AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS
STANDARDS

National Safety and Quality
Health Service Standards

Guide for Hospitals

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The Commission would like to thank all of our partners for their contributions to the development of the NSQHS Standards and their continuing commitment to improving safety and quality across the Australian healthcare system.

This document was released in November 2017.

Quick guide

Contents

Introduction

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health care. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

There are eight NSQHS Standards, which cover high-prevalence adverse events, healthcare-associated infections, medication safety, comprehensive care, clinical communication, the prevention and management of pressure injuries, the prevention of falls, and responding to clinical deterioration. Importantly, these NSQHS Standards have provided a nationally consistent statement about the standard of care consumers can expect from their health service organisations.

The NSQHS Standards require the implementation of organisation-wide systems for clinical governance, partnering with consumers, healthcare-associated infections, medication safety, comprehensive care, effective communication, blood management, and recognising and responding to acute deterioration.

The Commission has developed the National Safety and Quality Health Service Standards Guide for Hospitals to assist health service organisations to align their patient safety and quality improvement programs using the framework of the NSQHS Standards.

The Clinical Governance Standard and the Partnering with Consumers Standard set the overarching system requirements for the effective implementation of the remaining six standards, which deal with specific high-risk clinical areas of patient care. The NSQHS Standards describe the patient care journey and are designed to be implemented in an integrated way. Similar implementation strategies apply to multiple actions across the NSQHS Standards. It is important to identify the links between actions across each of the eight NSQHS Standards. This will help health service organisations to ensure that their safety and quality systems are integrated, and reduce the duplication of effort in implementing the eight standards separately.

Important improvements in the safety and quality of patient care have been documented following implementation of the first edition of the NSQHS Standards from 2011, including:

- A decline in the *Staphylococcus aureus* bacteraemia rate per 10,000 patient days under surveillance between 2010 and 2014, from 1.1 to 0.87 cases
- A drop in the yearly number of methicillin-resistant *S. aureus* bacteraemia cases between 2010 and 2014, from 505 to 389
- A decline of almost one-half in the national rate of central line-associated bloodstream infections between 2012–13 and 2013–14, from 1.02 to 0.6 per 1,000 line days
- Greater prioritisation of antimicrobial stewardship activities in health service organisations
- Better documentation of adverse drug reactions and medication history
- Reduction in yearly red blood cell issues by the National Blood Authority between mid-2010 and mid-2015, from approximately 800,000 units to 667,000 units
- Declining rates of intensive care unit admissions following cardiac arrests and in-hospital cardiac arrest rates.

The Commission has worked closely with partners to review the NSQHS Standards and develop the second edition, embedding person-centred care and addressing the needs of people who may be at greater risk of harm. The NSQHS Standards (2nd ed.) set requirements for providing comprehensive care for all patients, and include actions relating to health literacy, end-of-life care, care for Aboriginal and Torres Strait Islander people, and care for people with lived experience of mental illness or cognitive impairment.

The eight NSQHS Standards are:

Clinical Governance, which describes the clinical governance, and safety and quality systems that are required to maintain and improve the reliability, safety and quality of health care, and improve health outcomes for patients.

Partnering with Consumers, which describes the systems and strategies to create a person-centred health system by including patients in shared decision making, to ensure that patients are partners in their own care, and that consumers are involved in the development and design of quality health care.

Preventing and Controlling Healthcare-Associated Infection, which describes the systems and strategies to prevent infection, to manage infections effectively when they occur, and to limit the development of antimicrobial resistance through prudent use of antimicrobials, as part of effective antimicrobial stewardship.

Medication Safety, which describes the systems and strategies to ensure that clinicians safely prescribe, dispense and administer appropriate medicines to informed patients, and monitor use of the medicines.

Comprehensive Care, which describes the integrated screening, assessment and risk identification processes for developing an individualised care plan, to prevent and minimise the risks of harm in identified areas.

Communicating for Safety, which describes the systems and strategies for effective communication between patients, carers and families, multidisciplinary teams and clinicians, and across the health service organisation.

Blood Management, which describes the systems and strategies for the safe, appropriate, efficient and effective care of patients' own blood, as well as other supplies of blood and blood products.

Recognising and Responding to Acute Deterioration, which describes the systems and processes to respond effectively to patients when their physical, mental or cognitive condition deteriorates.

For each standard, this guide contains:

- A description of the standard
- A statement of intent
- A list of criteria that describe the key areas covered by the standard
- Explanatory notes on the content of the standard
- Item headings for groups of actions in each criterion
- Actions that describe what is required to meet the standard
- Key tasks, strategies, and use of examples of evidence to support each action.

Icons for specific actions

This guide uses icons to indicate actions that are relevant for particular groups or issues.

This icon indicates actions for which considering Aboriginal and Torres Strait Islander people specifically can improve the care provided.

The following icons identify actions relating to safety and quality issues that were addressed in separate standards in the first edition of the NSQHS Standards. These issues have been incorporated into the requirements of the second edition.

The Comprehensive Care Standard includes actions relating to:

Preventing falls and harm from falls

Preventing and managing pressure injuries

The Communicating for Safety Standard includes actions relating to:

Patient identification and procedure matching

This guide relates to the second edition of the NSQHS Standards, released in November 2017.

The key tasks, strategies, and use of resources provided in this guide are not mandatory.

Health service organisations can choose improvement strategies that are specific to their local context. These strategies should be meaningful, useful and relevant to the organisation's governance, structure, workforce and consumers.

Organisations that are part of a corporate group may need to refer to the implementation strategies recommended by the group's governing body or management.

More information

A range of other supporting resources to assist health service organisations to implement the NSQHS Standards are available on the Commission's website.

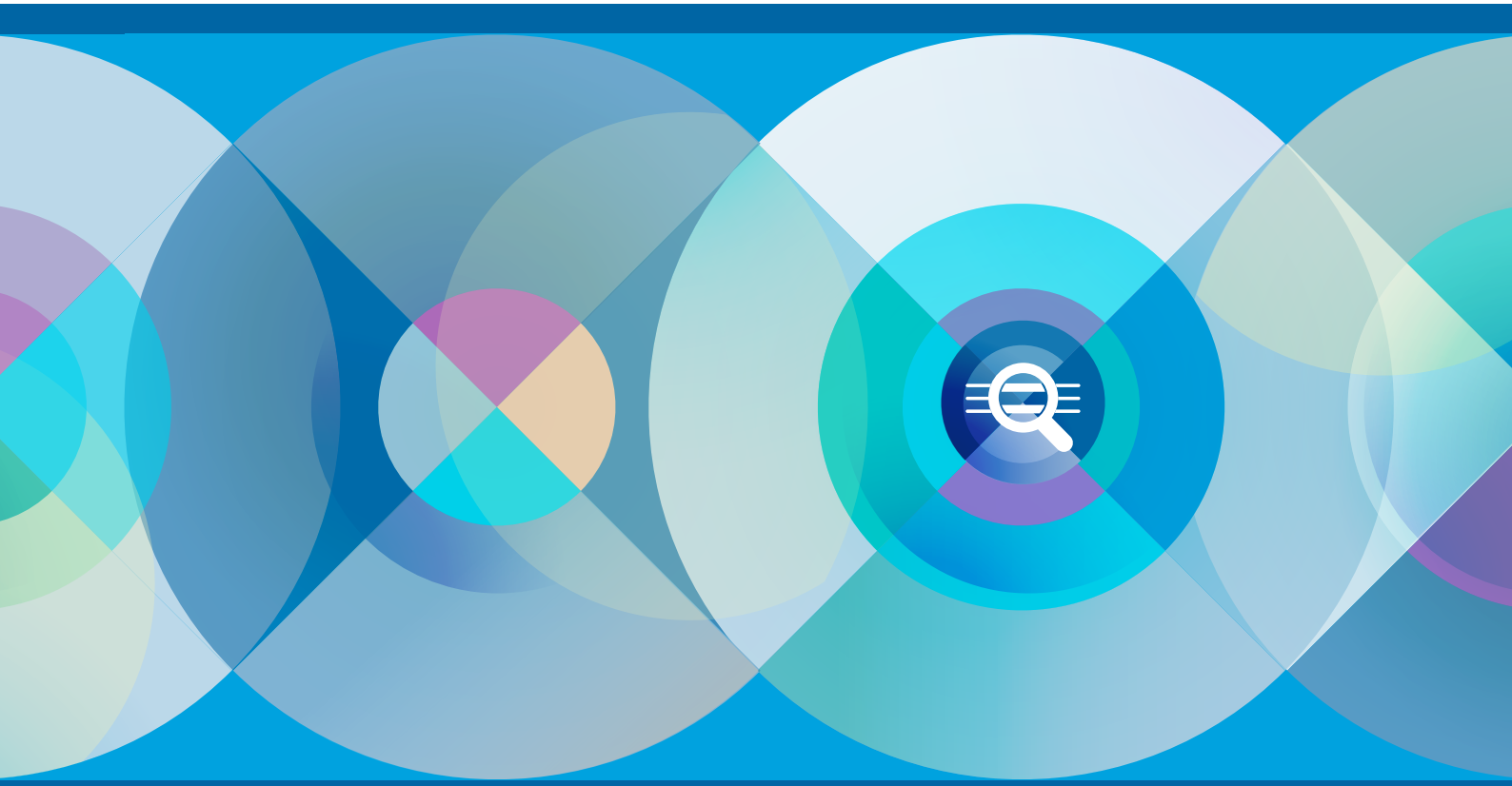
The Advice Centre provides support for health service organisations, surveyors and accrediting agencies on NSQHS Standards implementation.

Email: accreditation@safetyandquality.gov.au

Phone: 1800 304 056

1

Clinical Governance Standard



Clinical Governance Standard

Leaders of a health service organisation have a responsibility to the community for continuous improvement of the safety and quality of their services, and ensuring that they are person centred, safe and effective.

Intention of this standard

To implement a clinical governance framework that ensures that patients and consumers receive safe and high-quality health care.

Criteria

Governance, leadership and culture

Patient safety and quality systems

Clinical performance and effectiveness

Safe environment for the delivery of care

Introduction

Patients and the community trust clinicians and health service organisations to provide safe, high-quality health care.

Clinical governance is the set of relationships and responsibilities established by a health service organisation between its department of health (for the public sector), governing body, executive, workforce, patients and consumers, and other stakeholders to deliver safe and high-quality health care. It ensures that the community and health service organisations can be confident that systems are in place to deliver safe and high-quality health care, and continuously improve services.

Clinical governance is an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of health services that are safe, effective, high quality and continuously improving.

Each health service organisation needs to put in place strategies for clinical governance that consider its local circumstances.

To support the delivery of safe and high-quality care for patients and consumers, the Australian Commission on Safety and Quality in Health Care (the Commission) has developed the National Model Clinical Governance Framework. The framework has five components based on the criteria in the Clinical Governance Standard and the Partnering with Consumers Standard. Health service organisations should refer to the framework for more details on clinical governance, and the associated roles and responsibilities.

See the National Model Clinical Governance Framework[1] and *National Safety and Quality Health Service Standards Guide for Governing Bodies*.[2]

CRITERION: Governance, leadership and culture

> *Leaders at all levels in the organisation set up and use clinical governance systems to improve the safety and quality of health care for patients.*

Corporate governance encompasses the establishment of systems and processes that shape, enable and oversee the management of an organisation. It is the activity undertaken by governing bodies (often boards) of formulating strategy, setting policy, delegating responsibility, supervising management, and ensuring that appropriate risk management and accountability arrangements are in place throughout the organisation.

Management has an operational focus, whereas governance has a strategic focus. Managers run organisations, whereas the governing body ensures that the organisation is run well and in the right direction. It is the board's responsibility to ensure good governance.[3]

The governing body derives its authority to conduct the business of the organisation from the enabling legislation, licences and the organisation's constitutional documents. The organisation is governed using corporate and clinical governance processes, elements of which are implemented by the governing body and by the workforce. As part of governance, the governing body:

- Establishes the strategic direction for the organisation
- Endorses a strategic and policy framework
- Delegates responsibility for operating the organisation to the chief executive officer, who in turn delegates specific responsibilities to the workforce
- Supervises the performance of the chief executive officer
- Monitors the organisation's performance.[1]

Action 1.1

The governing body:

a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation

b. Provides leadership to ensure partnering with patients, carers and consumers

c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community

d. Endorses the organisation's clinical governance framework

e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce

f. Monitors the action taken as a result of analyses of clinical incidents

g. Reviews reports and monitors the organisation's progress on safety and quality performance

Intent

The governing body must assure itself that a culture of safety and quality improvement operates in the organisation.

Key tasks

- Identify the governing body – this is the group of people or individuals with ultimate responsibility and accountability for decision-making about safety and quality
- Ensure that the roles, responsibilities and accountabilities for safety, quality and clinical governance within the organisation are clearly articulated
- Review the organisational structure, and the position descriptions and contracts for managers, and ensure that roles, responsibilities and accountabilities for safety (including clinical safety) and quality are clearly defined and articulated at all levels in the organisation
- Endorse the organisation's clinical governance framework and strategic plans, such as the safety and quality improvement plan, and the plan for partnering with consumers
- Review the template or calendar for reporting to the governing body on safety and quality indicators and data, and ensure that it covers all services, locations, major risks, dimensions of quality and key elements of the quality improvement system
- Regularly review quality indicators to ensure that they are relevant and comprehensive
- Review relevant data from clinical incidents, and reports of complaints and other incidents
- Review the processes for providing feedback to the workforce, patients, consumers and the community about the organisation's safety and quality performance
- Review the organisation's audit program to ensure that it has enough safety and quality content
- Ensure that mitigation strategies are in place to manage all major risks
- Ensure that systems are in place to regularly survey and report on organisational culture.

Strategies for improvement

Leaders, managers and clinicians have an important role in influencing the safety and quality of care by shaping culture within the organisation, setting direction, providing support to the workforce, and monitoring progress and improvement in safety and quality performance.[4,5]

Define safety culture

There are many definitions of a safety culture. It involves the interaction of attitudes, beliefs and behaviours of members of the workforce that influence their commitment to the organisation's safety management.

A common interpretation of safety culture – which is perhaps more meaningful – is 'the way things are done around here'.[6]

Positive safety cultures in health care have strong leadership to drive and prioritise the safety of all. Commitment from leadership and management in this context is important because their actions and attitudes influence the perceptions, attitudes and behaviours of members of the workforce throughout the organisation.

Organisations with positive safety cultures have:

- Strong leadership to drive the safety culture
- Strong management commitment, with safety culture a key organisational priority
- A workforce that is engaged and always aware that things can go wrong
- Acknowledgement at all levels that mistakes occur
- Ability to recognise, respond to, give feedback about, and learn from, adverse events.

Define governance processes

The governing body has ultimate responsibility for the clinical governance of the organisation. It has obligations to ensure that effective safety and quality systems, and robust governance practices are in place and performing well. The governing body must ensure that safety and quality are consistently and effectively monitored, and that responses to safety and quality matters are prompt and appropriate.

The governing body should define its expectations about the safety and quality performance of the organisation, and the behaviours expected from its workforce. It should also be clear about how and when the safety and quality culture of the organisation will be measured and monitored.

The governing body and management need to regularly assess the systems in place to help them perform their clinical governance roles, such as:

- Identifying the appropriate structures and processes to manage and monitor clinical performance
- Describing the expected outcomes in safety and quality through the organisation's vision, mission and goals
- Setting the requirements for time frames, targets, and reporting on safety and quality performance
- Monitoring implementation and compliance with strategic, business, or safety and quality improvement plans.

Involve consumers and define patient experience

The governing body should ensure that effective partnerships are developed, and promote the organisation's engagement with patients and consumers. Strategies may involve:

- Allocating time in meeting agendas to hear and discuss patient stories or consumer feedback
- Ensuring that resources are available to support activities such as collecting patient experience data, engaging with consumers and local communities, supporting workforce training in person-centred care, and developing or adapting shared decision support tools
- Including consumer representatives on committees or working groups.

The governing body should define the expected quality of the patient experience. Setting priorities and targets for safety and quality enables the organisation to define the roles and responsibilities of the workforce to achieve these goals, and to set up systems that support quality patient experiences.

Information about the expected quality of the patient's experience can be communicated to the workforce by:

- Incorporating it into strategic plans that are translated into operational statements, policies, procedures or protocols
- Including it in workforce news bulletins and presentations in regular and ad hoc communication to the workforce
- Discussing it during executive rounds or as standing items on meeting agendas.

Endorse the clinical governance framework

The responsibility of a governing body (such as a board) for clinical governance is an integrated element of its overall responsibility and accountability to govern the organisation. As a component of broader systems for corporate governance, clinical governance involves a complex set of leadership behaviours, policies, procedures, and monitoring and improvement mechanisms that are directed towards ensuring good clinical outcomes.

The clinical governance system of a health service organisation therefore needs to be conceptualised as a system within a system – a clinical governance system within a corporate governance system.

Under this model, it is important to recognise the following points:

- Clinical governance is of equivalent importance to financial, risk and other business governance
- Decisions regarding other aspects of corporate governance can have a direct impact on the safety and quality of care, and decisions about clinical care can have a direct impact on other aspects of corporate governance, such as financial performance and risk management
- Governing bodies are ultimately responsible for good corporate (including clinical) governance
- Governing bodies cannot govern clinical services well without the deep engagement of skilled clinicians working at all levels of the organisation
- Clinicians, managers and members of governing bodies have individual and collective responsibilities for ensuring the safety and quality of clinical care. As well as being reflected in the NSQHS Standards, many of these are also specified in relevant professional codes of conduct.

Clinical governance relies on well-designed systems that deliver, monitor and account for the safety and quality of patient care. Although it is ultimately the responsibility of a governing body to set up a sound clinical governance system and be accountable for outcomes and performance within this system, implementation involves contributions by individuals and teams at all levels of the organisation.

The Commission has developed the National Model Clinical Governance Framework.[1] Health service organisations can adapt and implement the framework to best meet the needs of their patients and local situation, and to ensure that systems are regularly evaluated to improve safety and quality. See Action 1.3 for establishing and maintaining a clinical governance framework.

The National Model Clinical Governance Framework is based on the NSQHS Standards – in particular, the Clinical Governance Standard and the Partnering with Consumers Standard.

The Clinical Governance Standard and the Partnering with Consumers Standard together ensure the creation of clinical governance systems within health service organisations that:

- Are fully integrated within overall corporate governance systems
- Are underpinned by robust safety and quality improvement systems
- Maintain and improve the reliability, safety and quality of health care
- Improve health outcomes for patients, and ensure the safety and quality of care.

Together, these two standards constitute a complete and robust clinical governance framework.

Support the governance system

The governing body should describe the roles and accountabilities for the safety and quality of care within the health service organisation.

The governance system should provide:

- A clear definition for safety and quality that articulates reporting lines, responsibilities and accountabilities
- Position descriptions for all members of the workforce that clearly document responsibilities and accountabilities for the safety and quality of clinical care
- Position descriptions, or similar documents, and, if appropriate, contracts for senior clinicians that describe their roles, responsibilities and accountabilities, including supervising the performance of the junior clinical workforce
- Safety and quality policies, procedures or protocols that describe how patient safety is embedded in the operation of the organisation
- A structured performance development system for clinicians and managers that incorporates a regular review of their engagement in safety and quality activities, including peer review and audit, supervision of the junior workforce, and goal-setting for future activities.

Monitor and review performance

The governing body is responsible for reviewing reports and monitoring the organisation's safety and quality performance. The governing body should regularly review a selection of the organisation's most important quality metrics, which may include:

- Key national priority indicators and regulatory requirements
- A selection of measures covering safety, clinical effectiveness, patient experience, access, and efficiency and appropriateness of care
- Trends in complaints from patients and the workforce, and action taken to resolve complaints
- Trends in reported adverse events, incidents and near misses, and actions taken
- Workforce surveys to monitor the organisational culture
- Risk ratings
- Compliance with best-practice pathways
- Comparisons with peer organisations, and state and territory or national performance data.

