 A system is in place for ensuring access at all times to at least one clinician, either on-site or in close proximity, who can practise advanced life support	• Clinicians who respond to calls for emergency assistance (Action 9.5.1) need to be able to provide advanced life support to patients whose condition is deteriorating. • Hospitals need to have rosters or systems to enable access to at least one clinician who can provide advanced life support at all times.	• Systems for ensuring that there is access to a clinician who can provide advanced life support at all times need to be developed with regard to the location of, and resources available at, your hospital. • Options include: – the provision of additional training to some doctors and nurses to ensure that the required level of care can be provided 24 hours per day and when key clinicians are absent. External training programs can be used to provide training in advanced life support skills if this cannot be provided locally – in health services without 24-hour medical coverage, schedule training for registered nurses in a First Line Emergency Care course – use of external providers such as local general practitioners, visiting medical officers or ambulance services. In some situations, the use of retrieval services to provide an emergency response may also be required. • Where clinicians with advanced life support skills are located off-site, response times need to be rapid so that patient safety and care is not compromised. This may require early contact of the clinician during patient episodes of deterioration, or if response times are prolonged, the capacity to have the clinician on-site.

Communicating with patients and carers

Action	Overview of what is required	Suggested approach in small hospitals
9.7 Ensuring patients, families and carers are informed about, and are supported so that they can participate in, recognition and response systems and processes		
9.7.1 Information is provided to patients, families and carers in a format that is understood and meaningful. The information should include: • the importance of communicating concerns and signs/symptoms of deterioration, which are relevant to the patient's condition, to the clinical workforce • local systems for responding to clinical deterioration, including how they can raise concerns about potential deterioration	• Patients and carers are part of the clinical team, and opportunities should be identified to improve communication between clinicians, patients and carers about possible deterioration. This proactive and patient-centred approach to care may help confirm physical assessment findings or obtain additional information about a patient's clinical presentation or problem. • Opportunities for communication may include: – on presentation to an acute care area – at regularly scheduled intervals throughout a patient's hospital admission – daily, during healthcare team rounds – at bedside handover. • Communication can include written information such as brochures, fact sheets, newsletters and posters and online information and information broadcast on internal hospital media systems.	• Identify if there are resources and frameworks for communication with patients and families available from your local health network, private hospital group, state or territory. These may be part of the policy framework that is required for *Standard 6: Clinical Handover*. • If so, ensure these are adapted as required and used in your hospital. • If not, you need to develop mechanisms and/or resources for patients and carers about the importance of communicating about possible deterioration, and how this can be done. • The communication processes and information resources required to meet this action may not need to be developed separately. These could be linked to policies, procedures and/or protocols for activities such as clinical handover (as required under *Standard 6: Clinical Handover*). • As part of this development process, it may be useful to review resources for patients and carers that are available from state- and disease-based consumer organisations. See the *Safety and Quality Improvement Guide for Standard 2: Partnering with Consumers* (ACSQHC 2012) for information about how to access these groups.