In addition to monitoring indicators and trends, governing bodies should review relevant clinical and organisational systems to ensure that they are fit for purpose and being used in the organisation.

Action 1.2

The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people

Intent

The health needs of Aboriginal and Torres Strait Islander people are identified in partnership with local communities, and improvement actions are supported by the governing body.

Key tasks

- Establish partnerships with local Aboriginal and Torres Strait Islander communities to identify priority health needs and any barriers to accessing health services
- Endorse priorities and identified targets, and have mechanisms in place to review strategies to improve the safety and quality of health care
- Routinely review progress against Aboriginal and Torres Strait Islander safety and quality improvement strategies
- Collect relevant data to inform planning and future decision-making relating to service development.

Strategies for improvement

Setting organisational goals to consider the specific health needs of Aboriginal and Torres Strait Islander

people can focus the whole organisation on the elements of care that need to be provided.

The governing body and management should review the demographic profile of the patient population, and consider the health issues facing Aboriginal and Torres Strait Islander people who use their services. This will help to inform their decisions on which strategies might be used to best meet the needs of Aboriginal and Torres Strait Islander patients and consumers.

To understand the safety and quality issues facing Aboriginal and Torres Strait Islander people and the priorities for improving care, the governing body may need to:

- Consult with Aboriginal and Torres Strait Islander health service providers and communities with established referral processes
- Review information on the number and needs of Aboriginal and Torres Strait Islander patients using the health service
- Review performance data relating to Aboriginal and Torres Strait Islander patients, such as discharges against medical advice or unplanned readmissions within 28 days; these data may also include information on neonatal birth weight, or records of participation in chronic care and other programs
- Review feedback, outcome data, incidents and complaints to identify potential barriers for Aboriginal and Torres Strait Islander people in using the organisation's services
- Review workforce indicators such as the proportion of the workforce who identify as being of Aboriginal or Torres Strait Islander origin, as well as the effectiveness and coverage of cultural competency training for the workforce
- Discuss the safety and quality issues facing Aboriginal and Torres Strait Islander patients with the workforce, especially members of the Aboriginal and Torres Strait Islander health workforce, and Aboriginal and Torres Strait Islander consumers or community representatives
- Review the scope and effectiveness of strategies in place to improve care for Aboriginal and Torres Strait Islander people
- Review the appropriateness and effectiveness of models of care for Aboriginal and Torres Strait Islander people.

The governing body should review how this information is incorporated into organisational strategies to improve the care and experience for Aboriginal and Torres Strait Islander patients and consumers, and receive routine reports on the implementation of these strategies.

Further strategies are available in *NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health*.

Organisational leadership

Action 1.3

The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality

Intent

The clinical governance framework is comprehensive and effective in improving safety and quality.

Key tasks

- Develop a clinical governance framework
- Educate the workforce about the key aspects of the clinical governance framework, and their responsibilities for improving safety and quality

- Review policies, procedures and protocols to ensure that they align with the clinical governance framework
- Review results of clinical audits and system evaluation reports for compliance with the clinical governance framework.

Strategies for improvement

Health service organisations are responsible for designing and implementing the systems to operationalise an effective clinical governance system as directed by the governing body.

Management should ensure that well-designed and integrated systems are in place that provide safe and high-quality health care. This may include systems and processes for:

- Identifying and managing risk
- Testing and influencing organisational culture
- Ensuring quality improvement
- Managing clinical practice
- Managing workforce performance and skills
- Managing incidents and complaints
- Ensuring patients' rights and engagement.

To ensure the effectiveness of these systems and processes, managers should use the clinical governance framework to:

- Monitor, analyse and report on performance
- Collect, analyse and report on feedback
- Recommend actions to improve the safety and quality of care, and provide advice to the governing body about the issues identified and actions taken.

Strategies may include:

- Establishing a committee that is responsible for overseeing the clinical governance framework
- Implementing policies, procedures and protocols that describe the clinical governance framework
- Clearly defining and articulating the roles and responsibilities of clinical leaders and members of the workforce at all levels in improving safety and quality
- Reviewing the implementation of the clinical governance framework
- Reviewing audit findings of compliance with policies, procedures and protocols.

See the National Model Clinical Governance Framework for more information.[1]

Action 1.4

The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people

Intent

Strategies to improve the safety and quality of care provided to Aboriginal and Torres Strait Islander people are implemented and monitored for effectiveness.

Key tasks

- Review data for Aboriginal and Torres Strait Islander patients relating to safety and quality outcomes, patient experience and engagement, and complaints
- Engage with Aboriginal and Torres Strait Islander patients and communities to review safety and quality information to set priorities for safety and quality improvement
- Implement, monitor and report on strategies to improve health outcomes for Aboriginal and Torres Strait Islander patients.

Strategies for improvement

Although the governing body is responsible for ensuring that the organisation's priorities consider the specific health needs of Aboriginal and Torres Strait Islander people, management is responsible

for designing, implementing and monitoring the strategies to achieve these priorities. Strategies for improvement may include:

- Forming sustainable partnerships with local Aboriginal and Torres Strait Islander people by working with local communities to understand and acknowledge their healthcare needs, and the risks and barriers to accessing health care, and developing strategies and priorities for improved care delivery
- Providing flexibility in health service delivery and the patient journey; flexible health service organisations are more likely to be person centred and, as a result, increase patient engagement and participation in their care
- Employing Aboriginal and Torres Strait Islander people at all levels of the health service, and supporting and empowering them, which can improve the cultural competency of an organisation; Aboriginal and Torres Strait Islander liaison officers are key to supporting and advocating for Aboriginal and Torres Strait Islander patients, and with Aboriginal and Torres Strait Islander clinicians and interpreters
  - improve the quality of care provided
  - reduce the rate of discharge against medical advice
  - provide cultural mentors for non-Indigenous members of the workforce
- Monitoring safety and quality for Aboriginal and Torres Strait Islander people; health service organisations should have goals or targets in place for the care of their Aboriginal and Torres Strait Islander patients, and should routinely measure and report on specific performance indicators related to those goals and targets.

Identify and develop strategies

Strategies have the greatest chance of being effective when:

- The Aboriginal and Torres Strait Islander community is actively engaged in the development, implementation and evaluation of strategies
- Interventions are multidisciplinary and operate across services
- The organisation promotes collaboration with Aboriginal and Torres Strait Islander community controlled health services and adopts a holistic model of health and wellbeing.

To develop appropriate strategies, organisations need to:

- Accurately identify the Aboriginal and Torres Strait Islander people who are accessing care
- Agree on measures for analysing health outcomes and risks facing Aboriginal and Torres Strait Islander patients
- Engage with the workforce in planning, designing and implementing improvement strategies
- Evaluate the effectiveness of the changes that are put in place
- Routinely report on improvement initiatives to the governing body, clinicians and the local Aboriginal and Torres Strait Islander communities.

Examples of strategies may include:

- Establishing mechanisms to review and develop tailored care plans for Aboriginal and Torres Strait Islander people who frequently use the health service
- Reviewing the appropriateness and effectiveness of models of care for Aboriginal and Torres Strait Islander people, including options to provide care using outreach services
- Developing a workforce and employment strategy that sets targets and identifies how to increase or maintain the participation of Aboriginal and Torres Strait Islander people in the health workforce across clinical, managerial, support and advocacy roles
- Coordinating early discharge planning that considers the need for community social and health services
- Providing information materials in Aboriginal and Torres Strait Islander languages, if appropriate
- Coordinating service provision using flexible hours of service delivery (that is, outside a 9-to-5 working day).[7,8]

Further strategies are available in *NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health*.

Action 1.5

The health service organisation considers the safety and quality of health care for patients in its business decision-making

Intent

Decisions relating to equipment, plant, building works, consumables, staffing and other resources consider the safety and quality implications for patients.

Key tasks

- Review the organisation's strategic planning and business planning processes to ensure that they explicitly capture safety and quality improvement strategies and initiatives, including those articulated in the organisation's clinical safety and quality plan
- Review templates for submitting business proposals to the governing body and management, and ensure that they take account of impacts on safety and quality.

Strategies for improvement

Include safety and quality goals, objectives and strategies prominently in business and strategic plans. This will ensure that all strategic and decision-making processes consider the safety and quality of all services being provided.

If a proposal for service development or a change in scope of clinical practice explicitly identifies implications for patient safety and quality of health care, adopt policies, procedures or protocols to explain how clinical risks will be managed.

Train the workforce to consider safety and quality issues when developing business cases or influencing business decisions.

Other strategies may include ensuring that:

- The terms of reference for committees (for example, finance and audit committees, strategic planning committees) consider safety and quality implications when making business decisions
- Decisions about the procurement of building, plant, consumables and equipment are informed, and that products and services are fit for purpose, comply with relevant standards, and take into consideration safety and quality issues such as multiple chemical sensitivity.

Action 1.6

Clinical leaders support clinicians to:

a. Understand and perform their delegated safety and quality roles and responsibilities

b. Operate within the clinical governance framework to improve the safety and quality of health care for patients

Intent

Clinical leaders and leaders of clinical services work with other clinicians to optimise the safety and quality of care.

Key tasks

- Define and allocate the delegated safety and quality roles and responsibilities of the clinical workforce
- Conduct clinical audits to ensure that clinicians operate within the clinical governance framework
- Report audit findings to the governing body.

Strategies for improvement

Strong leadership can drive safety and quality improvements, and make them a priority. Commitment from leaders is important, because their actions and attitudes influence the perceptions, attitudes and behaviours of the workforce.[9]

Define the delegated safety and quality roles and responsibilities of clinical leaders. These may include implementing strategic direction, managing the operation of the clinical governance system, reporting on safety and quality, and implementing the organisation's safety culture.

Clinical leaders may support other clinicians by:

- Supervising relevant members of the clinical workforce
- Conducting performance appraisals or peer reviews
- Reviewing safety and quality performance data within their unit and comparing these data with units of similar size
- Ensuring that the workforce understands the clinical governance system.

Strategies to achieve this may include:

- Providing safety and quality training for clinicians
- Ensuring that the workforce has access to information about their expected roles and responsibilities for safety and quality, and the operation of the clinical governance framework
- Clearly documenting the reporting lines and relationships for safety and quality performance
- Conducting performance appraisals and auditing clinical practice to ensure that clinicians operate within the clinical governance framework
- Reviewing clinical audit results and taking action to deal with any issues identified.

CRITERION: Patient safety and quality systems

> *Safety and quality systems are integrated with governance processes to enable organisations to actively manage and improve the safety and quality of health care for patients.*

Effective clinical governance creates a learning environment and a comprehensive program of continuous quality improvement. The organisation's safety and quality systems should ensure that patient safety and quality incidents are recognised, reported and analysed, and used to improve the care provided. It is important that these systems are integrated with governance processes to enable health service organisations to actively manage risk, and to improve the safety and quality of care.

The organisation's approach to delivering and supporting clinical care should be described in policies, procedures and protocols, which may need to be endorsed by the governing body. Include the following topics:

- Developing policies, procedures and protocols
- Monitoring and reporting clinical performance
- Managing clinical risk
- Managing and reporting adverse events, including reporting on sentinel events
- Managing complaints and compliments
- Managing open disclosure
- Engaging clinicians in planned, systematic audits of clinical services following agreed protocols and schedules.

Policies and procedures

Action 1.7

The health service organisation uses a risk management approach to:

a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols

b. Monitor and take action to improve adherence to policies, procedures and protocols

c. Review compliance with legislation, regulation and jurisdictional requirements

Intent

The health service organisation has current, comprehensive and effective policies, procedures and protocols that cover safety and quality risks.

Key tasks

- Set up a comprehensive suite of policies, procedures and protocols that emphasise safety and quality
- Set up mechanisms to maintain currency of policies, procedures and protocols, and to communicate changes in them to the workforce
- Review the use and effectiveness of organisational policies, procedures and protocols through clinical audits or performance reviews
- Periodically review policies, procedures and protocols to align them to state or territory requirements, and ensure that they reflect best practice and current evidence
- Develop or adapt a legislative compliance system that incorporates a compliance register to ensure that policies, procedures and protocols are regularly and reliably updated, and respond to relevant regulatory changes, compliance issues and case law.

Strategies for improvement

The governing body should ensure the development, review and maintenance of a comprehensive set of organisational policies, procedures and protocols. These documents should cover clinical safety and quality risks, and be consistent with the organisation's regulatory obligations.

Develop policies, procedures and protocols

The governing body must clearly delegate responsibility for developing and maintaining policies, procedures and protocols. This includes identifying a custodian to ensure that the processes for developing, reviewing and monitoring compliance with policies, procedures and protocols are documented. Roles and responsibilities of individuals and committees with the authority to amend or endorse each policy, procedure or protocol should be documented.

Clinical policies may be developed or adapted at different levels within the organisation. However, all policy, procedure and protocol documents should be incorporated into a single coherent suite to maximise the effectiveness of the policy development process.

Support effective implementation of a policy system by ensuring that the workforce has:

- Ready access to relevant policies, procedures and protocols
- Position descriptions, contracts, by-laws or other mechanisms that require the workforce to comply with their roles, responsibilities and accountabilities, and with organisational policies, procedures and protocols.

Monitor compliance with legislation, regulation and state or territory requirements

Keep information about instances of noncompliance with the organisation's policies, procedures and protocols. Where appropriate, incorporate the information into the organisation's risk register and quality improvement planning processes.

Maintain well-designed legislative compliance processes. Incorporate a compliance register to ensure that the organisation's policies are regularly updated, enabling the organisation to respond to regulatory changes, compliance issues and case law.

Identify relevant industry standards, and develop processes to implement and monitor compliance with these standards, which may include:

- Service-specific standards such as for mental health, pathology or medical imaging, where these services are applied
- Standards Australia standards
- The Building Code of Australia
- Guidance developed by peak bodies, such as the *Australian Medicines Handbook*.

Action 1.8

The health service organisation uses organisation-wide quality improvement systems that:

a. Identify safety and quality measures, and monitor and report performance and outcomes

b. Identify areas for improvement in safety and quality

c. Implement and monitor safety and quality improvement strategies

d. Involve consumers and the workforce in the review of safety and quality performance and systems

Intent

An effective quality improvement system is operating across the organisation.

Key tasks

- Define quality for clinical services (for example, effectiveness, safety, consumer experience) and share this information with the workforce
- Review the quality improvement system, including the vision, mission, values and objectives, to ensure that they reflect the organisation's clinical safety and quality priorities, and strategic direction
- Decide how feedback will be collected from the workforce, patients and consumers
- Consider whether there is a coherent, planned and systematic schedule of audits of clinical and organisational systems, and reliable processes to capture findings and implement necessary improvements
- Develop a schedule for reporting to the governing body and managing the design and performance of key clinical systems
- Monitor and review progress on actions taken to improve safety and quality, and provide feedback to the workforce, patients and consumers
- Provide information and training, where necessary, to the workforce, patients and consumers to encourage their involvement in the analysis of performance data.

Strategies for improvement

Develop a quality improvement system

The elements of a successful quality improvement system include:

- A description of 'high quality' that is reflected through the organisation's vision, mission and values
- A definition of the organisation's stakeholders
- Clearly defined and aligned organisational objectives and clinical quality objectives
- Clearly defined processes and responsibilities that are required to meet quality objectives
- Training for the organisation's workforce in safety and quality
- Processes to verify that the quality improvement system is operating effectively
- Mechanisms for monitoring consumer satisfaction, measuring quality and implementing improvements.

Define quality and how it will be measured

Define the elements of quality to be used by the organisation (for example, safety, effectiveness, consumer experience). Provide a common language and understanding for the design, implementation and monitoring of safety and quality performance throughout the organisation. An example of this is the national list of hospital-acquired complications (HACs).

HAC refers to a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring. The national list of HACs includes 16 complications that were selected based on the criteria of preventability, patient impact, service impact and clinical priority. HACs are identified using routinely collected data extracted from patient healthcare records. Codes are used to identify the diagnosis, and a flag is used to indicate that the diagnosis arose during the episode of care.

The HACs list provides a succinct set of complications to support monitoring of patient safety in a hospital setting. Regular reports to clinicians, boards and other stakeholders on HACs can help identify areas that require attention, as well as areas of best practice. While the identification and reporting of HACs are important elements supporting patient safety, they are intended to complement and be used alongside other quality improvement processes.

The HACs list was developed through a comprehensive process that included reviews of the literature, clinical engagement, and testing of the concept with public and private hospitals. The list was agreed by the Commission's Inter-Jurisdictional Committee in June 2016. In March 2017, the list was included in the National Health Reform Agreement for use in pricing and funding of Australian public hospitals.

The HACs list, and further information on how it was developed and tested, are available on the Commission's website.

Involve the workforce, patients and consumers in defining quality, and in processes such as reviewing quality improvement systems.

Define the key indicators for safety and quality measures that will be routinely collected and reported to management and the clinical workforce, as well as the level of detail required to enable the governing body and workforce to fulfil their responsibilities. These may include data from incidents and complaints management systems, safety and quality audit reports, infection control reports, reviews of clinical practice, and clinical indicators relating to specific actions in the NSQHS Standards.

Routinely measure and monitor patient experience by using national core common questions on patient experience developed by the Commission.

Conduct regular reviews and audits

Develop a schedule of reviews and audits that cover the variety of services and locations used for the delivery of care, to ensure that there is systematic oversight of safety and quality systems.

Conduct audits throughout the organisation, including the clinical, departmental, divisional and whole-of-organisation levels. Actively engage clinicians and consumers in the audit processes and analysis of results. Ensure that audits test the design and performance of the organisation's clinical governance system.

Audits are effective if their outcomes are used for improvement and assurance purposes. Independent auditors or reviewers can assist to ensure a high level of assurance of objective reporting for the governing body. Report audit outcomes throughout the organisation – to the governing body, the workforce, and patients and consumers.

Record the outcomes of clinical system audits on a register, together with proposed actions and responsibilities, and evidence of implementation and follow-up. These records can be used to show how risks and opportunities identified through the quality improvement system are addressed, to improve safety and continuously improve performance.

Action 1.9

The health service organisation ensures that timely reports on safety and quality systems and performance are provided to:

a. The governing body

b. The workforce

c. Consumers and the local community

d. Other relevant health service organisations

Intent

Health service organisations provide accurate and timely information on safety and quality performance to key stakeholders.

Key tasks

- Endorse a schedule of reporting that outlines the topic areas, format and frequency of reporting on safety and quality performance, and the effectiveness of the safety and quality systems
- Collaborate with the workforce, consumers, local communities and other health service organisations to identify the topic areas, format and frequency of reporting to these groups on safety and quality performance, and the effectiveness of the safety and quality systems.

Strategies for improvement

Routinely collecting process and outcome data, monitoring data for trends and reporting clinical alerts enables organisations to understand outcomes from service delivery, and to respond to deviations from the expected outcomes promptly.

Monitoring safety and quality performance data should include all clinical areas and cover all locations of service delivery to ensure a comprehensive picture of performance.

Clearly documented processes to ensure the accuracy, validity and comprehensiveness of information will increase the organisation's confidence in data quality. Providing the governing body and the workforce with access to the organisation's most important safety and quality metrics (indicators) will enable regular review of progress and will allow the organisation to respond to issues as they arise. Suitable metrics may include:

- Key relevant national priority indicators and regulatory requirements
- Those covering safety, clinical effectiveness, patient experience, access and efficiency across the organisation's range of services and service locations
- Trends in reported adverse events, incidents and near misses
- Compliance with best-practice pathways.

Provide the governing body and management with regular, comprehensive safety and quality presentations and reports from managers and clinicians. Schedule data presentations following agreed criteria (for example, significance of risk, patient volume, organisational priority or focus).

Effective data presentations should cover:

- The design of the systems and processes being used
- Evaluation and management of risks
- The effectiveness of the risk management system
- Compliance with evidence-based practice
- Safety and quality outcomes, including consumer experience and patient-reported outcome measures
- Plans to improve safety and quality, and reduce risk.

In addition to providing data to the governing body, provide information to:

- The workforce, who should review the data to identify emerging safety and quality issues, or assess the impact of safety and quality initiatives
- Consumers and local community members as major stakeholders
- Other relevant health service organisations that may use the information in planning for patients who are referred to or from the organisation.

Risk management

Action 1.10

The health service organisation:

a. Identifies and documents organisational risks

b. Uses clinical and other data collections to support risk assessments

c. Acts to reduce risks

d. Regularly reviews and acts to improve the effectiveness of the risk management system

e. Reports on risks to the workforce and consumers

f. Plans for, and manages, internal and external emergencies and disasters

Intent

The health service organisation identifies and manages risk effectively.

Key tasks

- Review the organisation's risk management system, and ensure that it is appropriately designed, resourced, maintained and monitored
- Consider existing sources of information about patient safety, and whether more information is needed to reliably assess risk
- Consider whether risk management orientation, education and training are adequately covered in the organisation's education and training program
- Ensure clear allocation of roles, responsibilities and accountabilities for maintaining the risk management systems and for performing the actions required
- Regularly review risks and report on risk to the governing body, the workforce and consumers
- Periodically review the effectiveness of the risk management system
- Use a risk management approach to planning for emergencies and disasters that may affect the organisation's operation or patient safety
- Implement and monitor a risk register and review it regularly to ensure that:
  - it is kept up to date
  - it includes all relevant information
  - members of the workforce with roles and responsibilities in risk management use and maintain the register, and are accountable for actions required
  - risks are regularly reviewed, and reports are provided to the governing body, the workforce and consumers
  - plans exist to manage emergencies and disasters that may affect the operation of the organisation or patient safety.

Strategies for improvement

Define the governing body's responsibility

The governing body is responsible for ensuring the integrity of the organisational risk management system. The governing body should:

- Determine the organisation's risk appetite and tolerance – that is, the amount and type of risk that an organisation is willing to take to meet its strategic objectives
- Ensure that the organisation's risk management system is clearly documented in policies, procedures and protocols that define a vision, principles, objectives, practices, responsibilities, resources, outcomes and how outcomes will be measured
- Ensure that enough resources are allocated to the organisation's risk management system
- Foster an organisational culture that focuses on clinical safety and continuous improvement in identifying and managing risk
- Ensure appropriate integration of clinical and non-clinical risk in all risk systems.

Embed a systems approach to risk management

Embed a systems approach to risk management by:

- Maintaining risk management policies, procedures and protocols that follow best practice, and ensuring that all clinical leaders, managers and other members of the workforce are familiar with them
- Establishing a reliable and systematic process of hazard identification across all areas
- Actively encouraging and supporting the workforce, patients and other stakeholders to report potential or actual risks
- Describing and establishing a mechanism for capturing non-clinical risks in the risk management system
- Maintaining a comprehensive, accurate and current risk register, which can be used as a practical tool for risk management
- Assigning all risks to a 'risk owner', who is responsible for managing and monitoring risks, and ensuring that appropriate accountability arrangements are in place
- Ensuring that the organisation has a reliable system to scan for, identify and respond to hazards and risks reported by other organisations (for example, from the scientific literature, government agencies, insurers, coroners, or safety and quality commissions)
- Conducting a planned, systematic program of in-house and external audits or reviews on the design and performance of safety and quality systems, in collaboration with clinicians and consumers, and incorporating this risk audit program into the organisation's formal audit program
- Ensuring that the risk management system includes strategies, resources and clear accountability for remedying risks
- Making use of clinical registers, if possible
- Systematically providing appropriate information, orientation, education and training to employees and students on using the risk management system, at induction and at regular intervals
- Regularly auditing the risk management system
- Systematically monitoring and assessing performance regarding risk, within a defined performance monitoring framework, at all levels of the organisation, including the governing body and management.

Engage the clinical workforce

The clinical workforce has the best knowledge of, and ability to identify, clinical risks. Foster engagement and participation of the workforce by:

- Regularly providing information about the organisation's risk management system at orientation, and through ongoing education and training
- Reinforcing information about roles, responsibilities and accountabilities for reporting and managing risk to managers, clinicians and other members of the workforce (for example, by using screensavers, the intranet, newsletters and standing items on meeting agendas)
- Establishing within the committee structure responsibility for systematic risk identification, assessment, review and management
- Using routine meetings as an opportunity to identify and discuss clinical and other safety concerns

- Including patient safety as a standing item on meeting agendas of the governing body and management
- Including questions about patient safety risks in employee culture surveys
- Providing feedback to the workforce and consumers on actions taken to mitigate risks
- Regularly assessing the organisational climate in areas of risk, safety and quality using validated survey tools.

Plan for, and manage, emergencies and disasters

Use the risk management system to prepare for potential emergencies and disaster management.

Perform a series of audits to identify potential risks and management opportunities to enable the organisation to respond efficiently and effectively in an emergency. This may involve considering:

- Appropriate infrastructure, such as emergency signage, lighting systems and backup generators
- Workforce training in evacuation systems and emergency drills
- Planning for the coordination of workforce rosters and reporting lines during an emergency
- Planning to support patient transfer internally or externally (to other health service organisations) during an emergency
- Business continuity planning for recovery and returning services to normal following an emergency.

Incident management systems and open disclosure

Action 1.11

The health service organisation has organisation-wide incident management and investigation systems, and:

a. Supports the workforce to recognise and report incidents

b. Supports patients, carers and families to communicate concerns or incidents

c. Involves the workforce and consumers in the review of incidents

d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers

e. Uses the information from the analysis of incidents to improve safety and quality

f. Incorporates risks identified in the analysis of incidents into the risk management system

g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems

Intent

Clinical incidents are identified and managed appropriately, and action is taken to improve safety and quality.

Key tasks

- Implement a comprehensive incident management and investigation system for the organisation that:
  - complies with state or territory requirements
  - is appropriately designed, resourced, maintained and monitored
  - clearly designates responsibility for maintaining the system

- Train the workforce about the risk management system
- Inform patients about how they can report risks or concerns
- Implement a reporting and management framework to ensure that incident data are used to inform the governing body, the workforce and consumers, to drive improvements in safety and quality
- Periodically audit the incident management and investigation system to improve its design and performance, and to see whether it is adequately resourced.

Strategies for improvement

Incident reporting can improve safety (especially when it is based on a cycle of quality improvement), improve care processes, change the way clinicians think about risk and raise awareness of good practice. The nature of the risks faced by organisations varies according to the type of organisation and the context of service delivery. This highlights the importance of evaluating the effectiveness of incident management and investigation systems at the local level.[10]

Review the incident management and investigation system

A well-designed incident management and investigation system should support the workforce to identify, report, manage and learn from incidents. The system should comply with legislative requirements and with state or territory clinical incident management policies.

A well-structured system would generally incorporate the following elements:

- A clear policy framework that defines the key elements of the system; the roles and responsibilities of individuals and committees; the type of events to be reported; the process for reporting, investigating, analysing and monitoring clinical incidents; and the responsibility of clinicians to report incidents they observe or that arise from the use of healthcare records, including digital healthcare records
- A focus on managing each incident appropriately from a clinical perspective and ensuring the provision of safe, high-quality care to the patient following the incident, including open disclosure, if appropriate
- A designated individual with responsibility for maintaining the integrity of the system and coordinating incident management
- Adequate and appropriate systems (including relevant equipment and technology) to support incident reporting and analysis
- Workforce responsibilities for managing reported incidents, including grading their severity and leading further investigations
- Policies, procedures and protocols regarding confidentiality of information and the ability of members of the workforce to report anonymously
- Responsibilities for analysing incident data, and identifying trends and opportunities for improvement
- Responsibilities for disseminating information about incidents and their quality improvement implications
- Responsibilities for following up incidents to ensure that improvements have been made, if appropriate; this may include ensuring that information about relevant incidents is incorporated into the organisation's risk management processes
- Responsibilities for reporting incidents to other parties (for example, health departments) under the relevant organisational obligations
- Links to the organisation's open disclosure, risk management, and credentialing and scope of clinical practice processes; the state or territory incident management and investigation system, if applicable; and the procedure for communicating with the organisation's professional indemnity insurers.

Support the workforce

Leaders, including clinical leaders, should encourage the workforce to use the incident management system to report clinical incidents, near misses and adverse events.

Engaging the workforce to find solutions to issues is important for improving safety[10], especially when the improvement actions require coordination across teams or departments.

Provide information about the intent and use of the organisation's incident management and investigation systems to the workforce at orientation and routinely throughout their employment.

Support patients, carers and families

Support patients, carers and families to communicate their concerns by:

- Distributing information to patients and carers about what incidents and concerns are, and how to report them
- Training the workforce on how to respond to patients or carers who raise concerns or report incidents
- Providing, when possible, appropriately skilled members of the workforce to liaise with patients or carers who report concerns or incidents
- Conducting patient experience surveys or seeking feedback on safety incidents on discharge
- Providing information about improvement activities that have been implemented based on patient feedback.

Report on, and review, incidents

Provide comprehensive information to the governing body and management on all serious incidents, and summary information about all other incidents. Include information such as the actions taken as a result of a specific incident or category of incidents, and indicators such as time to complete actions stemming from incident reports. This will enable governing bodies and management to fulfil their governance responsibilities.

Define a reporting framework that clearly identifies the data that will be available and reported at each level in the organisation. This will enable members of the workforce and the governing body to monitor and respond to system performance.

Ensure that the system facilitates timely and effective review of information about clinical incidents, and that information is used at all levels of the organisation to improve the safety and quality of care.

Ensure that each incident is reviewed by the clinicians involved and the manager responsible for the operational area in which the incident occurred. This enables lessons to be learned and local improvements to be implemented. A system to verify that managers follow up incidents appropriately will ensure integrity of the risk management system.

Set up classification and escalation processes to ensure that serious incidents, and incidents associated with major risk are managed appropriately, including external reviews, it required.

Periodically review the design and performance of the incident management and investigation system. The governing body should consider whether it complies with best-practice design principles, and whether enough resources have been allocated to support effective clinical governance and risk management.

The workforce and consumers can be involved in the review of clinical incidents through:

- Regular review of reports or data analysis on clinical incidents
- Periodic review of incident management and investigation systems to ensure that they are effective in improving safety.

Action 1.12

The health service organisation:

a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework[11]

b. Monitors and acts to improve the effectiveness of open disclosure processes

Intent

An open disclosure process is used to enable the health service and clinicians to communicate openly with patients following unexpected healthcare outcomes and harm.

Key tasks

- Adopt and implement the Australian Open Disclosure Framework in a way that reflects the context of service provision
- Ensure that members of the workforce who will be involved in open disclosure are trained
- Periodically conduct audits that focus on the management of clinical incidents and consistency with the Australian Open Disclosure Framework.

Strategies for improvement

Open disclosure is a discussion with a patient or carer about an incident that resulted in harm to the patient. Open disclosure is:

- A patient and consumer right
- An essential professional requirement and institutional obligation
- A normal part of an episode of care should the unexpected occur
- An attribute of a high-quality service organisation and an important part of healthcare quality improvement.

An open disclosure discussion should include:

- The elements of an apology or expression of regret (including the word 'sorry')
- A factual explanation of what happened
- An opportunity for the patient to relate their experience
- An explanation of the steps being taken to manage the event and prevent a recurrence.

Governing bodies should lead the implementation of an effective open disclosure program by:

- Requiring organisations to adopt the Australian Open Disclosure Framework[11]
- Ensuring that enough resources are allocated to support implementation of the framework
- Ensuring that the responsibility for implementing the framework is allocated to an individual or committee
- Ensuring that there is a system in place for monitoring compliance with the framework; all variations from the framework should be investigated and addressed
- Reviewing regular reports on open disclosure to ensure that the principles and processes of the framework are met
- Leading a 'just culture' marked by openness and constructive learning from mistakes.

Health service organisations implementing an open disclosure program should:

- Develop or adapt policies, procedures or protocols that are consistent with the Australian Open Disclosure Framework[11]
- Implement a monitoring and reporting process for open disclosure events to ensure that they are followed up and improvements are actioned
- Review open disclosure events to find out how the open disclosure program could be improved
- Provide access to training and support for relevant members of the workforce who have responsibility for managing issues involving open disclosure within the organisation[11]
- Provide access to, or require proof of, training for any credentialed clinicians who will be involved in open disclosure processes
- Learn from system errors that culminate in poor patient outcomes.

See the Australian Open Disclosure Framework web page for more information.[12]

Action 1.13

The health service organisation:

a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care

b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems

c. Uses this information to improve safety and quality systems

Intent

Feedback from the workforce, patients and carers is used to improve safety and quality.

Key tasks

- Implement a comprehensive feedback system that is appropriately designed, resourced and maintained to:
  - collect patient experience data
  - collect data on the workforce's understanding of safety and quality
- Describe the framework for reviewing feedback data from patients and the workforce, and incorporate issues identified into the organisation's quality improvement system
- Review reports on the analysis of patient experience data and the actions to deal with issues identified
- Periodically review the effectiveness of the organisation's feedback system.

Strategies for improvement

Reported patient experiences are an important element in determining the quality of care provided. Patient and carer feedback should be gathered systematically, using well-designed (and, ideally, validated) data collection tools. The data should be used to improve the quality of care.

The health service organisation should promote the organisation's ability to respond to patient experience information by:

- Ensuring that the organisation adopts a validated and reliable method to systematically seek feedback from patients and carers; systematic analysis and testing of feedback will enable system improvement
- Ensuring that a designated individual is responsible for maintaining the integrity of feedback systems
- Allocating enough resources to support the feedback system
- Seeking patient feedback regularly and from the types of patients who represent the patient population, to ensure that data are reliable and cover the services provided; feedback may be sought on a general (that is, organisation-wide) or specific (that is, individual service or unit) basis
- Providing a mechanism to regularly seek feedback from the workforce to test the culture of the organisation
- Ensuring that information gained from the feedback system is analysed for safety and quality risks and improvement opportunities, and used to inform the organisation's quality improvement system
- Reviewing information about the performance of the patient feedback system
- Ensuring that the workforce, patients and carers receive information about what has been learned from the feedback system, and how it has been used to generate improvements in the organisation
- Comparing performance with similar services and any nationally available benchmarks.

Strategies for obtaining patient experience feedback may include:

- Using a validated survey instrument that incorporates the national core common patient experience questions
- Regularly collecting feedback from patients, and providing feedback to the workforce, governing body and consumers
- Using focus groups of consumers to consider specific issues, or issues relating to a specific location or service provision.

Strategies for obtaining feedback from the workforce may include:

- Using a validated survey instrument
- Providing opportunities for the workforce to submit recommendations for improvement
- Using existing meetings, committees and human resources processes, such as performance reviews, to collect information from the workforce on safety and quality systems.

Action 1.14

The health service organisation has an organisation-wide complaints management system, and:

a. Encourages and supports patients, carers and families, and the workforce to report complaints

b. Involves the workforce and consumers in the review of complaints

c. Resolves complaints in a timely way

d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken

e. Uses information from the analysis of complaints to inform improvements in safety and quality systems

f. Records the risks identified from the analysis of complaints in the risk management system

g. Regularly reviews and acts to improve the effectiveness of the complaints management system

Intent

An effective complaints management system is in place and used to improve safety and quality.

Key tasks

- Implement and maintain a framework for reporting complaints and incorporating issues into the organisation's quality improvement system
- Implement a comprehensive complaints management and investigation system
- Review reports on the analysis of complaints data and the actions to deal with issues identified
- Implement processes to involve the workforce, patients and carers in the review of organisational safety and quality performance information
- Periodically review the effectiveness of the organisation's complaints management system.

Strategies for improvement

Implement a complaints management system

A well-designed complaints management system should incorporate the following elements:

- A clear policy framework defining the key elements of the system, and the roles, responsibilities and accountabilities of relevant individuals and committees
- Delegation of an individual or committee with responsibility for maintaining the integrity of the system, and receiving and coordinating the management of complaints

- A documented philosophy that acknowledges that complaints represent opportunities for improvement
- Compliance with state or territory requirements.

Support patients, carers and the workforce

Organisations may use different strategies to encourage the workforce, patients and carers to report complaints. These mechanisms should be documented in the organisation's policies, procedures or protocols. The policy documents for complaints management should consider confidentiality of information, and responsibilities for:

- Receiving, investigating and managing complaints, and taking immediate action if required
- Grading the severity of complaints
- Communicating effectively with complainants about the management of the complaint
- Analysing complaints data, and identifying trends and opportunities for improvement.

Provide information about the complaints process to the workforce, patients and carers. The information should include a statement about the organisation's philosophical approach to complaints management, and outline the formal and informal pathways to make a complaint. It may include information about how complaints are managed, the expected time frames for investigation and how the complainant will be notified of the outcome of the investigation.

Provide support for the workforce, patients and carers, and other individuals who are involved in incidents that lead to complaints. This may include:

- Nominating a support person to assist members of the workforce, patients or carers who wish to make a complaint
- Providing training to the workforce on complaints handling
- Ensuring that systems are in place to encourage the workforce, patients and carers to report complaints, and that support the analysis of the complaints process.

Involve the workforce, patients and carers in the review of complaints by:

- Inviting members of the workforce to join groups or committees responsible for reviewing complaints information or safety and quality performance data
- Providing information and training for consumers and the workforce to support them to understand data and measurements used by the organisation
- Providing safety and quality performance information to local community and consumer groups for feedback.

Refer to Action 2.11 for further information and strategies for involving consumers in committees.

Information on involving consumers in complaints handling committees is available from the Health Issues Centre.[13]

Report on, and review, complaints

Roles and responsibilities of those overseeing the complaints management system (including data analysis) should be clearly defined. Responsibilities may include:

- Initiating an open disclosure process
- Following up complaints to ensure that improvements have been made, if appropriate
- Disseminating information about complaints and their quality improvement implications
- Reporting complaints to other parties (for example, complaints commissioners, regulatory authorities) under the relevant organisational obligations
- Linking complaints to the organisation's policies on open disclosure, risk management, credentialing and scope of clinical practice, and quality improvement systems
- Linking complaints to the state or territory complaints management policy, if applicable
- Linking complaints to the procedure for communicating with the organisation's insurer.

Use information from complaints to improve the safety and quality of care. Ensure that each complaint is reviewed by the member(s) of the workforce involved and the manager responsible for the operational area in which the complaint was generated. This enables lessons to be learned and

local improvements to be implemented. Implement a system to verify that managers follow up complaints appropriately to ensure system integrity.

The complaints management system should enable prompt and effective review of information about complaints, in line with the organisation's policies, procedures or protocols. Organisations may use a complaints register to ensure that complaints are managed efficiently and effectively, and that each complaint process is completed. This will help analyse and report complaints data appropriately, and will enable tracking of relevant complaints data into the risk management system. Regularly review the complaints register.

Implement classification and escalation processes to ensure that complaints associated with considerable risk are managed appropriately.

Define a reporting framework that clearly identifies the data that will be available and reported on at each level in the organisation. This will enable the workforce and members of the governing body to monitor and respond to system performance. A reporting schedule may help to identify when reports should be submitted to various committees or individuals, to ensure that issues are incorporated into relevant meeting agendas.

Provide comprehensive information to the governing body and management about complaints associated with major risks, and summary information, including trend reports, about all other complaints. Include information such as the actions taken as a result of a specific complaint or category of complaints, and indicators such as the time taken to complete actions stemming from complaints. This will enable the governing body and management to fulfil their clinical governance responsibilities.

Incorporate relevant information from the complaints management system into the risk management system and the quality improvement system, and report it to the governing body or management, if appropriate.

Periodically review the design and performance of the complaints management system. The governing body should consider whether it complies with best-practice design principles, and whether enough resources have been allocated to support effective clinical governance and risk management.