Action	Overview of what is required	Suggested approach in small hospitals
9.8 Ensuring that information about advance care plans and treatment limiting orders is in the patient clinical record, where appropriate		
9.8.1 A system is in place for preparing and/or receiving advance care plans in partnership with patients, families and carers	• These two actions relate to one specific aspect of communication with patients and carers, namely advance care plans and treatment-limiting orders. • This communication is important as patients may develop advance care plans that contain instructions about consent to, or refusal of, specified medical treatments. These plans become effective when a patient's condition deteriorates to the extent that they can no longer communicate or make decisions. • There are two aspects of advance care planning included in Standard 9: – receiving and/or preparing advance care plans with patients and carers (Action 9.8.1) – documenting advance care plans (Action 9.8.2). • Advance care planning may involve actions ranging from simple discussion and documentation of a patient's goals of care in the clinical record, to formal documentation of an advance care directive in accordance with your state or territory's legislative requirements.	• Identify if your local health network, private hospital group, state or territory have systems available to guide the preparation of advance care plans in partnership with patients. • If so, ensure that these systems are operating effectively in your hospital. • If not, you should develop a system for preparing advance care plans in partnership with patients. These will need to include processes for: – asking patients in your hospital if they have advance care plans or advance care directives – incorporating the content of advance care plans into the patient's plan of care throughout admission to your hospital.
9.8.2 Advance care plans and other treatment-limiting orders are documented in the patient clinical record		• Identify if your local health network, private hospital group, state or territory have protocols and tools available to facilitate the documentation of advance care plans and treatment-limiting decisions. • If so, ensure that these systems are operating effectively in your hospital. • If not, you should develop protocols and tools for this purpose. • Documentation of advance care plans and treatment-limiting decision should enable clinicians to easily access and understand the patient's documented wishes for their care and be consistent with the requirements of relevant state or territory legislation.

Communicating with patients and carers

Action	Overview of what is required	Suggested approach in small hospitals
9.9 Enabling patients, families and carers to initiate an escalation of care response		
9.9.1 Mechanisms are in place for a patient, family member or carer to initiate an escalation of care response	• These actions build on Action 9.7.1 and relate to the introduction of systems to allow patients, family members or carers to initiate an escalation of care response. • Escalation of care by patients, families and carers acts in a similar way to escalation protocols triggered by clinicians. When patients and families identify deterioration, have concerns or if there is confusion about what is happening with care, they are able to trigger a call that brings members of the healthcare team to the patient's bedside. The healthcare team can then assess the situation, provide assistance and resolve any concerns. • Any system for family and patient escalation of care needs to be: – part of your organisation-wide recognition and response systems (Action 9.1.1) – linked to your existing processes for escalating care (Action 9.4.1). • The main tasks required for these actions are to: – put in place processes for patients and families to escalate care (Action 9.9.1) – provide information about these processes for patients families and carers (Action 9.9.2) – monitor the performance of these processes (Action 9.9.3) – take action to improve these processes if needed (Action 9.9.4).	• Identify if your local health network, private hospital group, state or territory have processes in place to enable patients, families and carers to independently escalate care. • If so, ensure that these are operating effectively in your hospital. • If not, you will need to decide on the triggers for patients, families and carers to escalate care and systems that allow them to do this independently – for example, this may involve providing independent access to the rapid response system. As part of this development process, you will need to develop and distribute information for patients, families and carers that outlines the triggers to escalate care and the processes for doing so. • A Patient and Family Escalation Network has been established by the NSW Clinical Excellence Commission to share information, resources and provide a platform for collaboration. Contact alison.gal@cec.health.nsw.gov.au to join this network.
9.9.2 Information about the system for family escalation of care is provided to patients, families and carers		
9.9.3 The performance and effectiveness of the system for family escalation of care is periodically reviewed		• You should systematically review the circumstances and outcome of all escalation calls made by patients, families and carers in your hospital. This should be done locally, even if the policy and governance framework for your recognition and response systems sits at a higher level. • Your local health network, private hospital group, state or territory may have frameworks and tools you can use to structure these reviews.
9.9.4 Action is taken to improve the system performance for family escalation of care		• Develop or improve information resources for patients, families and carers about escalating care. • See Action 9.2.4 regarding improvement actions that can be taken at a local level.

Key resources

Australian Commission on Safety and Quality in Health Care. *Safety and Quality Improvement Guide Standard 9: Recognising and Responding to Clinical Deterioration*. Sydney. ACSQHC, 2012.
www.safetyandquality.gov.au/our-work/accreditation/nsqhss/safety-and-quality-improvement-guides-and-accreditation-workbooks/

Australian Commission on Safety and Quality in Health Care. *National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration*. Sydney. ACSQHC, 2010.
www.safetyandquality.gov.au/our-work/recognition-and-response-to-clinical-deterioration/the-national-consensus-statement/

Australian Commission on Safety and Quality in Health Care. *A Guide to Support Implementation of the National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration*. Sydney. ACSQHC, 2011.
www.safetyandquality.gov.au/our-work/recognition-and-response-to-clinical-deterioration/implementing-r-and-r-systems/

Notes

The intention of this Standard is to reduce the incidence of patient falls and miminse harm from falls when they occur. In small hospitals the elements of implementation will all be present; however strategies for implementation including policies, consumer material and tools may be accessed through networks.