Diversity and high-risk groups

Action 1.15

The health service organisation:

a. Identifies the diversity of the consumers using its services

b. Identifies groups of patients using its services who are at higher risk of harm

c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care

Intent

The diversity of consumers and high-risk groups are considered in the planning and delivery of care and services.

Key tasks

- Periodically audit the clinical and administrative data systems to identify the diversity of the patients using the organisation's health services
- Develop strategies to identify high-risk patients, and mechanisms to provide extra safety and quality protections for these patients.

Strategies for improvement

Understanding the characteristics of the patient population allows organisations to identify groups of patients who may be at greater risk of harm, or who are more likely to have a poor experience of health care because of their condition, age or gender; social, economic or geographic circumstances; cultural background, religion or preferred language; or sexuality.

Identify the groups of patients using the health service who have an increased risk of harm, and implement strategies to proactively manage these risks. This may involve:

- Reviewing demographic data (such as age, gender, postcode or ethnicity) to understand the diversity of the patient population
- Analysing relevant data to determine the key risks faced by different demographic groups
- Conducting a risk assessment for groups of patients, procedures or locations of treatments that are known to be high risk
- Discussing the strategies to overcome these risks with the clinical governance committee, the clinical workforce or representatives of the different risk groups.

Strategies for each group may vary widely, and may need to be tailored to individual patients.

Incorporate patient risk assessment processes in the organisation's quality improvement system if there are specific risks associated with particular types of patients or locations of treatment.

Ensure that clinical guidelines and pathways for particular conditions or interventions incorporate risk management strategies (for example, preoperative anaesthetic assessment) relevant to known patient risk groups (for example, bariatric patients).

Monitor the health outcomes for at-risk patient groups and the actions taken to manage the risks.

Monitor the risk management system and relevant external sources of information (for example, coroners' reports, published literature) to identify emerging risks affecting particular groups of patients.

Healthcare records

Action 1.16

The health service organisation has healthcare records systems that:

a. Make the healthcare record available to clinicians at the point of care

b. Support the workforce to maintain accurate and complete healthcare records

c. Comply with security and privacy regulations

d. Support systematic audit of clinical information

e. Integrate multiple information systems, where they are used

Intent

Comprehensive, accurate, integrated and accessible healthcare records are available to clinicians at the point of care.

Key tasks

- Review the availability of healthcare records at the point of care

- Review the processes for maintaining confidentiality and privacy of patient information, including infrastructure, policies and workforce training for paper-based and digital healthcare records, and ensure that they are consistent with the law and good practice
- Review the design of the healthcare record to ensure that it facilitates documentation of the relevant clinical elements and clinical audit
- Ensure that systems are in place for data entry to clinical registries, if required
- Periodically audit the performance of the healthcare records systems, and improve them as necessary
- If multiple information systems are used to capture patient clinical information, periodically review the data systems to ensure that the processes for information capture are well designed, well resourced and working effectively
- Identify the individuals or committees responsible for the development, review and document control of forms, documents and files that make up the paper or digital healthcare record.

Strategies for improvement

The governing body and managers should ensure that an effective system is in place for recording, communicating, using and securely storing patient clinical information. This is to provide safe, high-quality care to individual patients, and to enable relevant information to be extracted for quality assurance, teaching and research purposes.

Access to the healthcare record at the point of care facilitates recording of the patient's status and changes to treatment.

Review the healthcare records system

A number of standards, guidelines and policies apply to healthcare record documentation – for example, medical record–keeping requirements for good medical practice[14] of the Medical Board of Australia, and state or territory health department standards for healthcare record documentation and data capture.[15,16]

An effective healthcare records system should incorporate:

- A workforce that is appropriately qualified and experienced in the management of healthcare records systems, with appropriate leadership skills and authority
- Orientation and training of the clinical workforce in the organisation's requirements for healthcare record documentation, including the safety and quality rationale for those requirements
- Clearly documented accountabilities and terms of reference for the individual or committee responsible for governance of the healthcare records system
- Accountability for healthcare record documentation in performance development processes for the clinical workforce
- Position descriptions and statements of responsibility for all members of the workforce (clinical and non-clinical), which may explicitly define
  - the obligation of all members of the workforce to protect patient privacy and confidentiality
  - the link to the organisation's performance management system
  - the consequences of intentional breach of the obligation
- Policies, procedures and protocols addressing
  - standards and processes for managing healthcare records (including retention, digital and manual storage and transport systems, access at the point of care, emergency access to records when a patient is unable to consent, and record disposal requirements)
  - standards for documentation, with a focus on the information that should be recorded to enable monitoring of quality of care, contemporaneous recording of clinical information, and the availability of formal reports on investigations, including imaging and pathology tests
  - how changes to the healthcare record are authorised
  - standards and processes for establishing standalone clinical registries for quality or research purposes
  - the conduct of compliance audits
  - compliance with the relevant standards, and professional and legislative requirements in the relevant state or territory

- Structures (for example, healthcare record committees) and processes to enable healthcare record risks and opportunities to be evaluated, and changes made to improve the standard of documentation
- Physical or digital facilities for the reliable and secure management of patient healthcare records
- Periodic audit and continuous improvement of the healthcare records system.

Review privacy and confidentiality

Information about an individual's physical or mental health and wellbeing is both personal and sensitive, and there are many ethical, professional and legal restrictions on the way this information can be used.

People assume all communications with their clinicians are private, and the law reflects this expectation. The confidentiality or privacy of most health information is protected by statutory or common law requirements of confidentiality and privacy. However, the precise legislative requirements vary between states and territories.

Providing the appropriate physical infrastructure (for example, private interview rooms, patient status boards that are screened from public view) is not enough to ensure privacy and confidentiality. The culture and practices of the workforce are key to the appropriate protection of patient clinical information.

Consider the need to:

- Explicitly recognise the sensitivity of patient clinical information, and the need to protect confidentiality and privacy
- Recognise the role of patient consent in the use or disclosure of information for purposes other than direct provision of care
- Explain to patients and carers how patient information is collected, used and disclosed, and the safeguards that apply
- Develop and implement specific policies and procedures addressing the use of clinical information for clinical, educational, quality assurance and research purposes, including robust authorising procedures for any uses or disclosures outside the usual provision of care (including the development of clinical registries).

Audit the system

Periodically audit the design and performance of the healthcare records system to ensure system effectiveness. Structure the healthcare record to guide the clinical workforce to record important information relevant to the safety and quality of care. This will also assist organisations to audit compliance with relevant standards.

If more than one information system is used to capture patient clinical information, periodically review these systems to ensure that the processes for information capture are well designed, well resourced and working effectively (that is, the transfer of information is accurate, prompt, compatible and secure).

Action 1.17

The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that:

a. Are designed to optimise the safety and quality of health care for patients

b. Use national patient and provider identifiers

c. Use standard national terminologies

Intent

Health service organisations securely share a patient's clinical information with authorised clinicians in other settings, including the My Health Record system.

Key tasks

- Use unique national identifiers for patients, clinicians and health service organisations in local information systems and in clinical documents loaded into the My Health Record system
- Implement standard national terms such as the Australian Medicines Terminology (AMT) in healthcare records and clinical documents loaded into the My Health Record system.

Strategies for improvement

The My Health Record system allows secure collection, storage and exchange of health information between consumers and providers. It uses information from general practitioners, pharmacies, pathology laboratories, imaging services and hospitals to improve the safety and quality of care by supporting clinical handover and making clinical information accessible in different settings.

Health service organisations will have different levels of preparedness to provide clinical information to the My Health Record system. Implementation of this action may depend on the resources available and the organisation's current healthcare records system.

For more information on My Health Record visit the Commission's Safety in e-health web page.

Use unique national healthcare identifiers

Unique healthcare identifiers help ensure that individuals and clinicians are confident that the correct information is associated with the correct individual at the point of care.

The My Health Record system uses unique national identifiers for patients, clinicians and health service organisations to ensure secure access to healthcare records. Using national patient identifiers in local information systems can prevent duplication of records and minimise the chance of information being assigned to the wrong patient. It also allows correct identification of treating clinicians and health service organisations, enabling follow-up by other clinicians involved in the patient's care.

Every Australian resident is allocated a unique 16-digit identifier called the Individual Healthcare Identifier (IHI).

The Australian Health Practitioner Regulation Agency issues unique national identifiers to the clinicians it registers.

Health service organisations that employ one or more clinicians can apply for an organisational identifier from the Healthcare Identifiers Service.

For more information, see Healthcare Identifiers Service – frequently asked questions.[17]

Use standard national terminologies

Adopting standard terms such as AMT and SNOMED CT-AU ensures that clinical information captured in local information systems can be readily understood and used by other clinicians accessing this information. See the Australian Digital Health Agency website for more details.[18]

For more information on My Health Record, visit the Commission's Safety in e-health web page.

Action 1.18

The health service organisation providing clinical information into the My Health Record system has processes that:

a. Describe access to the system by the workforce, to comply with legislative requirements

b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system

Intent

Clinical information held in the My Health Record system is accurate, complete and accessible by authorised clinicians.

Key tasks

- Develop, maintain and regularly review organisational policies for using the My Health Record system, to ensure that access follows the requirements of the *My Health Records Act 2012*
- Take reasonable steps to ensure that clinical documents provided to the My Health Record system are accurate at the time of loading, and that any amendments made to these clinical documents are also loaded into the system.

Strategies for improvement

Health service organisations that use, or load documents into, the My Health Record system are required to develop and maintain a My Health Record system policy that outlines the:

- Process for authorising clinicians to use the system, and for deactivating accounts of those who no longer need access
- Training to be provided to the workforce on the professional and legal obligations in using the system
- Physical and technical security measures to control access to the system
- Identification and management of system-related security risks to be escalated to the executive.

Implementing these strategies would be considered reasonable steps to ensure the accuracy of the records uploaded. Regularly review this policy to ensure that it is up to date and in line with any changes to the My Health Records Act.

The Act also requires that health service organisations take reasonable steps to ensure that clinical documents provided to the My Health Record system are accurate at the time of loading. If a clinical document on the My Health Record system contains incorrect information, the organisation should remove the incorrect version as soon as practically possible.

A clinical document may be subsequently amended or updated. This can occur, for example, when diagnostic test results are provided and the discharge summary is reissued with these results added. In such cases, the corrected version should be loaded into the My Health Record system.

Conduct periodic audits to ensure that:

- Clinicians loading information into, or amending information in, the My Health Record system do so following the organisation's policies, procedures and protocols
- Access to data and records complies with legislative requirements.

See the Australian Digital Health Agency website for information on how to register with the My Health Record system.

CRITERION: Clinical performance and effectiveness

> *The workforce has the right qualifications, skills and supervision to provide safe, high-quality health care to patients.*

The delivery of safe and quality health care is dependent on the effective organisation of the health workforce. The opportunity, and risk, for safe care are executed at the interface between people, whether it is between teams within an organisation, or directly between clinicians and patients.

Health service organisations must have strategies in place to manage workforce issues with a systems focus that ensures excellent leadership and operational processes, a healthy culture and optimum patient outcomes.

Credentialing, clinical audit, performance review, education and training, compliance with acceptable clinical guidelines and evaluating variation in practice can all assist in the provision of safe, high-quality services.[19]

Members of the workforce should:

- Be suitably qualified for the role in which they are employed and only work within their scope of clinical practice
- Complete an orientation program, incorporating workforce cultural capability as relevant to the service
- Complete training relating to occupational health and safety (for example, manual handling, fire safety, infection control)
- Complete training relating to safety and quality in health care
- Attend continuing education and skill enhancement programs
- Be competent in basic life support (clinical workforce only).

Several methods are used to confirm and assess a clinician's qualifications, experience, professional standing and other relevant professional attributes.

These include recruitment processes, registration checks, peer review, oversight and supervision, and competency assessment. For some clinicians, a credentialing process is used.

Credentialing is a formal process used to confirm a clinician's competence, experience and professional suitability to provide safe, high-quality care. Scope of clinical practice is defined following credentialing. This involves delineating the extent of an individual clinician's practice within the organisation based on their credentials, competence, performance and professional suitability, and the needs and capability of the organisation.

Performance development programs enable an organisation to ensure that members of its clinical workforce meet their professional registration and continuing professional development requirements. Issues affecting an individual's performance are identified and addressed as part of the performance development process. Goals for quality improvement, and further education and training are also agreed to.

The values of fairness, accountability and support underpin effective systems of performance development. If underperformance is identified, the first response that is triggered should include increased support, and access to relevant tools, education and expertise. However, patient safety is paramount, and remedial strategies need to protect patient safety at all times.

Health service organisations are accountable for ensuring adequate supervision of the clinical workforce. In particular, junior clinicians who have limited clinical experience require oversight and regular review of their clinical practice. The purpose of supervision is to ensure that the practice of less experienced clinicians is of an acceptable standard, and to identify opportunities for learning and development.

Orientation is an important activity that provides the workforce with the basic knowledge and skills to work safely within the health service organisation. Comprehensive orientation includes an introduction to the organisation's:

- Model of care
- Policies, procedures and protocols
- Risk reporting and risk management processes
- Quality assurance, improvement and monitoring systems
- Incidents management and investigation systems
- Feedback and complaints management systems
- Healthcare records systems

- Performance development and human resources systems
- Information systems.

Health service organisations need to support clinicians to use the best available evidence to provide safe, high-quality care. Good clinical governance promotes clinical practice that is effective and based on evidence.[20] The introduction, use, monitoring and evaluation of evidence-based clinical pathways support the provision of effective care.

Clinicians are accountable for their practice. This includes compliance with accepted clinical guidelines or pathways. Oversight of clinical practice should enable the early identification and management of practices that place patients at risk of harm.[21]

Effective quality improvement systems should identify the extent of variation from agreed clinical guidelines or pathways, and how such variation is managed. The Commission's clinical care standards support the delivery of appropriate care, reduce unwarranted variation in care, and promote shared decision making between patients, carers and clinicians.[22]

Safety and quality training

Action 1.19

The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for:

a. Members of the governing body

b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation

Intent

Members of the governing body and the workforce understand the approach to, and the roles and responsibilities for, safe and high-quality performance in the organisation.

Key task

- Review the organisation's orientation policies and programs, and consider whether they provide appropriate and effective orientation in safety, quality and clinical governance.

Strategies for improvement

Orientation introduces a member of the governing body or workforce to the organisation. A well-designed orientation program will detail the key safety and quality systems.

Provide orientation that, among other things, covers the essential elements of clinical governance and quality improvement systems to set expectations for members of the governing body and managers, and help develop or maintain their competence and expertise in clinical governance.

Consider whether induction is reliably provided to all members of the workforce, including contracted, locum, agency, student and volunteer members.

Periodically evaluate the content of the orientation and induction training program for its effectiveness and currency of content.

Action 1.20

The health service organisation uses its training systems to:

a. Assess the competency and training needs of its workforce

b. Implement a mandatory training program to meet its requirements arising from these standards

c. Provide access to training to meet its safety and quality training needs

d. Monitor the workforce's participation in training

Intent

The workforce is appropriately trained to meet the need of the organisation to provide safe and high-quality care.

Key task

- Review the organisation's education and training policies and programs, and consider whether they provide appropriate and effective education and training in safety, quality and clinical governance.

Strategies for improvement

Maintaining a competent and capable workforce requires education and training. All health service organisations have a responsibility to provide access to ongoing education and training for their workforce.

The governing body and management should consider whether regular training in safety, quality, leadership and risk (including orientation to relevant organisational policies, procedures and protocols) is reliably provided to the whole workforce.

The governing body and management should ensure that the organisation's education and training policies:

- Define mandatory education and training requirements in relevant aspects of safety, quality, leadership and clinical risk for all members of the workforce
- Support the provision of education and training to the workforce based on comprehensive and regularly updated assessment of need
- Require evaluation of the outcomes of education and training in safety, quality, leadership and risk
- Ensure that appropriate records are maintained of education and training undertaken by each member of the workforce
- Provide each member of the workforce with the opportunity (through performance review and development programs) to define their education and training goals, and agree with their manager on opportunities to achieve these goals.

Training for the governing body and the workforce can be provided internally or externally using a variety of formats, including:

- Face-to-face programs
- Short sessions
- Peer review, mentoring and supervised practice
- Self-directed programs
- Online learning modules
- Audio or video content
- Competency-based assessments
- Conferences and seminars
- Secondments and placements.

Regularly assess the training needs of workforce members, and implement a training program that both meets the needs of the workforce to effectively perform their roles and incorporates elements to meet the requirements of the NSQHS Standards. Training needs may be identified through several pathways, including professional development activities, analysis of incident management and investigation systems, or a workforce survey.

Use a risk management approach to schedule training for the workforce based on a needs assessment.

Use external training providers if training cannot be efficiently provided internally. Record and monitor attendance at training sessions to ensure that the workforce maintains skills and competencies.

The organisation is responsible for ensuring that members of the workforce who are employed indirectly (for example, using contract or locum arrangements) have the required qualifications, training and skills to effectively perform their roles.

Organisations may:

- Have a contractual arrangement with agencies that provide temporary or locum members of the workforce
- Implement a formal process to verify that visiting medical practitioners or locum members of the workforce have the required qualifications, training and skills
- Provide training to locum or agency members of the workforce at orientation and induction.

Action 1.21

The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients

Intent

Health service organisations provide a supportive environment and clear processes for the workforce to explore the cultural needs of Aboriginal and Torres Strait Islander patients.

Key tasks

- Ensure that actions to improve cultural competency are implemented and monitored for effectiveness
- Review the organisation's education and training policies and programs to ensure that they adequately cover cultural competency and monitor workforce participation in training
- Review and maintain the organisation's targets regarding the participation of Aboriginal and Torres Strait Islander people in the health workforce across clinical, managerial, support and advocacy roles.

Strategies for improvement

Having an effective culture in place means that an organisation has a defined set of values and principles, and demonstrates behaviours, attitudes, policies and structures that enable it to work effectively.[23]

Health service organisations should acknowledge and be respectful of the cultural factors and complex kinship relationships that exist in the local Aboriginal and Torres Strait Islander community.[24]

Aboriginal and Torres Strait Islander people do not always see mainstream health services as offering them a safe and secure place to get well. In many instances, they experience[25]:

- Isolation from community and kin
- Language barriers in understanding health messages and difficulty in informing clinicians of their needs
- Financial difficulties in gaining access to treatments (for example, travel costs) and funding the costs of the treatment
- Perceived inferior treatment.

To improve the cultural competency of both the workforce and the organisation, consider[26]:

- Incorporating culturally specific requirements into recruitment processes, or including Aboriginal and Torres Strait Islander people on the interview panel
- Addressing cultural competency as part of performance review processes
- Ensuring that the workforce participates in cultural competency activities and training in a variety of learning formats, such as training exercises, reflective practice and face-to-face training whenever possible

- Providing access to ongoing learning for individuals through training, professional development, critical reflection and practice improvement
- Providing cultural competency training that is developed in collaboration with the local Aboriginal and Torres Strait Islander communities and includes content relevant to those communities
- Monitoring and reporting on the implementation and effectiveness of the cultural competency program to the governing body or management
- Implementing follow-up strategies (including counselling, performance improvement or more stringent approaches when necessary) if a culturally appropriate approach is not adopted
- Expanding the Aboriginal and Torres Strait Islander workforce and supporting them to fulfil their role as cultural mentors
- Incorporating cultural competency into policies and program development
- Collaborating with partner communities about service and facility design, delivery and evaluation, and to seek feedback on, and improve, cultural competency.

Further strategies are available in *NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health*.

Performance management

Action 1.22

The health service organisation has valid and reliable performance review processes that:

a. Require members of the workforce to regularly take part in a review of their performance

b. Identify needs for training and development in safety and quality

c. Incorporate information on training requirements into the organisation's training system

Intent

The health service organisation routinely reviews and discusses individuals' performance and systematically collects information on individuals' safety and quality training needs.