Governance and systems for preventing falls

Action	Overview of what is required	Suggested approach in small hospitals
10.1 Developing, implementing and reviewing policies, procedures and/or protocols, including the associated tools, that are based on the current national guidelines for preventing falls and harm from falls		
10.1.1 Policies, procedures and/or protocols are in use that are consistent with best practice guidelines (where available) and incorporate screening and assessment tools	• These actions are at the core of Standard 10. The organisation-wide falls prevention system brings together the policies, procedures and/or protocols that are needed for patients receiving care, therapy or services and who are at risk from falling or who fall. • The main components of the organisation-wide falls prevention system that are included in this Standard concern processes for: – screening for the risk of falls – assessment of patients at risk of falling – use of falls prevention strategies – management of falls risks – responding to falls.	• Identify whether there is a policy for falls prevention that applies to your hospital from your local health network, private hospital group, state or territory. • If there is, then ensure that this policy framework is in place in your hospital and functioning effectively. • If there is not, you need to have a policy and procedure about establishing, maintaining and checking for falls prevention. This should include details and activities such as: – falls prevention requirements – falls risk screening and/or assessment – management of falls risk (including care planning) – post-falls management.
10.1.2 The use of policies, procedures and/or protocols is regularly monitored		• Identify responsibility for the falls prevention policy locally. • Review audit data, falls incidents, adverse events and near misses from your hospital to identify where falls prevention improvement is needed. • Conduct local audits, or participate in audits of compliance conducted by your local health network, private hospital group, state or territory.

Action	Overview of what is required	Suggested approach in small hospitals
10.2 Using a robust organisation-wide system of reporting, investigation and change management to respond to falls incidents		
10.2.1 Regular reporting, investigating and monitoring of falls incidents is in place	• These actions relate to processes for recording, reporting and responding to falls when they occur in your hospital. • The main tasks required for these actions are to ensure that: – incident reporting occurs (Actions 10.2.1 and 10.2.2) – actions taken draw on incident data set – outcomes are reviewed and reported (Action 10.2.3) – results inform falls prevention quality improvement activities (Action 10.2.4). • The quality improvement requirements of this item (Action 10.2.4) are linked to the actions taken as part of the organisation-wide falls prevention system. For example, activities such as screening and falls assessment will contribute to a reduction in the frequency and severity of falls.	• Identify whether there is an incident reporting system that applies to your hospital from your local health network, private hospital group, state or territory. • If there is, then ensure that the system is in place in your hospital and functioning effectively. • If there is not, ensure that a system is implemented as required under Item 1.14 of *Standard 1: Governance for Safety and Quality in Health Service Organisations*. • Falls incidents need to be included in the incident reporting system and the clinical workforce should be encouraged to report them.
10.2.2 Administrative and clinical data are used to monitor and investigate regularly the frequency and severity of falls in the health service organisation		• Review and monitor falls incidents, adverse events and near misses from your hospital to identify where improvements are needed. • There should be a local process for this, even if overall governance for your organisation-wide falls prevention system rests at the level of a local health network or private hospital group.
10.2.3 Information on falls is reported to the highest level of governance in the health service organisation		• Routinely provide the results from audits and incident reviews to the local governance bodies, and any relevant governance bodies within a local health network, private hospital group, region, state or territory.