Key task

- Implement performance review processes for clinicians and other members of the workforce.

Strategies for improvement

It is recognised that a single 'model' performance review process is unlikely to be readily applicable in health service organisations because of the diversity of occupational groups, and the need to build commitment to performance development processes within each health service organisation by involving key players in the design and review of systems.

However, the primary requirements of a performance review system are to:

- Set and clarify expectations for employees
- Monitor employee performance
- Plan and review employee performance
- Develop employee capability
- Recognise employee achievements
- Resolve unsatisfactory employee performance.

'Performance review' and 'performance development' describe the systematic processes of goal-setting and periodic one-on-one review of workforce performance.

The organisation is responsible for:

- Establishing a culture in which safe, high-quality care can be delivered
- Assisting members of the workforce to develop their competence and performance by supporting them to achieve agreed goals.

Members of the workforce are responsible for:

- Understanding organisational objectives
- Setting professional goals that are consistent with the organisation's objectives
- Working collaboratively with the organisation to achieve professional and organisational goals.

Performance review processes present an opportunity for managers and clinicians to clarify reciprocal obligations between organisations and the workforce. Through performance review processes, organisations can state how they will meet their responsibility to clinicians, and clinicians can clarify their obligations to the organisation.

For organisations, this may mean describing how they will provide clinicians with support, resources, training, and access to evidence-based tools and data on their performance, and how time will be allocated to support a clinician's practice. Performance review also provides an opportunity to describe a clinician's roles and responsibilities for safety and quality in the organisation.

For clinicians, performance review processes support reflective practice and provide opportunities to identify practice improvements. Reflective practice is effective when accurate and timely data are available that describe and benchmark a clinician's practice outcomes. Organisations should seek to collect and present clinician-specific data that can be used to support practice improvement and encourage clinicians to participate regularly in performance appraisals.

Develop an effective system

The governing body should ensure that effective performance review systems are in place.

Effective performance review systems rely on continuous, constructive interaction between members of the workforce and their managers. The systems are flexible and responsive, and include, but are not limited to, periodic performance review. The performance review system should include systematic monitoring of each clinician's participation in formal audit, peer review and continuing professional development, following the requirements of their professional organisation and registration body, and identify individual training needs.

Formal performance review processes may not be in place for members of the workforce who are employed indirectly (for example, through contract or locum arrangements). In these cases, performance management may be addressed by:

- Using the processes for credentialing and scope of clinical practice outlined in Actions 1.23 and 1.24
- Reviewing clinical performance data when contracts are due for renewal
- Addressing feedback or issues identified by the medical advisory committee
- Liaising with the locum agency.

Monitor and review the system

Clearly document the requirements of the organisation's performance development system. This includes identifying a designated person(s) who is responsible for ensuring compliance with the organisation's performance development policy. Monitor and report on performance to support effective implementation of the performance development system.

Review the performance of the performance development system, including workforce participation, and actions to respond to training and development needs. Consider how to assess the skills of the clinical workforce when competency-based assessment and training are required.

Credentialing and scope of clinical practice

Action 1.23

The health service organisation has processes to:

a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan

b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice

c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered

Intent

Clinicians are appropriately skilled and experienced to perform their roles safely, and to provide services within agreed scope of clinical practice.

Key tasks

- Verify that the organisation has adopted and implemented an evidence-based process for defining scope of clinical practice for all clinicians, including those with independent decision-making authority or working under supervision
- Consider whether the process for defining scope of clinical practice is appropriately designed, resourced, maintained and monitored
- Incorporate periodic review of the organisation's process for defining scope of clinical practice into audit programs, with a focus on consistency with adopted standards, performance measures and outcomes.

Strategies for improvement

Scope of clinical practice processes are key elements in ensuring patient safety. The purpose is to ensure that only clinicians who are suitably experienced, trained and qualified to practise in a competent and ethical manner can practise in health service organisations.[27]

All clinicians providing care in a health service organisation must have their scope of clinical practice clearly defined. The processes for defining scope of clinical practice may include developing a position description, conducting a credentialing process or describing the clinician's role in a contract for services. Regardless of the form, the process describes the mutual commitment between the organisation and each member of the clinical workforce to provide safe, high-quality care.

The governing body should ensure that processes are in place for monitoring and maintaining effective processes for defining scope of clinical practice. The governing body is responsible for ensuring that compliance is monitored and reported, and that variations are investigated.

Define scope of clinical practice

The *Standard for Credentialling and Defining the Scope of Clinical Practice*[28] describes structures and processes that ensure:

- Clear definition of clinicians' scope of clinical practice in the context of the organisation's needs and capability
- Regular review of clinicians' scope of clinical practice
- Safe and appropriate introduction of new clinical services, procedures and other technologies
- Appropriate supervision of clinicians, when necessary
- Effective processes for reviewing clinicians' competence and performance
- Procedures to be followed if a concern arises about the capability of a clinician.

Outline policies for junior clinicians

Junior clinicians routinely provide services under supervision. The number of junior clinicians is large, their skills are developing, and their employment may be transient as they move through training programs. Therefore, individualised approaches to defining the scope of clinical practice for junior clinicians may be impracticable. Although some organisations may choose to include junior clinicians in their general credentialing and scope of clinical practice processes, most organisations adopt policies that set clear limits on the scope of clinical practice of junior clinicians of varying levels. These policies define the scope of clinical practice for varying levels of seniority, and the requirements for effective supervision and support at each level.

Supervising all junior clinicians according to their assessed capabilities and consistent with organisational policies is a key safeguard of the safety and quality of care. Define clinical supervision responsibilities in senior clinicians' employment contracts.

Action 1.24

The health service organisation:

a. Conducts processes to ensure that clinicians are credentialed, where relevant

b. Monitors and improves the effectiveness of the credentialing process

Intent

A formal process is used to ensure that clinicians have the appropriate qualifications, experience and skills to fulfil their delegated roles and responsibilities.

Key tasks

- Ensure that the processes for credentialing clinicians are documented in the organisation's policies, procedures or protocols
- Review results of audits and system evaluation reports for compliance with the credentialing policies, procedures or protocols.

Strategies for improvement

Health service organisations are required to appoint clinicians who are suitably experienced, skilled and qualified to practise in a competent and ethical manner, taking into account service needs and organisational capability. Organisations have several processes to ensure that clinicians are suitably credentialed before they start work.

These are detailed in the Commission's *Credentialing Health Practitioners and Defining their Scope of Clinical Practice: A guide for managers and practitioners*.[27]

Collect evidence of credentials

Collect evidence of minimum credentials as part of any recruitment process, and reconsider the evidence when there is a change in circumstances or a change in role for clinicians. Verify the information submitted by, or on behalf of, a clinician for determining scope of clinical practice, even when a recruitment agency is used to source applicants and they perform some verification processes.

Collect evidence for each of the following areas[27]:

- Education, qualifications and formal training
- Previous experience, including relevant clinical activity and experience in similar settings to the relevant scope of clinical practice
- Clinician references and referee checks
- Continuing education that relates to a role in which the clinician is engaged and that is relevant to the scope of clinical practice
- Current registration with the relevant national board

- Professional indemnity insurance
- Other documentation and pre-employment checks, such as
  - a current curriculum vitae
  - an applicant's declaration
  - proof of identity (100-point identity check)
  - passport and copies of relevant visas (for overseas-trained practitioners)
  - a police or working with children check
- The applicant having no registration board restrictions or conditions on their registration, no criminal history, no report of professional misconduct against them, no report of unsatisfactory professional conduct and no outstanding complaints
- Permission to contact previous facilities or organisations where the clinician has been employed.

The credentialing process requires submission and review of a number of supporting documents. If the originals are not supplied or previously verified through other processes, organisations may require certification by a Justice of the Peace or similar recognised certifying agent.

Given the diversity of skills and experience of internationally qualified clinicians, it is important that the references and checks on education, training, competencies and experience are thorough and diligent. Consider any added support, supervision or training that may be required by international clinicians to ensure that their practices are safe.[27]

Improve the credentialing process

Monitoring and improving the effectiveness of the credentialing process may involve:

- Setting up credentialing committees with clear terms of reference, and ensuring that committee members understand their responsibilities, and have the required knowledge and skills to fulfil their responsibilities
- Reviewing and validating the processes for credentialing, defining and managing scope of clinical practice, and ensuring that these are diligent and effective
- Verifying (and periodically re-verifying) each clinician's credentials following defined organisational policy.

Safety and quality roles and responsibilities

Action 1.25

The health service organisation has processes to:

a. Support the workforce to understand and perform their roles and responsibilities for safety and quality

b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff

Intent

Every member of the workforce understands and enacts their safety and quality roles and responsibilities.

Key tasks

- Ensure that the governing body appropriately delegates responsibility for governance
- Review the organisation's performance development policy, and ensure that it incorporates leadership in safety and quality management and governance for all managers and clinicians

- Review the organisational structure, position descriptions and contract templates of management, clinicians and other members of the workforce to ensure that responsibility for safety and quality is clearly defined at all levels.

Strategies for improvement

Implement the governance arrangements determined by the governing body and ensure that the workforce understands their roles, responsibilities and accountabilities for safety and quality.

Ensure that foundational educational programs include:

- Clinical risk from the patient's perspective
- Clinical governance responsibilities for safety and quality
- Legislative responsibilities related to patient harm and reportable incidents
- Incident investigation methods
- Human error and human factors principles
- Principles of teamwork and leadership style
- Open disclosure
- Creating and sustaining a patient safety culture that has person-centred care at its centre
- Applying evidence-based practices to develop and support effective multidisciplinary teams.

The clinical governance system should be supported by:

- Clear definition and delegation of reporting lines and responsibilities for safety and quality
- Clearly documented accountabilities for safety and quality of clinical care within the position descriptions and contractual responsibilities of the chief executive, management and clinicians
- Descriptions of roles, responsibilities and accountabilities for supervising the performance of the junior clinical workforce within the position descriptions and contractual responsibilities of senior clinicians
- Safety and quality policies, procedures or protocols that allocate responsibility to specific roles within the organisation
- A structured performance development system for all clinicians and managers, incorporating regular review of
  - their engagement in safety and quality, and in specific activities such as peer review and audit
  - supervision of the junior workforce.

Consider the following strategies when implementing delegated roles and responsibilities in the workforce:

- Ensure that safety and quality roles and responsibilities are clearly defined by
  - reviewing workforce position descriptions
  - discussing safety and quality responsibilities in routine performance management processes
  - providing information to the workforce about their safety and quality roles and responsibilities
- Educate and train members of the workforce in their governance roles, responsibilities and accountabilities
- For managers and senior clinicians, identify professional development opportunities in clinical safety and quality, leadership and risk, and schedule training in clinical governance
- Ensure that contractual arrangements are in place for the agency and locum workforce, and verify that credentialing and scope of clinical practice are undertaken before or after they start
- Provide agency and locum members of the workforce 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 help the workforce orientate agency and locum members of the workforce.

Action 1.26

The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate

Intent

The clinical workforce is appropriately supervised as and when required to ensure the provision of safe, high-quality care.

Key task

- Identify clinicians who require supervision, including junior clinicians, clinicians in training, clinicians who are expanding their scope of clinical practice and clinicians who require oversight of their performance.

Strategies for improvement

Effective clinical supervision enables health professionals to practise effectively and enhances patient safety.

Supervision is a key safeguard for safe and high-quality care. Supervision of junior clinicians should be appropriate to their assessed capabilities, and be consistent with organisational policies, procedures and protocols. A key goal of supervision is to safely develop a clinician's capabilities.

Formally document the roles and responsibilities of clinicians who are in training in their position description and training program. Monitor compliance with training requirements as part of the clinician's training program and performance reviews.[27]

As trainees gain experience, they achieve greater independence. Some organisations approve trainees undertaking increasingly higher levels of performance. In such circumstances, define and regularly review the trainee's scope of clinical practice as part of their training program to assess competence.[27]

Define who is responsible for monitoring trainees' performance and confirming they operate within their scope of clinical practice or training portfolio requirements. Ensure that this information is readily available to other clinicians working with the trainee. Provide regular feedback to trainees on their performance.

Clearly define clinical supervision responsibilities in the contracts of employment or engagement of all senior clinicians, and in relevant organisational policies, including those that apply to the performance development system. This will help to ensure that junior clinicians develop their skills, while protecting the safety and quality of patient care.

Ensure that clinicians who supervise other clinicians[27]:

- Have the qualifications and skills necessary to supervise in the nominated area of clinical practice
- Have experience at the appropriate level of practice
- Have the training and experience necessary to provide supervision
- Are located appropriately to provide adequate supervision
- Participate in the process of reviewing the supervised clinicians' scope of clinical practice.

Action 1.27

The health service organisation has processes that:

a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice

b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care

Intent

The clinical workforce is supported to use the best available evidence.

Key tasks

- Evaluate the extent to which documented clinical guidelines or pathways have been formally adopted by the clinical workforce, and whether opportunities exist to adopt clinical guidelines or pathways as a quality improvement activity
- Review how compliance with, and variations of practice from, evidence-based clinical guidelines or pathways are monitored, especially for high-volume or high-risk conditions.

Strategies for improvement

Use clinical guidelines and pathways

Good clinical governance promotes clinical practice that is effective and evidence based.[20] Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways, decision support tools, and the clinical care standards[22] developed by the Commission relevant to their clinical practice.

The introduction, use, monitoring and evaluation of evidence-based clinical pathways support effective care, and promote an organisational culture in which evaluation of organisational and clinical performance, including clinical audit, is expected in every clinical service.[29]

Promote clinical effectiveness by developing or adopting guidelines and protocols for particular diseases and clinical interventions. The National Health and Medical Research Council's clinical practice guidelines portal provides links to clinical practice guidelines developed for use in Australian healthcare settings.

Promote accountability of clinicians for their practice, including compliance with accepted clinical guidelines or pathways. Overseeing clinical practice should enable the early identification and management of practices that place patients at risk of harm.[21]

Effective quality improvement systems identify the extent of variation from agreed clinical guidelines or pathways, and how such variation is managed. Use audits to monitor the proportion of care that is provided following clinical guidelines or pathways, and communicate this to the workforce, managers and the governing body.

The governing body and management should periodically review compliance with, and variations from, evidence-based practice, to provide assurance of appropriate care and identify quality improvement opportunities.

Use clinical care standards

Clinical care standards support the delivery of appropriate care, reduce unwarranted variation in care, and promote shared decision making between patients, carers and clinicians.[22] Clinical care standards target key areas and provide opportunities to better align clinical practice with the best evidence.

Clinical care standards are designed to:

- Inform patients about the care they can expect to receive
- Provide guidance to clinicians on delivering appropriate, high-quality care
- Identify the systems that organisations need to have in place to support and monitor appropriate care.

Clinical guidelines form the evidence base for the clinical care standards. It is recommended that clinical care standards are used by health service organisations when they apply to services being provided.

If appropriate, build the requirements of the clinical care standard into the organisation's policies, processes or protocols, and give clinicians access to relevant clinical care standards.

Each clinical care standard includes nationally agreed quality statements outlining key areas of care.

In complex organisations, or the private health sector, the care described in the quality statements may not be offered or delivered by one care provider. Identify which of the quality statements are the responsibility of the health service organisation and which other service providers may be responsible for care set out in the quality statements. Establish formal agreements on responsibility for implementing the quality statements with any other organisations or service providers delivering care.

Action 3.15 and Action 5.29 include strategies related to the Antimicrobial Stewardship Clinical Care Standard and the Delirium Clinical Care Standard.

Clinical care standards are available to download from the Commission's website.

Support evidence-based practice

Ensure that systems are in place to periodically review compliance with, and variations from, evidence-based practice, and report to the governing body, to provide assurance of appropriate care and identify quality improvement opportunities.

Strategies to support clinicians to use the best available evidence and limit unwarranted variations in care may include:

- Adopting clinical guidelines, pathways or clinical care standards where they are appropriate
- Identifying or establishing the committees or individuals with responsibility for approving and reviewing the use of best-practice guidelines, integrated care pathways, clinical pathways, clinical care standards and decision support tools, and for communicating this information to the workforce
- Making resources available to implement clinical guidelines, pathways or clinical care standards
- Establishing processes that enable peer-based feedback to the clinical workforce about compliance with evidence and management of variation
- Monitoring compliance with the clinical care standards being used, and informing clinicians if unwarranted variation is detected.

Action 1.28

The health service organisation has systems to:

a. Monitor variation in practice against expected health outcomes

b. Provide feedback to clinicians on variation in practice and health outcomes

c. Review performance against external measures

d. Support clinicians to take part in clinical review of their practice

e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems

f. Record the risks identified from unwarranted clinical variation in the risk management system

Intent

Clinical practice levels of activity, processes of care and outcomes are reviewed regularly and compared with data on performance from external sources and other similar health service organisations.

Key tasks

- Identify key external data collections, registries, audits or reports that cover the specific areas of clinical practice relevant to patients, or procedures or services offered by the organisation
- Support and encourage clinicians to participate in national and state or territory clinical quality registries
- In collaboration with clinicians, review clinical practice data from the organisation, and compare them with data from similar geographic areas or health service organisations
- Identify any areas of practice that vary from best practice, that show widely differing practice within the organisation or that vary from practice in similar services
- Investigate the reasons for any variation, and identify whether it is unwarranted variation in the safety and quality of care
- Identify actions to ensure that practice changes align with best practice
- Consider issues of inappropriate resource allocation (including workforce) to ensure that practice changes align with best practice
- Identify any areas of risk and act to mitigate them
- Review the schedule of data and reports provided to the governing body and clinicians to ensure that they are comprehensive and relevant, and cover actions taken to align practice with desired care.

Strategies for improvement

People expect to receive care that is appropriate for their needs and informed by evidence. However, use of healthcare interventions and outcomes of care vary for different populations, across geographic areas, and among services and clinicians. Understanding this variation is critical to improving the quality, value and appropriateness of health care. Some variation is desirable and warranted – it reflects differences in peoples' healthcare needs. If variation is unwarranted, it signals that people are not getting appropriate care.

Review the data

Examining variation in care from that provided by similar services is an important first step in identifying and addressing any unwarranted variation. Identify internal and external data sources, and select quality metrics that are relevant to the population served and the services provided.

Review the data to see whether the organisation's performance varies from known best practice or from the performance of similar organisations.

Investigate any outlying data to identify whether any of the variation is warranted, and implement possible approaches to deal with unwarranted variation. Compare the service's data with data from peer services; data from other organisations; or state, territory or national performance data.

Data derived from the clinical care standards indicators can be used to show variation and improvement in clinical practice.[22]

The clinical and management teams should be responsible for analysing these data, and for:

- Identifying issues, and solutions to deal with them
- Disseminating information about any unwarranted variation, and how it will be addressed
- Acting to make changes to care if required
- Reporting actions taken to reduce unwarranted variation and ongoing performance to the governing body, through the clinical governance framework, and to other relevant organisations.

Analyse information on unwarranted clinical variation for opportunities to improve safety and quality. Support clinicians to take part in the data analysis, and encourage them to review and, if necessary, change their practice in light of the findings.

Use clinical quality registries

Australia currently has limited capacity to measure and monitor the degree to which health care benefits the patient (effectiveness), and how closely that care aligns with evidence-based practice and patient preferences (appropriateness). Clinical quality registries monitor and report on the appropriateness and effectiveness of health care, but only a small number of data collections currently capture and report process and outcomes data for specific clinical conditions or interventions.