Governance and systems for preventing falls

Action	Overview of what is required	Suggested approach in small hospitals
10.2 Using a robust organisation-wide system of reporting, investigation and change management to respond to falls incidents (continued)		
10.2.4 Action taken to reduce the frequency and severity of falls in the health service organisation	See overview of what is required for Actions 10.2.1, 10.2.2 and 10.2.3.	• Use data to guide the development of improvement strategies such as: – providing education and training to staff involved in falls prevention. The training may be delivered locally (including online) or through the local health network, private hospital group, state, territory or other external organisation – resolving any systems issues that may be identified (for example, timely access to necessary equipment) – making amendments to local policies, procedures and/or protocols or making recommendations to the local health network or private hospital group for policies that sit at that level – where relevant, participating in quality improvement activities that are conducted by your local health network, private hospital group, state or territory – undertaking local evaluation, or participating in external evaluations of the impact of quality improvement activities.

Governance and systems for preventing falls

Action	Overview of what is required	Suggested approach in small hospitals
10.3 Undertaking quality improvement activities to address safety risks and ensure the effectiveness of the falls prevention system		
10.3.1 Quality improvement activities are undertaken to prevent falls and minimise patient harm	• This action relates to the overarching quality improvement approach that is needed to prevent falls, reduce the harm from falls and improve their management. • Activities undertaken as part of Actions 10.2.4, 10.5.3, 10.6.3 and 10.7.3 can be used to demonstrate compliance with this action.	• Check all aspects of the local environment and modify where possible to reduce the risk of falls. • Document identified falls risks and actions taken to address them. • When conducting quality improvement activities locally, use a standardised quality improvement methodology to bring about change. This methodology may be determined by your local health network, private hospital group, state or territory. • See Action 10.2.4 for improvement actions that can be taken locally.
10.4 Implementing falls prevention plans and effective management of falls		
10.4.1 Equipment and devices are available to implement prevention strategies for patients at risk of falling and management plans to reduce the harm from falls	• The main tasks are to ensure that falls prevention equipment and devices are appropriate, maintained, available and provided to patients at risk as required.	• Identify available falls prevention equipment and devices. • Ensure existing equipment and devices are maintained and available. • Determine if additional equipment or devices are needed locally and options for accessing them. • If there is a process for accessing and maintaining equipment within your local health network or private hospital group, these activities should be done in accordance with this process.

Screening and assessing risks of falls and harm from falling

Action	Overview of what is required	Suggested approach in small hospitals
10.5 Using a best practice-based tool to screen patients on presentation, during admission and when clinically indicated for the risk of falls		
10.5.1 A best practice screening tool is used by the clinical workforce to identify the risk of falls	• The main tasks required for these actions are to ensure that: – patients are screened for their falls risk (either through a screening tool or through a process, such as clinical judgement) (Action 10.5.1) – the result is recorded (Action 10.5.2) – both screening and recording are to be monitored and, if appropriate, the rate of use increased (Action 10.5.3).	• Ensure the falls prevention policy used locally identifies a process or tool for falls risk screening and a process for recording the outcome.
10.5.2 Use of the screening tool is monitored to identify the proportion of at-risk patients that were screened for falls		• Conduct local audits, or participate in audits of compliance conducted by your local health network, private hospital group, state or territory. These audits should assess whether the falls prevention screening is being conducted.
10.5.3 Action is taken to increase the proportion of at-risk patients who are screened for falls upon presentation and during admission		• Identify strategies to increase the number of patients being screened locally. • See Action 10.2.4 for improvement actions that can be taken locally.

Screening and assessing risks of falls and harm from falling

Action	Overview of what is required	Suggested approach in small hospitals
10.6 Conducting a comprehensive risk assessment for patients identified at risk of falling in initial screening processes		
10.6.1 A best practice assessment tool is used by the clinical workforce to assess patients at risk of falling	• The main tasks required for these actions are to ensure that: – patients at risk of falling are assessed for individual falls risks (either through an assessment tool or through a process, such as clinical judgement) (Action 10.6.1) – the result is recorded (Action 10.6.1) – both assessment and recording are to be monitored and, if appropriate, the rate of use increased (Actions 10.6.2 and 10.6.3).	• Ensure the falls prevention policy used locally identifies a process or tool for assessing patients for falls risk factors and a process for recording the outcome.
10.6.2 The use of the assessment tool is monitored to identify the proportion of at-risk patients with a completed falls assessment		• Conduct local audits, or participate in audits of compliance conducted by your local health network, private hospital group, state or territory. These audits should assess whether falls prevention assessment is being conducted.
10.6.3 Action is taken to increase the proportion of at-risk patients undergoing a comprehensive falls risk assessment		• Identify strategies to increase the number of at-risk patients being assessed. • See Action 10.2.4 for improvement actions that can be taken locally.

Preventing falls and harm from falling

Action	Overview of what is required	Suggested approach in small hospitals
10.7 Developing and implementing a multifactorial falls prevention plan to address risks identified in the assessment		
10.7.1 Use of best practice multifactorial falls prevention and harm minimisation plans is documented in the patient clinical record	• The main tasks required for these actions are to ensure that: – outcomes from screening and/or assessment are recorded (Action 10.7.1) – care planning occurs (Action 10.7.1) – care plans are acted upon (Action 10.7.1) – the result is recorded (Action 10.7.1) – these tasks are monitored and action taken to reduce falls and harm from them (Action 10.7.2 and 10.7.3).	• Identify individual risk factors through assessment. Document these and develop a falls care plan. • Respond to individual risk factors with available interventions and in the context of standard falls prevention strategies.
10.7.2 The effectiveness and appropriateness of the falls prevention and harm minimisation plan are regularly monitored		• Conduct local audits, or participate in audits of compliance conducted by your local health network, private hospital group, state or territory. These audits should assess the effectiveness and appropriateness of prevention and harm minimisation plans.
10.7.3 Action is taken to reduce falls and minimise harm for at-risk patients		• Implement falls care plans to reduce patient risk. • Communicate falls risk information, including patient falls, at clinical handover. • Review the falls risk assessment whenever a patient falls and implement a prevention and management plan. • See Action 10.2.4 for improvement actions that can be implemented locally.
10.8 Patients at risk of falling are referred to appropriate services, where available, as part of the discharge process		
10.8.1 Discharge planning includes referral to appropriate services, where available	• This action relates to the need to consider falls risks as part of discharge planning.	• Discharge information to the general practitioner (or other provider) should detail falls risks identified, and falls experienced, during admission and actions taken. • Refer to available services consistent with local policy.

Communicating with patients and carers

Action	Overview of what is required	Suggested approach in small hospitals
10.9 Informing patients and carers about the risk of falls, and falls prevention strategies		
10.9.1 Patient information on falls risks and prevention strategies is provided to patients and their carers in a format that is understood and meaningful	• The main task is to assist patients and carers understand the patient's falls risk and strategies for managing it.	• Provide patient information to patients at risk of falls at discharge in a way which is understood. • Provide formal or informal feedback to those responsible for maintaining the resources.
10.10 Developing falls prevention plans in partnership with patients and carers		
10.10.1 Falls prevention plans are developed in partnership with patients and carers	• The main task is to engage with patients and carers during care planning which may ensure care plans better suited to patient preferences and possibilities.	• Involve patients and carers in discussions about falls prevention during episodes of care.