Clinical quality registries are organisations that systematically monitor the quality (appropriateness and effectiveness) of health care, within specific clinical domains, by routinely collecting, analysing and reporting health-related information. The information is used to identify benchmarks and marked outcome variance, and inform improvements in healthcare quality.[30]

A number of well-established clinical quality registries operate in Australia, to which hospitals contribute information. Examples are:

- Australia and New Zealand Intensive Care Society Adult Patient Database
- Australian and New Zealand Dialysis and Transplant Database
- Australian Orthopaedic Association National Joint Replacement Registry
- Australasian Cardiac Outcomes Registry
- Australian and New Zealand Neonatal Network
- Victorian Prostate Cancer Registry
- Victorian State Trauma Registry

Organisations should ensure that they contribute data to established clinical registries and, if possible, use the information generated from clinical quality registers as part of their data analysis.

Clinical registries are usually established and maintained by specialist groups. The clinical governance committee should investigate the clinical registries that are relevant to the organisation.

The Commission has developed a framework for Australian clinical quality registries in collaboration with states, territories and expert registry groups, to reduce the gap in the measurement of healthcare quality and inform improvements in patient care.[31]

More information on variation in healthcare provision across Australia is available in the *Australian Atlas of Healthcare Variation*.[32]

CRITERION: Safe environment for the delivery of care

> *The environment promotes safe and high-quality health care for patients.*

A variety of legislation covers building codes, and workplace health and safety issues. The actions in this criterion focus on how the health service environment can support the delivery of safe and high-quality care for patients.

The health service environment, which includes all facilities, plant and equipment, needs to be fit for purpose and maintained in good working order to reduce hazards and ensure patient safety. Good design can also reduce the potential for adverse events – for example, by providing good lighting in areas where medicines are dispensed or selecting surfaces that are easy to clean and disinfect.

Having clear directions and signage can help patients find the services they need, and the use of furnishings, artwork, light, colour and sound can improve patients' comfort and experience of care.

Spaces that are designed for flexible use can help clinicians provide the right level of engagement or stimulation for patients with mental health issues, and can assist patients with cognitive impairment by simplifying the environment to reduce unnecessary stimulation.

Safe environment

Action 1.29

The health service organisation maximises safety and quality of care:

a. Through the design of the environment

b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose

Intent

The physical environment supports safe and high-quality care and reflects the patient's clinical needs.

Key tasks

- Regularly conduct environmental audits to see whether the environment is safe and promotes best practice
- Implement a schedule of review to ensure that all buildings, plant and equipment are fit for purpose, safe and in good working order at all times.

Strategies for improvement

Develop maintenance strategies

Develop a comprehensive maintenance plan that includes:

- Clear and easy-to-use documentation of maintenance and repairs
- Records of all plant and equipment, including (as a minimum) the date of purchase, preventive maintenance schedule, location and serial number
- Details of routine and preventive maintenance performed for each item of equipment and plant, including electromedical equipment
- Records of dates when equipment is regularly tested to ensure its readiness, including information relating to generators and battery backup.

Where equipment is regularly tested to ensure its readiness, record these dates, including information relating to generators and battery backup.

Australian standards are available for devices and equipment, and these should be reflected in the organisation's policies and procedures so that purchases, repairs and replacements are carried out following a specified standard. Similarly, the Building Code of Australia articulates the technical provisions for the design and construction of buildings and other structures throughout Australia, and should also be reflected in the organisation's policies and procedures. Manufacturers also set guidelines for the use and tolerance of equipment and devices. Faulty devices may need to be reported (for example, to the Therapeutic Goods Administration) or may be subject to a recall.

Use evidence-based design principles to promote safe practice

The physical environment can have a major impact on safety and quality performance. Good design can contribute to safe and high-quality care by promoting safe practices and removing potential hazards. It can reduce healthcare-associated infections and medical errors[33], improve patient and workforce satisfaction, and increase organisational performance.[34]

Consider the following design principles when redesigning or upgrading amenities:

- Automating processes, if appropriate (for example, dispensing medicines, handwashing facilities)
- Designing spaces to prevent adverse events (for example, removing tight corners, selecting appropriate furnishings and surfaces that can be easily decontaminated, providing enough lighting)[33]
- Designing spaces to prevent adverse events relating to self-harm (for example, removing ligature points and installing safety glass, if relevant)
- Designing rooms for scalability, adaptability and flexibility, which can help to minimise patient transfers and provide space for family members
- Standardising the layout and placement of supplies and equipment in rooms to improve efficiency and reduce errors[34]
- Providing information that is visible and easily accessible to patients and the workforce
- Positioning nursing stations centrally on the ward to minimise workforce fatigue and maximise workforce overview
- Using soft furnishings to reduce the impact of background noise on patients
- Providing clearly marked signs, maps and instructions to help patients and visitors navigate the health service.

Action 1.30

The health service organisation:

a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce

b. Provides access to a calm and quiet environment when it is clinically required

Intent

Aspects of the environment that can increase risks of harm are identified and managed.

Key tasks

- Review the design of the clinical environment to identify safety risks for patients, carers, family and the workforce

- Conduct a risk assessment to identify service areas where there is a high risk of unpredictable behaviours, and develop strategies to manage identified risks
- Identify areas where patients could be treated that offer a calm and quiet environment.

Strategies for improvement

Health service environments are stressful – they are brightly lit, noisy and constrained. In emergency department waiting rooms, people with different presenting problems are crowded together, uncertain about what is about to happen, and often frustrated by actual or perceived delays in accessing treatment. This can add to stress for people who are already experiencing stress.

This action is not intended to apply to every patient. People respond to stress in different ways, and have different needs in terms of environmental response. A calm and quiet environment is clinically appropriate for a person experiencing agitation and aggressive feelings. Access to sensory modulation resources may help a person who is experiencing psychosis or depersonalisation. Conversely, a person with thoughts of self-harm may consider being moved to a space on their own as isolating, and may require one-to-one nursing until they have been assessed and treatment has been initiated.

The Victorian Department of Health and Human Services has developed an audit tool that organisations can use to perform environmental audits and to develop action plans for improving the physical environment for older people using their services.[35]

Action 1.31

The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose

Intent

Patients, carers and visitors can locate relevant facilities and services.

Key task

- Review the signage and directions provided throughout the facility.

Strategies for improvement

Consider how to direct patients to get to the health service, find their way around the campus, and find the right unit or service within a building. When designing the wayfinding system, consider[36]:

- The physical environment, including layout, lighting, landmarks, and changes to interior finishes and colours
- How to provide information to patients to prepare for their journey
- The types of signs, graphics and terminology
- How to ensure that members of the workforce can provide appropriate directions for patients who need assistance.

Instructions should:

- Be simple, intuitive, user friendly and accessible
- Integrate with the requirements of a safe and secure facility
- Meet the legal requirements for accessibility
- Be easy to maintain
- Align with the principles of universal design.

Wayfinding strategies may include hard copies of signs, maps and written directions, or more interactive approaches such as employees or volunteers who help people with directions, interactive information kiosks or smartphone apps.

Action 1.32

The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so

Intent

Flexible visitation contributes to improved safety and quality of care for patients.

Key tasks

- Review policies, procedures or protocols about visiting arrangements
- Ensure that infrastructure and supports are available to provide flexible visiting arrangements
- Monitor the effectiveness of flexible visiting arrangements.

Strategies for improvement

The unrestricted presence and participation of a support person can improve the safety of care, and patient and family satisfaction. By facilitating unrestricted access for a chosen support person(s), patients can be provided with emotional and social support.

For patients, flexible visiting can reduce anxiety, confusion and agitation. It can make them feel safe and increase their satisfaction with the care provided. Flexible visiting arrangements can also increase satisfaction for family members and reduce their anxiety. It can promote communication and allow family members to learn about the patient's condition, because they are involved in their care.

Although there are perceived concerns with unrestricted visiting hours – such as family members getting in the way when care is provided, potential for increased infections and family members overextending the hours they visit – these barriers are not supported by evidence.

Support flexible visiting arrangements by developing or revising the organisation's policies and procedures on visiting arrangements to allow unrestricted visiting hours, if practicable. Include information about limiting visitation for those who infringe on the rights of others, or whose presence is medically or therapeutically contraindicated.[37]

The governing body and management should provide leadership and support for changes in visiting arrangements. Document these changes to ensure that there is clear direction for implementation. Communicate changes to the workforce through established communication channels, at orientation and through ongoing education, and during the professional development process.

Consider how patients and carers are advised about their right to identify a partner in care and inform them about how they can be involved. Document the patient's preferences about the chosen support person and their level of involvement in the patient's healthcare record.

Some other examples of strategies can be found in the Canadian Better Together campaign and the Institute for Patient- and Family-Centered Care Better Together campaign.

Action 1.33

The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people

Intent

Aboriginal and Torres Strait Islander people feel welcome and respected when receiving care.

Key tasks

- Establish relationships with local Aboriginal and Torres Strait Islander communities, and seek feedback on current practices in the organisation and areas for improvement
- Review the factors that create a welcoming environment for Aboriginal and Torres Strait Islander people.

Strategies for improvement

Providing a welcoming, culturally sensitive and safe environment for Aboriginal and Torres Strait Islander people may improve their patient and carer experience during an episode of care. This may lead to improved health outcomes and may reduce the rate of early discharge.

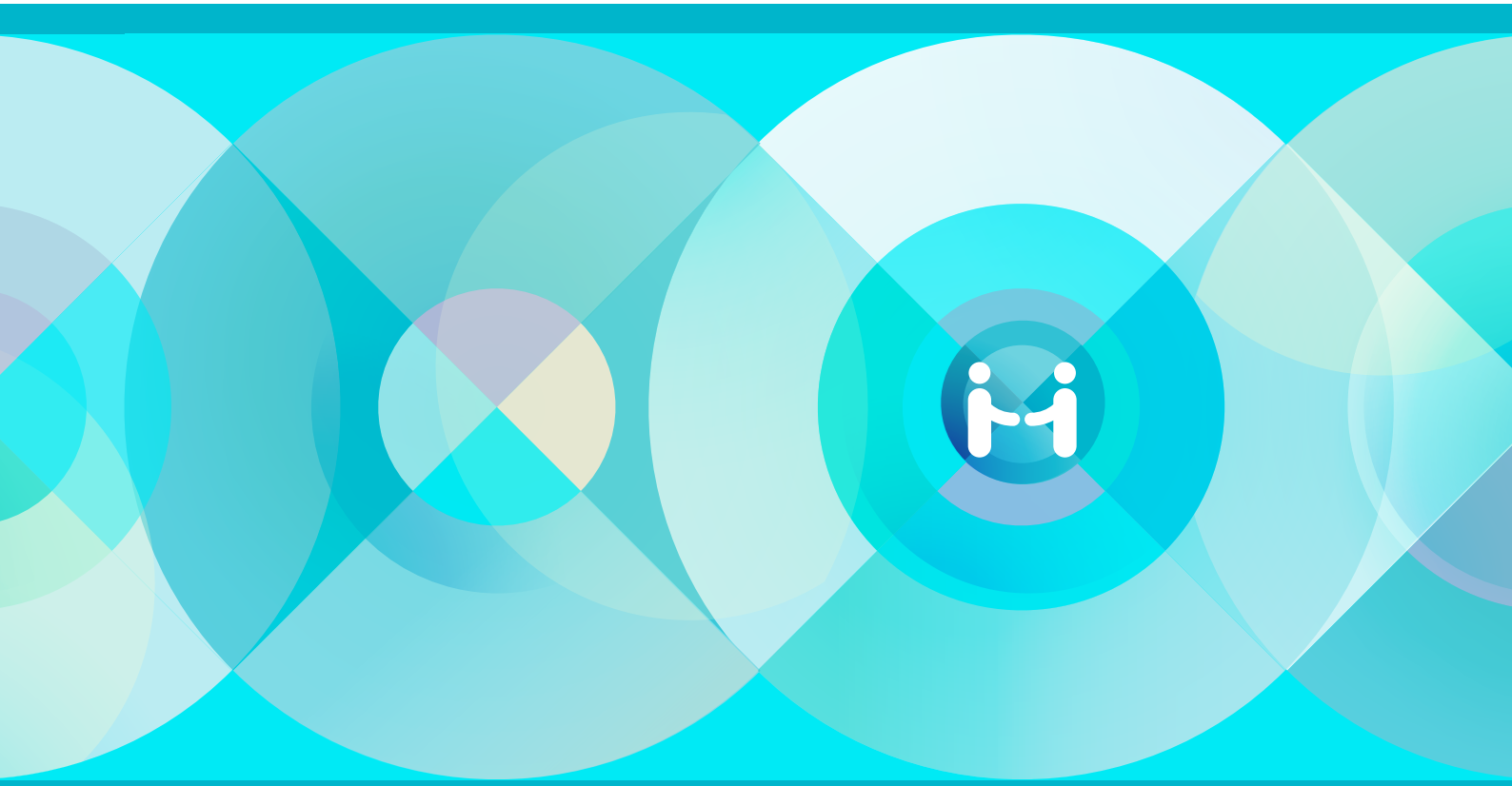
Create a welcoming, culturally sensitive and safe environment for Aboriginal and Torres Strait Islander people by[38]:

- Collaborating with local Aboriginal and Torres Strait Islander people and communities to review the design, use and layout of public spaces, and to maximise privacy and minimise distress in clinical spaces
- Engaging the community in the development of messages to explain organisational processes
- Identifying spaces for Aboriginal and Torres Strait Islander people to hold family conferences, and to consult with members of the clinical workforce, carers and family; this could include outdoor spaces, if appropriate
- Seeking feedback on the signs, symbols and displays that could be used, such as
  - Aboriginal or Torres Strait Islander flags
  - artwork from local and partner communities
  - statements of reconciliation and acknowledgement of traditional owners
  - participation in cultural events
- Supporting Aboriginal and Torres Strait Islander consumers to have access to culturally appropriate services.

Further strategies are available in *NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health*.

2

Partnering with Consumers Standard



Partnering with Consumers Standard

Leaders of a health service organisation develop, implement and maintain systems to partner with consumers. These partnerships relate to the planning, design, delivery, measurement and evaluation of care. The workforce uses these systems to partner with consumers.

Intention of this standard

To create an organisation in which there are mutually beneficial outcomes by having:

- Consumers as partners in planning, design, delivery, measurement and evaluation of systems and services
- Patients as partners in their own care, to the extent that they choose.

Criteria

Clinical governance and quality improvement systems to support partnering with consumers

Partnering with patients in their own care

Health literacy

Partnering with consumers in organisational design and governance

Introduction

After more than 40 years of growing recognition and acceptance, consumer partnerships in health care are now viewed as integral to the development, implementation and evaluation of health policies, programs and services.[39-41] Patient and consumer partnerships are also a pillar of person-centred care – that is, care that focuses on the relationship between a patient and a clinician, and recognises that trust, mutual respect and sharing of knowledge are needed for the best health outcomes.[42]

Patient and consumer partnerships should take many forms, at many levels

Different types of partnerships with patients and consumers exist within the healthcare system. These partnerships are not mutually exclusive, and are needed at all levels to ensure that a health service organisation achieves the best possible outcome for all parties.[43] Partnerships with patients and consumers comprise many different, interwoven practices that reflect the three key levels at which partnerships are needed:

- **Individual**

  At the level of the individual, partnerships relate to the interaction between patients and clinicians when care is provided. This involves providing care that is respectful; sharing information in an ongoing way; working with patients, carers and families to make decisions and plan care; and supporting and encouraging patients in their own care and self-management.[44]

- **Service, department or program of care**

  At the level of a service, department or program of care, partnerships relate to the organisation and delivery of care within specific areas. Patients, carers, families and consumers participate in the overall design of the service, department or program. They could be full members of quality improvement and redesign teams, including participating in planning, implementing and evaluating change.

- **Health service organisation**

  At the level of the health service organisation, partnerships relate to the involvement of consumers in overall governance, policy and planning. This level overlaps with the previous level in that a health service organisation is made up of various services, departments and programs. Consumers and consumer representatives are full members of key organisational governance committees in areas such as patient safety, facility design, quality improvement, patient or family education, ethics and research. This level can also involve partnerships with local community organisations and members of local communities.

Supporting effective consumer partnerships means supporting multiple mechanisms of engagement. Meaningful methods of engagement range from representation on committees and boards, to contributions at focus groups, to feedback received through surveys or social media. When selecting methods of consumer participation, consider the diversity of the consumer population that uses, or may use, the services.[39]

Consumer partnerships should not be viewed in isolation, but as a continuum of activity. From partnering with consumers in their own care to representation on boards or governance committees, consumer partnership is needed at multiple levels of healthcare delivery. Consumers need to be represented at the highest levels of governance for their input to have the greatest impact.[39,40] Table 1 shows an example of a continuum of consumer participation. A number of different models are used to describe this continuum, and a variety of terms are used to describe different levels of engagement.

Table 1: Continuum of participation

		Description	Examples
Information	LOWER	The organisation develops or adopts a policy, plan or program, and provides information about this to consumers, carers and the community	Giving: Flyers, mail-outs, fact sheets, press releases, brochures, newsletters, public displays, websites, public meetings Gathering: Surveys, phone-ins, focus groups, in-depth interviews, suggestion boxes
Consultation		The organisation identifies an issue and proposes a policy, plan or program that responds to the issue. It provides information to consumers, carers and the community on that proposal, and seeks views and comments to maximise acceptance	Workshops Consumer representatives on management committees or advisory groups Public meetings or patient forums Online discussion groups Circulation of proposal for comment Conferences or seminars Evaluation surveys
Partnership		The organisation identifies an issue and presents a tentative policy, plan or program that responds to the issue. The organisation seeks active involvement and feedback from consumers, carers and the community, which is incorporated into the plan	Strategic alliances built using a combination of methods (including those in Information and Consultation), such as: • Workshops • Consumer representatives on committees or advisory groups • Roundtables • Patient forums • Surveys • Focus groups
Delegation		The organisation identifies an issue and presents this to consumers, carers and the community for them to make decisions or propose actions to deal with the issue	Shifting some or all of the decision-making on particular issues to consumers. For example: spending on specific budget items, management of particular programs by consumers (e.g. mental health consumer advisory groups)
Control	HIGHER	The organisation asks consumers, carers and the community to identify an issue, and they make all the key decisions on the development of solutions to deal with the issue. The organisation supports them to accomplish this	Community-appointed management committees (e.g. Aboriginal community controlled health organisations)

Source: Brager & Specht[45], and Queensland Health[46]

Consumer partnerships add value

Consumer partnerships add value to healthcare decision-making. Consumer involvement in the development, implementation and evaluation of health care contributes to[40,41]:

- Appropriately targeted initiatives
- Efficient use of resources
- Improvement in the quality of care provided by a health service.

There is growing acceptance that practices supporting partnerships at the level of the individual – from communication and structured listening, through to shared decision making, self-management support and care planning – can improve the safety and quality of health care, improve patient outcomes and experience, and improve the performance of health service organisations.[44]

As consumer partnership becomes more embedded in the healthcare system, there is an increasing need to monitor and evaluate its impact. Monitoring, measuring and evaluating consumer partnerships – through mechanisms such as recording patient experience and patient-reported outcome measures – are vital to ensure that the partnerships are meeting the needs of the community and consumers.[41]

Organisational leadership and support are essential to nurture consumer partnerships

Regardless of the mechanisms used, all forms of consumer partnership require organisational commitment, support and appropriate resourcing. Organisational commitment and support can be demonstrated through the support of executive leadership and governing bodies. Strong leadership in support of consumer partnerships can lay a solid foundation for adopting partnerships at the service level. Appropriate resourcing may include consumer training, workforce roles that focus on nurturing consumer partnerships, and remuneration and reimbursement to support consumers to actively participate.[39,40]

Consumer partnerships should be meaningful and not tokenistic. To maximise the contribution of partnerships, consumers need to be seen and treated as people with expert skills and knowledge. In the same way that clinicians and other organisational partners are respected for their areas of expertise, consumer partnerships need to be recognised and valued for their unique perspective on the patient experience.[40]

Many resources are available to help organisations of any size set up and support consumer partnerships

There are multiple successful approaches to partnering with consumers. Different health service organisations have different contexts and resources available to embed consumer partnerships in their systems, and partnering approaches can be adapted to the nature and context of the health service organisation. Although capacity and resource limitations may appear to pose a barrier to forming consumer partnerships, a simple approach to partnering can often be the most effective.