Key resources

Australian Commission on Safety and Quality in Health Care. *Safety and Quality Improvement Guide Standard 10: Preventing Falls and Harm from Falls*. Sydney. ACSQHC, 2012.
www.safetyandquality.gov.au/our-work/accreditation/nsqhss/safety-and-quality-improvement-guides-and-accreditation-workbooks/

Australian Commission on Safety and Quality in Health Care. *Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines for Australian Hospitals*. Sydney, ACSQHC, 2009.
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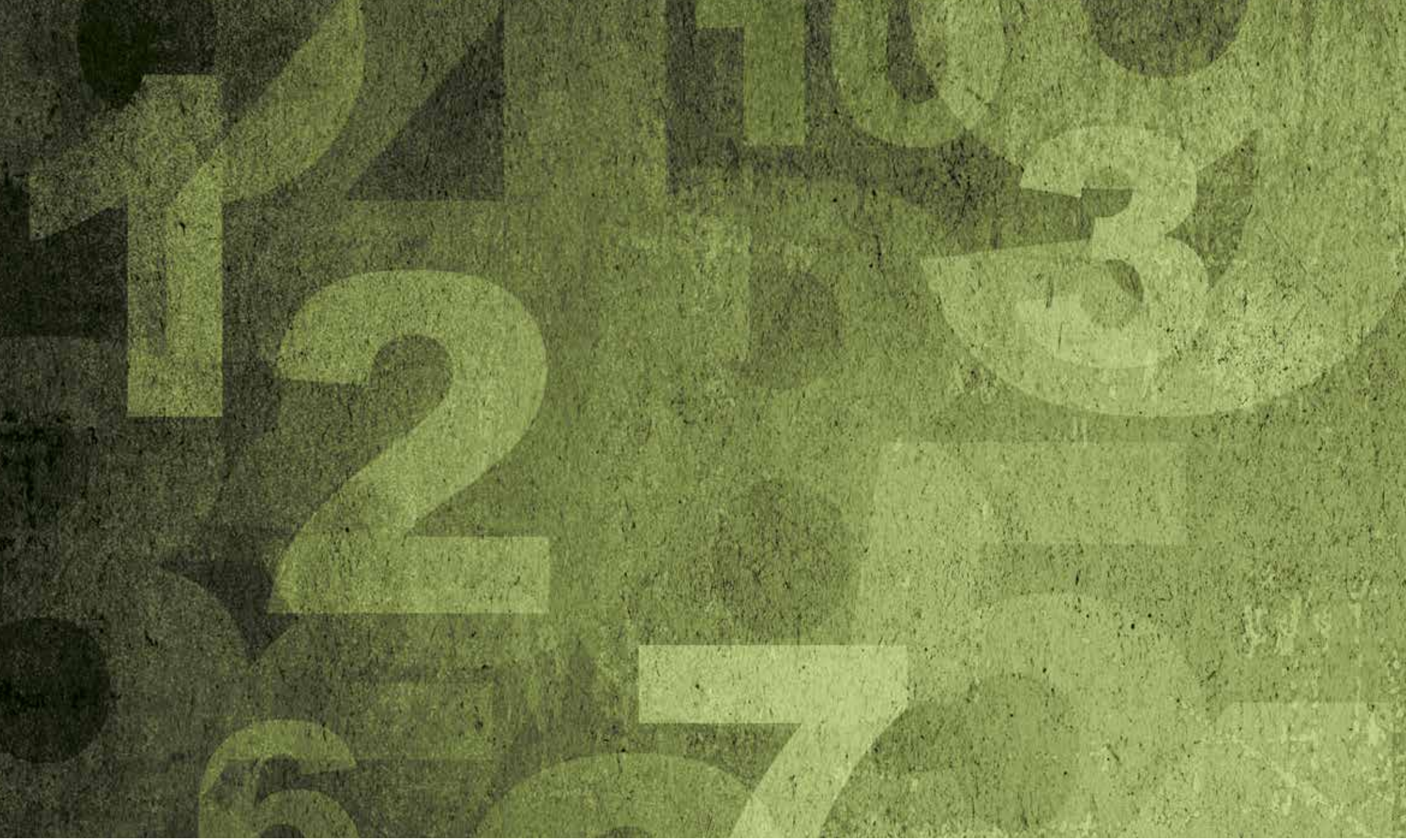

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