CRITERION: Clinical governance and quality improvement systems to support partnering with consumers

> *Systems are designed and used to support patients, carers, families and consumers to be partners in healthcare planning, design, measurement and evaluation.*

Good governance systems promote the effective delivery of health care, empower patients and contribute to improvements in health outcomes.[47,48]

Consumer engagement at multiple levels of governance is a key element for effective and sustainable governance systems.[49]

This criterion requires organisation-wide governance, leadership and commitment to partnering with consumers.

To meet this criterion, health service organisations are required to:

- Apply safety and quality systems to processes for partnering with consumers
- Use quality improvement systems to monitor, review and improve processes for partnering with consumers.

This criterion aligns closely with the Clinical Governance Standard.

Integrating clinical governance

Action 2.1

Clinicians use the safety and quality systems from the Clinical Governance Standard when:

a. Implementing policies and procedures for partnering with consumers

b. Managing risks associated with partnering with consumers

c. Identifying training requirements for partnering with consumers

Intent

Safety and quality systems support clinicians in partnering with consumers in the delivery of care.

Key tasks

- Set up and implement governance structures for partnering with consumers
- Develop and implement policies and procedures for partnering with consumers
- Use organisation-wide risk management systems to identify, monitor, manage and review risks associated with partnering with consumers
- Deliver or provide access to training on partnering with consumers based on the specific needs of the clinical workforce.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' safety and quality systems.

Action 1.7 – policies and procedures

Action 1.10 – risk management systems

Actions 1.19, 1.20 and 1.21 – education and training

Health service organisations should:

- Use these and other established safety and quality systems to support policies and procedures, risk management and training for partnering with consumers
- Ensure that current versions of all relevant policies and procedures are readily available and accessible to clinicians.

Clinical policies may be developed or adapted at different levels within the organisation. However, all policy documents should be incorporated into a single, coherent set to maximise the effectiveness of the policy development process.

Establish governance for partnering with consumers

For Action 2.1, the health service organisation should ensure that all actions in the Partnering with Consumers Standard have appropriate governance structures and support from the governing body and management.

Actions 2.11, 2.12, 2.13 and 2.14 outline strategies for partnering with consumers in discussions and decisions regarding the design, implementation and evaluation of health policies, programs and services.

Implement policies and procedures

Ensure that organisational policies and procedures are in place that cover:

- Healthcare rights
- Informed consent, including financial consent
- Shared decision making and planning care
- Health literacy and effective communication with patients, carers, families and consumers
- Partnering with consumers in governance.

Manage risks

Use the organisation's risk management systems (see Action 1.10) to identify, monitor, manage and review risks associated with partnering with consumers. Develop processes to manage clinical risks for different populations served within the organisation, clinical and workplace risks for the workforce, and organisational risks.

Use information from measurement and quality improvement systems, adverse events, clinical outcomes and patient experiences to inform and update risk assessments and the risk management system.

Identify training requirements

Assess the competency and training needs of the workforce in line with the requirements of Actions 1.19, 1.20 and 1.21. Perform a risk assessment to inform the training schedule and to set priorities for the members of the workforce who require training. Develop, or provide access to, training and education resources to meet the needs of the workforce with regard to partnering with consumers

Education and training to support understanding and awareness of the value of partnerships with consumers can include training on person-centred care, shared decision making, communication techniques and health literacy. It may also involve consumer input through stories, presentations or advice on the development of training materials.

Consider the training the workforce may need to effectively use the incident management and investigation system to inform risk management, and to plan and implement quality improvement processes to mitigate risks.

Action 2.2

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:

a. Monitoring processes for partnering with consumers

b. Implementing strategies to improve processes for partnering with consumers

c. Reporting on partnering with consumers

Intent

Quality improvement systems are used to support processes for partnering with consumers at the level of the organisation.

Key tasks

- Review, measure and assess the effectiveness and performance of organisational and clinical strategies for partnering with consumers
- Implement quality improvement strategies for partnering with consumers based on the outcomes of monitoring activities
- Provide information on the outcomes of quality improvement activities to the governing body, the workforce, consumers and other organisations.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' quality improvement systems.

- Action 1.8 – quality improvement systems
- Action 1.9 – reporting
- Action 1.11 – incident management and investigation systems

Health service organisations should use these and other established safety and quality systems to support monitoring, reporting and implementation of quality improvement strategies for partnering with consumers.

Monitor effectiveness and performance

Use the organisation's quality improvement systems to identify and set priorities for the organisational and clinical strategies for partnering with consumers.

Strategies to monitor the effectiveness of systems for partnering with consumers include:

- Developing or adopting meaningful performance indicators that are relevant to the organisation and can be used to measure improvements in consumer partnerships
- Conducting an internal evaluation of consumer partnerships across governance, strategic leadership, safety and quality, and performance management systems;[39] use the *Organisational Self-Assessment Survey for Consumer Engagement*[50] to assist with an internal evaluation
- Engaging independent evaluators or state- or territory-based consumer peak organisations to provide an external perspective on the organisation's consumer partnership systems[39]
- Integrating consumer partnership into the overall goals of the organisation, so that it is assessed alongside other business goals, such as productivity[39]
- Conducting a gap analysis to identify areas that need improving by comparing current systems for partnering with consumers with an ideal future state[51]
- Routinely collecting data about the experience of consumers, including
  - feedback and complaints through surveys or suggestion forms[41,51]
  - patient stories
  - feedback from consumers who are currently using the service, through informal discussions, interviews, and the use of handheld devices or computers for capturing survey responses.[41]

Implement quality improvement strategies

Strategies to improve systems and performance for partnering with consumers may include:

- Problem-solving methods such as hosting a brainstorm involving consumers, the workforce and governance members to generate improvement ideas[51]
- Engaging managers to act as champions of consumer partnership
- Providing education to the workforce to reinforce the roles of consumers.[41]

Review the strategies for partnering with consumers presented in Action 2.11 to identify opportunities for improving systems of partnership.

Report outcomes

Strategies for reporting on the effectiveness and outcomes of partnering with consumers may include[52]:

- Developing formal progress and evaluation reports for members of the organisation's leadership and governing body, the workforce, consumers and consumer organisations, and the wider community
- Using internal newsletters or memos to report on the effectiveness and outcomes of the organisation's consumer partnership
- Using local community media to disseminate stories about the effectiveness and outcomes of the organisation's consumer partnership to the wider community
- Publishing profiles or stories of consumers involved in consumer partnerships with the organisation, and the contributions they have made
- Hosting events to present the outcomes of systems for partnering with consumers, inviting members of the organisation's leadership and governing body, the workforce, consumers and consumer organisations, and the wider community.

CRITERION: Partnering with patients in their own care

> *Systems that are based on partnering with patients in their own care are used to support the delivery of care. Patients are partners in their own care to the extent that they choose.*

Person-centred care is globally recognised as the gold standard approach to healthcare delivery. It is a diverse and evolving practice, encompassing concepts such as patient engagement and patient empowerment. Partnering with patients in their own care is an important pillar of person-centred care. It focuses on the relationship between a consumer and a clinician, and recognises that trust, mutual respect and sharing of knowledge are needed for the best health outcomes.[42]

Partnerships with patients comprise many different, interwoven practices – from communication and structured listening, through to shared decision making, self-management support and care planning. There is growing acceptance that these practices can improve the safety and quality of health care, improve patient outcomes and experience, and improve the performance of health service organisations.[44]

Effective partnerships between clinicians and patients require:

- Organisational development and promotion of person-centred care
- Education and training to equip clinicians with a rounded mix of skills
- Tools and resources to support communication and shared decision making
- Integrated care models
- Meaningful methods of measuring success, such as recording patient experience and patient-reported outcome measures.

Today, health service organisations and clinicians are adopting strategies to encourage patients to become partners in their own care.[43] Key strategies have included:

- Providing health information in engaging and accessible formats, such as print, mobile apps and online channels
- Eliciting and documenting individual needs, preferences and goals
- Using patient decision aids
- Encouraging and prompting patient questioning during clinical encounters
- Providing education to support self-management
- Establishing self-help and support groups
- Developing programs to encourage treatment adherence
- Providing consumers with open access to their own healthcare record.

Health service organisations can also look at strategies for engaging with patients' carers and families.[43] Carers and families can often provide unique insight into a patient's health history, and provide valuable reassurance to the patient during their treatment.

Action 2.3

The health service organisation has a charter of rights that is:

a. Consistent with the Australian Charter of Healthcare Rights[53]

b. Easily accessible for patients, carers, families and consumers

Intent

Consumers are provided with information about their healthcare rights.

Key tasks

- Adopt the Australian Charter of Healthcare Rights (with or without amendments)
- Provide ready access to copies of the charter, in appropriate languages or formats, to all patients, and their carers and families.

Strategies for improvement

The Australian Charter of Healthcare Rights[53] was developed by the Australian Commission on Safety and Quality in Health Care (the Commission) and adopted by all health ministers in 2008. It describes the rights of patients and other people using the Australian healthcare system. These rights are essential to ensure that safe and high-quality care is provided to all people, in all health settings in Australia (including public and private hospitals).

Review or develop a charter of rights

If the organisation does not have a charter of rights, use the Australian Charter of Healthcare Rights as a foundation for developing a charter.

Review the Australian Charter of Healthcare Rights and, if necessary, adapt it to meet the specific needs of the organisation; however, the seven original rights must remain in place.

If the organisation already has a charter of rights in place, review how it aligns with the Australian Charter of Healthcare Rights.

Health service organisations may need to:

- Replace their existing charter with the Australian Charter of Healthcare Rights
- Edit the existing charter so that it better aligns with the Australian Charter of Healthcare Rights
- Keep the existing charter, noting that it is consistent with the Australian Charter of Healthcare Rights but may include modifications to suit the organisation's services.

Adopt the charter of rights

Support the effective adoption of the charter in the organisation. Strategies may include:

- Allocating responsibility for implementing and reviewing the charter to a manager with decision-making authority
- Including information about the charter during orientation for new members of the workforce
- Running regular education and training sessions for the workforce on their responsibilities for implementing the charter; this includes clinical and non-clinical members of the workforce, and, if relevant, volunteers
- Building the charter into organisational processes, policies and codes of conduct
- Developing policies and procedures that outline how the rights in the charter will be achieved at the organisation.

Inform patients, carers and families about the charter, and make sure that they can find it easily. Strategies may include:

- Discussing the charter with patients
- Displaying brochures or posters advertising the charter at reception desks, and in waiting areas, wards, corridors, consulting rooms and other strategic locations
- Incorporating information about the charter into communication with patients, such as on the organisation's website or in information brochures
- Incorporating the charter into information packs sent to elective patients before admission
- Making information about the charter available to patients at their bedside
- Ensuring that copies of the charter are available in community languages, and providing copies of the charter to any nominated interpreters
- Providing information in a format that is suitable for patients who are visually impaired, such as audio, in braille or on fully accessible websites.

Review the effectiveness of the charter

Measure the impact of the charter to see whether promotion efforts are successful and whether this affects patient experience. Strategies may include:

- Conducting surveys of patients to check whether they have received the charter, and whether the rights in the charter have been respected
- Conducting surveys of the workforce about their awareness of, and attitudes towards, the charter
- Monitoring patient requests for the charter
- Monitoring printing of the charter.

The brochure *Using the Australian Charter of Healthcare Rights in Your Health Service*[54] is a guide that outlines ways in which health service organisations can provide information about health rights and incorporate a charter in their systems. This brochure is available on the Commission's website, along with other resources to assist with the adoption of the Australian Charter of Healthcare Rights.

Action 2.4

The health service organisation ensures that its informed consent processes comply with legislation and best practice

Intent

Patients are involved in appropriate informed consent processes.

Key tasks

- Adopt a comprehensive policy and associated procedures on informed consent by patients in clinical decision-making
- Schedule periodic reviews of the effectiveness and outcomes of the policy.

Strategies for improvement

Informed consent is a person's voluntary decision about their health care that is made with knowledge and understanding of the benefits and risks involved.[55]

Ensure that the organisation has effective processes in place to:

- Inform patients (and, if applicable, their carers and substitute decision-makers) about the risks, benefits and alternatives of a treatment, including any fees and charges associated with treatment and referrals

- Determine patient preferences for treatment
- Document patient consent to treatment.

This includes processes for consent relating to transfusions of blood or blood products (Action 7.3), and specific situations that require informed consent for treatment with a medicine (Action 4.11).

Effective processes may include policies and procedures to guide and support the clinical workforce towards good standards of practice that meet legal and ethical requirements.

Review current informed consent processes

Informed consent processes should comply with legislation and best practice. The following are best-practice principles for informed consent systems[55,56]:

- Provide information to patients in a way that they can understand before asking for their consent – for example, provide an accredited interpreter to help with communication, or adapt information into accessible formats (such as translation into community languages, or providing audio or visual information); other strategies for tailoring communications to the diverse needs of the patient population are provided in Action 2.8
- Obtain informed consent or other valid authority before undertaking any examination or investigation, or providing treatment (except in an emergency)
- Document consent appropriately, and provide guidance on what to do if there are concerns about a patient's capacity to provide consent
- Meet the common law and legal requirements of the relevant state or territory relating to
  - providing information about treatment
  - obtaining consent to treatment, including the requirement to disclose all risks
- Nominate a manager who is responsible for maintaining the integrity of the consent system and its continuous improvement
- Support informed consent through safety and quality systems across all areas of the organisation that ensure that
  - no treatment is provided without the patient's informed consent (or, if applicable, that of their substitute decision-maker)
  - specific consent requirements established by state or territory legislation – such as mental health Acts, guardianship and administration Acts, and human tissue Acts – are complied with
- Support informed consent through education and training for all members of the clinical workforce in
  - effective communication to underpin good clinical practice
  - the legal, ethical and practical foundations of requirements for patient consent and engagement in clinical decision-making
  - the organisation's consent policy and procedures
  - understanding how individual health literacy levels and the health literacy environment can act as barriers to understanding during the consent process
- Incorporate protocols for receiving, investigating and managing complaints about consent processes
- Link informed consent to the organisation's open disclosure policy and the state or territory consent policy (if applicable).

If an organisation's informed consent processes do not meet the best-practice principles outlined above, adapt the policies and procedures accordingly.

Some states and territories have developed informed consent templates or identified appropriate consent strategies for use in that state or territory. Adopt or adapt these if available; otherwise, develop processes for the health service organisation.

The National Health and Medical Research Council's *General Guidelines for Medical Practitioners on Providing Information to Patients*[56] provides guidance on the information that clinicians need to give to patients.

The Queensland Health *Guide to Informed Decision-Making in Health Care*[57] provides guidance on how to implement the principles of informed decision-making in clinical practice.

Monitor design and performance of informed consent processes

Periodically review the design and performance of informed consent processes to evaluate whether they comply with best-practice principles. This will support effective clinical governance, including risk management.

For private sector organisations where informed consent may be obtained in a process separate from the health service organisation, it is not intended that visiting medical officer practices are monitored. Rather, the health service organisation takes a risk management approach and confirms with patients on admission, or at the commencement of an episode of care, that they understand why they are there and what treatment they will receive.

Action 2.5

The health service organisation has processes to identify:

a. The capacity of a patient to make decisions about their own care

b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves

Intent

Patients who do not have the capacity to make decisions about their care are identified, and systems are put in place so that they, or agreed substitute decision-makers, are involved in decision-making, including informed consent.

Key tasks

- Adopt a comprehensive policy and associated procedures to identify patients who do not have the capacity to make decisions about their own care
- Schedule periodic reviews of the effectiveness and outcomes of the policy.

Strategies for improvement

Under Australian legislation, all adults are presumed to have the capacity to decide whether they wish to receive health care, except when it can be shown that they lack the capacity to do so.

A person has the capacity to make a decision about their care if they can[57]:

- Understand and retain the information needed to make a decision
- Use the information to make a judgement about the decision
- Communicate the decision in some way, including by speech, gestures or other means.

Decision-making capacity can be decision- and situation-specific. This means that a person's capacity can vary at different times, in different circumstances and between different types of decisions.

Review processes for determining patients' capacity to make decisions

Ensure that effective processes are in place to identify:

- Patients who do not have the capacity to make decisions about their own health care
- Appropriate substitute decision-makers who can make decisions on behalf of the patient.

If these systems are not in place, use the strategies below to develop them:

- Review the local legislation regarding the criteria for a patient to be considered capable of making decisions about their own care, and incorporate these criteria into any policies and procedures that the organisation develops; state and territory legislation may differ in its definition of patients who have the capacity to make healthcare decisions[57,58]
- Develop an organisational policy that outlines the requirements of clinicians to assess patients for their capacity to make health decisions

- Work with clinicians and consumers to develop procedures to support the organisational policy, including guidance on
  - assessing fluctuations in decision-making capacity
  - considerations for special populations, such as children
  - requirements for recording and documenting decisions
- Educate the workforce about assessing a person's capacity to make decisions about their care; consider training from a third party with expertise in this area, such as Capacity Australia
- Develop or provide resources and tools to reinforce training and assist the workforce to assess a person's capacity to make decisions; SA Health's *Impaired Decision-Making Factsheet*[59] is an example.

Review processes for identifying substitute decision-makers

If a patient does not have the capacity to make decisions about their own care, a substitute decision-maker may be appointed.[57] Consult local legislation and best-practice guidelines to identify who is authorised to provide substitute decision-making in the state or territory. Examples of substitute decision-makers are a nominated carer, a health attorney, or a person nominated under an enduring power of attorney or guardianship arrangement.

Incorporate a list of appropriate substitute decision-makers into the organisation's informed consent policy. Educate the workforce about these appropriate substitute decision-makers during orientation and ongoing training sessions.

Include information about substitute decision-makers in any consumer communications about informed consent.

Develop an associated procedure for identifying and appointing a substitute decision-maker, such as a determination flowchart.

Periodically review the design and performance of these processes

Periodically review processes to evaluate whether they meet the needs of patients and reflect best practice. Strategies may include:

- Collecting informal feedback from patients during discussions in waiting rooms and during ward rounds to see whether they felt involved in their healthcare decision-making
- Collecting formal feedback from consumers through submissions and events (such as focus groups or community meetings) to see whether they felt involved in their healthcare decision-making
- Surveying patients to self-report on their experience and satisfaction with the level of engagement they had in their healthcare decision-making.

For guidance on undertaking consultations and surveys, see the Scottish Health Council's Participation Toolkit.[60]

Action 2.6

The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care

Intent

Patients receive safe and high-quality care by being involved in decisions and planning about current and future care.

Key tasks

- Develop policies and processes (or review existing policies and processes) to involve patients or their substitute decision-maker in planning, communication, goal-setting and decision-making for their current and future care, and review workforce compliance with these policies and processes
- Set up mechanisms to support communication between clinicians and patients or their substitute decision-maker
- Periodically review the systems for partnering with patients or their substitute decision-maker in their own care.

Strategies for improvement

Partnering with patients in their own care is integral to the delivery of safe and high-quality person-centred health care. Ensure that effective processes are in place to support clinicians to partner with patients or their substitute decision-maker in the planning, communication, goal-setting and decision-making relating to their current and future care.

Review current systems for supporting clinicians and patients to be partners in care

If systems are already in place to support clinician and patient partnerships, review the strategies outlined below and consider any additions or updates.

If the organisation does not have systems in place to support partnerships between clinicians and patients, use the strategies outlined below to develop or adapt policies and processes for partnering with patients in their care.

Create a supportive organisational culture

Supportive organisational climates are vital for achieving person-centred care, in which partnerships between clinicians and patients become the established norm. Strategies may include:

- Engaging leadership and governing bodies to act as champions for partnerships between clinicians and patients
- Incorporating the importance of clinician and consumer partnerships into the organisation's strategic planning, vision and goals
- Engaging consumers in organisational governance and strategic planning to support organisational redesign (see Action 2.1 for guidance)
- Providing enough resources to support clinicians to partner with patients in their care
- Providing education and training to equip clinicians to partner with patients in their care; further information on education and training for clinicians is provided in Action 2.7.[42]

Enable communication and knowledge exchange between clinicians and patients

Patients can be partners in their own care in many ways, including shared decision making, self-management of their condition and personalised care planning. For these partnerships to be meaningful, both the clinician and the patient must feel trusted and respected. Good communication is vital to foster this trust and respect, and drive clinician and patient partnerships.[42]

Use the following strategies to encourage communication and knowledge exchange between clinicians and patients:

- Review the current admissions process to see what information is provided to patients and how that information is given; identify any communication barriers and areas for improvement, and implement solutions to overcome these; consider engaging consumers in this review process by holding informal discussions with patients in waiting rooms, or discussing the admission process during a consumer advisory group or focus group
- Provide consumers with access to information and resources in a format that meets their needs; this may include
  - general information about their health, condition and healthcare arrangements
  - information and tools about how they can be involved in their own care
  - information that has been developed specifically for them
- Provide patients with timely and open access to their healthcare record, test results and other clinical information relevant to their care
- Encourage clinicians to create an environment in which patients feel confident asking questions, and in which clinicians respond positively to patient needs; this may involve speaking with patients in a neutral environment, away from the clinical setting
- Use technology such as telehealth, and mobile and tablet apps to interact and share information with patients before, during and after their care, especially as a strategy for facilitating clinician and patient partnerships across long distances; ensure that any healthcare records transmitted electronically are encrypted or aligned with privacy regulations
- Develop a policy and procedure to support active engagement of patients during bedside rounding and clinical handovers
- Support patients to take part in shared decision making with decision support tools, such as information sheets, pamphlets and videos that provide structured information about their health options
- Implement self-management of certain aspects of care, such as medicine use, to encourage engagement.[61-64]

The Agency for Healthcare Research and Quality[65] provides practical advice for improving clinician and patient communication, including tools to educate consumers on how to be involved in their own care.

The SA Health *Guide for Engaging with Consumers and the Community*[66] provides a tool to help clinicians encourage questions from their patients.

The Commission and Healthdirect Australia developed Question Builder[67], a free web-based tool to help consumers prepare for a visit to the doctor. In addition, the Commission's *Top Tips for Safe Health Care*[68] can help consumers, families, carers and other support people get the most out of their health care.

Develop policies and procedures to guide care planning in partnership with patients

Involve patients in the development of any current and future care planning, such as:

- Inpatient treatment and recovery planning
- Treatment and preventive health strategies for ongoing care outside the health service organisation
- Advance care planning (see Action 5.9).

Strategies for involving patients in care planning may include systematically discussing patient preferences for care during admission consultations, and at regular times during their care. This may be facilitated by including patients in bedside rounding and clinical handovers.[64]

Develop meaningful measures to monitor success

Monitoring and measuring the success of clinician and patient care partnerships is important for ensuring that systems are relevant and useful to consumers and the organisation.[42,64]

Strategies for monitoring and measuring the success of the systems may include:

- Collecting informal feedback from patients in waiting rooms and during rounds
- Collecting formal feedback from consumers through submissions and events, such as focus groups or community meetings
- Surveying patients to self-report on their experience and satisfaction with the level of engagement they had in their care.

Use the outcomes of these evaluations to set realistic goals for improving partnerships between clinicians and patients.

Several established measures and tools can be used to capture patient-reported outcomes, including:

- The Point of Care Foundation's Patient and Family-Centred Care toolkit, which provides guidance and tools to measure consumer partnerships
- The Agency for Healthcare Research and Quality CAHPS hospital surveys, which ask patients to report on their experiences with a variety of healthcare services.

For guidance on undertaking consultations and surveys, see the Scottish Health Council's Participation Toolkit.[60]

Tools and resources to help guide the integration of clinician and patient care partnerships include:

- The NSW Clinical Excellence Commission's Partnering with Patients[69] program, which supports health service organisations to transform services by partnering with consumers, carers and family as members of the health team
- The NSW Agency for Clinical Innovation's Designing Change Projects[70] model, which provides a simple methodology and tools to support health service organisations through the change process
- Planetree's improvement guide and accreditation scheme that demonstrates whether a health service organisation has fulfilled its goals for person-centred care[71]
- The Institute for Patient- and Family-Centered Care's getting started guide for advancing the practice of patient- and family-centred care in hospitals.[72]

Action 2.7

The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care

Intent

Clinicians work with patients to enable them to be partners in their own care.

Key task

- Implement an education and training program to develop the skills of the health workforce to partner with patients in their care.

Strategies for improvement

Do not assume that clinicians have all the interpersonal or communication skills required to effectively partner with patients in their care. It is important to develop clinicians' skills so that they feel confident about approaching consumer partnerships.

Education and training may include:

- Communication and interpersonal skills
- Techniques for shared decision making
- Awareness of individual health literacy and the health literacy environment.

Education and training can be developed by the organisation, in partnership with consumers (see Action 2.14). Alternatively, several established clinician education and training programs support engagement with consumers, including:

- The Health Issues Centre and other state-based health consumer organisations that provide consumer engagement training for clinicians[73]
- The NSW Clinical Excellence Commission Partnering with Patients program Patient Based Care Challenge, which can be adopted as a training tool[69]
- The Point of Care Foundation's Patient and Family-Centred Care toolkit, which provides a step-by-step method to help clinicians understand the importance of partnering with consumers[74]
- The Agency for Healthcare Research and Quality Communicating to Improve Quality Strategy, which provides a PowerPoint presentation and handout on communication competencies for clinicians[65]
- The Australian Institute for Patient and Family Centred Care clinical education play *Hear Me*.

CRITERION: Health literacy

Health service organisations communicate with consumers in a way that supports effective partnerships.

Health literacy refers to how people understand information about health and health care, and how they apply that information to their lives, use it to make decisions and act on it.

The Commission separates health literacy into two components[75]:

- **Individual health literacy** is the skills, knowledge, motivation and capacity of a person to gain access to, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action
- **Health literacy environment** is the infrastructure, policies, processes, materials, people and relationships that make up the healthcare system and affect the way that people gain access to, understand, appraise and apply health-related information and services.

Health literacy plays an important role in facilitating communication and enabling effective partnerships with consumers. For partnerships to work, everyone involved needs to be able to give, receive, interpret and act on information such as treatment options and plans.

Health literacy is important for:

- Consumers, because it affects their capacity to make informed decisions and take action to manage their health
- Clinicians, because it affects the way they manage their communication and partnerships with consumers and deliver care
- Managers and policymakers, because the complexity of their systems can affect consumers' ability to navigate health services and systems, collaborate with organisations and engage with their own care.

Health literacy is a complex and challenging area for health service organisations. Only about 40% of adults have the level of individual health literacy required to meet the demands of everyday life. This means, for example, that only 40% of adults can understand and follow health messages in the way in which they are usually presented.[76]

Consumers' individual health literacy may be affected by:

- **Age** – people aged 15–19 years and those over 45 years have been shown to have lower rates of health literacy
- **Education** – higher levels of education are associated with high rates of adequate or better individual health literacy
- **Disability** – people living with disability may be at risk of low individual health literacy for functional reasons, such as poor vision or cognitive impairment
- **Culture and language** – these factors can affect the way people make meaning out of their experiences, which can have a direct impact on their expectations and understanding of health issues; in addition, difficulty with the English language has been associated with lower rates of individual health literacy
- **Aboriginal and Torres Strait Islander status** – national data on the individual health literacy of Aboriginal and Torres Strait Islander people are limited; however, factors such as lower school-based literacy and socioeconomic disadvantage across education, employment and income may place Aboriginal and Torres Strait Islander people at risk of lower individual health literacy.

Health service organisations can play an important role in addressing health literacy. Organisations have a responsibility to build a health literacy environment that supports effective partnerships with consumers. This may involve[75,77]:

- Developing and implementing health literacy policies and processes that aim to reduce the health literacy demands associated with information materials, the physical environment and local care pathways
- Providing and supporting access to training for clinicians in health literacy and interpersonal communication, including training in communicating risk
- Providing education programs for consumers to develop health knowledge and skills
- Reducing unnecessary complexity for consumers in using and navigating the health service.

Action 2.8

The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community

Intent

Consumers receive the information they need in a way that is appropriate for them.

Key tasks

- Develop a framework for meeting the communication needs of a diverse consumer and community population
- Ensure that accredited interpreter services are available to consumers who require them
- Use a variety of mechanisms to meet the communication needs of a diverse consumer and community population.

Strategies for improvement

Language and cultural factors can create barriers to accessing health care, leading to poorer health outcomes and a lower quality of care for some sections of diverse populations. Diversity comes in many forms – for example:

- Language factors may affect consumers for whom English is not their first language, consumers with a cognitive impairment and consumers with a physical condition such as deafness or blindness
- Cultural factors may affect consumers from culturally and linguistically diverse communities, whose view of health and wellbeing may differ from the Australian experience; the diversity of cultures accessing health care in a multicultural country such as Australia can pose challenges for a health service organisation and its workforce to engage in a culturally responsive way.

There is no 'one size fits all' solution to meeting the communication requirements of a diverse consumer population. However, health service organisations can work to develop a framework that integrates cultural competency into its communication mechanisms.[78]

Different consumers will engage with different communication mechanisms. Some consumers may prefer casual, verbal conversations, whereas others may prefer written information resources or audiovisual presentations. Communication mechanisms should not be viewed in isolation; instead, the mechanisms chosen should complement each other and aim to appeal to different consumer communication preferences.

Determine the diversity of consumers and the local community

Patient and community data are essential to understanding consumer communication needs, and developing or improving communication mechanisms to meet these needs.[78] Review the diversity of the consumers who use the organisation's services and make up the local community by[66]:

- Undertaking a community profiling project, which involves gathering information about the diversity within the community; its history, social and economic characteristics; the groups and networks within the community; and the social and infrastructure services that exist
- Administering surveys to help identify diversity among consumers
- Using demographic data from the Australian Bureau of Statistics, or local, or state and territory government sources to understand the background of the organisation's consumers

- Networking with other organisations or individuals in the community – such as culturally and linguistically diverse community groups; community participation managers; Primary Health Networks; Local Hospital Networks; local, state and territory government organisations; and professional associations – to share knowledge about communication preferences and needs.

For guidance on undertaking consultations and surveys, see the Scottish Health Council's Participation Toolkit.[60]

Review current communication mechanisms

Determine whether the organisation's current communication mechanisms meet the needs of diverse patient populations by reviewing:

- Consumer information developed by the organisation, such as patient brochures, posters and consent forms, to see whether they are
  - culturally appropriate or available in culturally appropriate formats
  - available in a variety of community languages
  - available in a variety of accessible formats, such as audio or braille
- The availability of interpreting services, and methods of access to these services for patients and members of the workforce
- The cultural competency and confidence of the workforce in communicating with diverse patient populations.

One Size Does Not Fit All: Meeting the health care needs of diverse populations[78] can be used to help evaluate the current services provided for diverse patient populations.

If the organisation currently uses communication mechanisms that are tailored to the needs of its diverse consumer and local community populations, review them to determine whether any additions or improvements can be made.

If the organisation does not use communication mechanisms that are tailored to the needs of its consumers, use the strategies outlined below to develop or adapt a framework to help meet these needs.

Set up a supportive foundation for tailoring communication mechanisms

This may involve:

- Engaging the support of the organisation's management and governing body to help drive change and build workforce support
- Implementing a policy that requires cultural and language considerations to be incorporated into all communication strategies
- Implementing a plain-language policy that makes written information easier to understand[79]
- Educating the workforce about the diversity of the consumers who use the organisation's services; consider accessing cultural competency training if people from culturally and linguistically diverse communities, or Aboriginal and Torres Strait Islander communities regularly use the service[80]
- Engaging consumers in developing and reviewing health communications
- Facilitating easy access to interpreting services by
  - identifying and promoting appropriate interpreting services that are competent at working in a health setting (for example, discussing health and medical issues); the Australian Government's Translating and Interpreting Service can supply phone and on-site services
  - developing policies and procedures, and educating the workforce on when and how to engage an interpreting service
  - educating the workforce on the appropriate use of interpreters – family or friends may not be appropriate interpreters because of health privacy issues.

Resources and tools include:

- The Agency for Healthcare Research and Quality Health Literacy Universal Precautions Toolkit[81]
- Centers for Disease Control and Prevention *Simply Put: A guide for creating easy-to-understand materials*[82]
- The Plain Language Action and Information Network's PlainLanguage.gov website.[83]

Implement communication mechanisms that meet the needs of specific populations

This may involve:

- Adapting existing consumer information into culturally appropriate formats by changing the design and messaging used in a resource, or adapting the information for an alternative delivery channel, such as video or audio
- Translating existing consumer information into community languages
- Providing multiple opportunities for consumers to gain access to information in a variety of formats
- Employing or engaging interpreters to be part of the patient care team
- Using techniques to check a consumer's understanding of information, such as a 'teach back' method[66]
- Using symbols or cue cards for communicating with patients during care, such as instructions for the correct use of medicines
- Using technology, mobile apps or social media to help communication, if appropriate.

A number of tools and resources can help guide effective and tailored communication with diverse patient populations, including:

- SA Health *Guide for Engaging with Consumers and the Community*, Tool 3: Tips for communicating clearly[66]
- Health Translations directory, which provides links to reliable translated health resources produced in Australia
- Eastern Health Cue Cards in community languages[84]
- Centers for Disease Control and Prevention Health literacy website.[85]

Action 2.9

Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review

Intent

Consumers are involved in the development of information about health and health services, so it is easy to understand and act on.

Key tasks

- Develop and implement a process for engaging consumers during the development of consumer information about health and health care
- Develop and implement a process for sourcing consumer feedback on internally developed consumer information and incorporating this feedback to inform future improvements.

Strategies for improvement

Consumers can play an important role in supporting health service organisations to develop information that is clear, easy to understand, and relevant to the needs of consumers and the local community.[41,86]

Review existing processes for involving consumers in the development of consumer information

This could include identifying the publications that the organisation has produced, looking at how they were developed and determining whether consumers were involved in their development.

If consumers were not involved in developing the publications, develop and implement a process to involve consumers for all relevant new consumer information. Strategies may include:

- Establishing a consumer-based patient information working group to lead and advise on developing consumer information[41]
- Attending community meetings to discuss the information needs of consumers, and the barriers and facilitators to understanding health information in the community
- Holding waiting-room discussions, focus groups or workshops to plan and develop consumer information
- Engaging consumers to co-author information in conjunction with the organisation
- Collaborating with local health consumer organisations to develop information
- Conducting interviews or one-on-one consultations with consumers to inform the development of information.

Engage consumers to review and provide feedback on existing patient information

Strategies may include:

- Conducting email, mail or phone surveys of consumers who have used the organisation's publications
- Making follow-up phone calls to consumers who have been provided with patient information publications, to identify any problems they had with understanding the information
- Holding waiting-room discussions, focus groups or workshops for consumers to review and provide feedback on consumer information.[41,86]

Further information on involving patients in testing information publications can be found in:

- The Agency for Healthcare Research and Quality Health Literacy Universal Precautions Toolkit[81]
- Can they understand? Testing patient education materials with intended readers[87]
- Health Consumers Queensland Consumer Representatives Program *Agency Handbook*.[88]

Incorporate feedback and report on how this was done

Feedback from consumers could be[77]:

- Directly incorporated into the development of patient information publications (for example, feedback might indicate that language needs to be modified so that the information is understandable for consumers with low levels of literacy)
- Used as a basis for the development of new publications (for example, if feedback indicates that there are gaps in the information, a new publication could be developed to avoid misunderstanding)
- Analysed by committees or groups tasked with the development of patient information publications to identify key themes for action (for example, many consumers may be experiencing a similar misunderstanding, which might require changes in programs and policies)
- Used as a basis for a broader organisation-wide communication strategy or policy to reduce health literacy barriers.

When a publication has been refined after consumer feedback, show the revised document to consumers to check that the interpretation and changes are appropriate. This could be through one-on-one conversations, committee meetings, discussions in waiting rooms or workshops.

Provide feedback to the community about the kinds of changes made to the publications in response to consumer feedback. This could be through information and updates in newsletters, meetings or reports for the people who were involved in identifying, developing and implementing the changes.

If the organisation does not develop its own information publications, source and use publications that have been developed in partnership with consumers, such as those developed by state and territory health or other government departments, professional associations or external providers. Publications from other organisations may need to be tested with the local community and adapted.

Action 2.10

The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that:

a. Information is provided in a way that meets the needs of patients, carers, families and consumers

b. Information provided is easy to understand and use

c. The clinical needs of patients are addressed while they are in the health service organisation

d. Information needs for ongoing care are provided on discharge

Intent

Consumers receive the information they need to get the best health outcomes, and this information is easy to understand and act on.

Key task

- Set up processes to support clinicians to communicate effectively with consumers about their health and healthcare needs.

Strategies for improvement

Clear and open communication between consumers and clinicians is vital for the delivery of effective, efficient and ethical health care. It also facilitates good clinical decision-making, protects the legal rights of consumers to be informed and involved in decision-making, and assists when supported decision-making is required.

Processes to support clinicians to communicate effectively with patients and their carers about all aspects of their care involve obtaining informed consent, and determining a patient's treatment preferences and goals of care. Use the strategies below to adapt current processes or adopt new processes for supporting communication between clinicians and consumers.

Set up an environment that supports open, clear and effective communication between clinicians and consumers

This may involve[77,80]:

- Engaging leadership and governing bodies to integrate the importance of health literacy and clear communication into the organisation's operations, and align it with other organisational priorities, such as reducing health disparities
- Assigning responsibility to an individual or group for actions to improve the health literacy environment
- Auditing the health literacy environment (either in the annual audit program of the organisation or as a standalone audit)
- Providing clinicians with training that highlights the importance of health literacy
- Implementing a plain-language policy that makes written information easier to understand.

Refer to the Resources section at the end of this standard for links to useful tools for this action.

Provide access to appropriate consumer information resources and tools to support communications

Consumer information should be at a level that can be understood and used by diverse consumers. It may be appropriate to identify or develop both simpler and more complex information resources, so that clinicians have access to the most appropriate information for an individual patient.

Information resources and tools that clinicians can use to support their communications may include:

- Written information (for example, brochures, fact sheets, posters, online material); if developed locally, consumers should be involved in developing these resources (Action 2.9)
- Visual diagrams and decision aids (for example, the Commission's patient decision aids)
- Cue cards or symbols to support communication with people who do not understand English (for example, Eastern Health's Cue Cards in community languages[84]).

Health service organisations are responsible for ensuring that the information provided to patients is current.

Educate consumers about their important role in supporting effective communication

Develop information resources about communication processes and provide these to patients receiving or preparing to receive care. Resources may include brochures, fact sheets, newsletters, posters, online resources and information broadcast on internal media communication channels in the service.

Include information about:

- The important role that patients and carers play in providing information to the healthcare team
- When agreed communication processes occur (times, locations)
- Which clinicians take part in these processes
- Alternative methods for communicating concerns to the healthcare team
- Ways of providing feedback on these communication processes.

Involve patients and carers in developing information and resources about communication processes (Action 2.9).

Monitor and assess communication

Strategies may include:

- Auditing healthcare records to assess the information provided to patients and carers
- Providing a mechanism for patients to give feedback about the communication and information they receive during an episode of care
- Seeking feedback on communication and information resources from consumers who use the services (for example, including questions about medicines information in patient experience surveys).

CRITERION: Partnering with consumers in organisational design and governance

> *Consumers are partners in the design and governance of the organisation.*

The role of consumer representatives within the Australian healthcare system has evolved significantly during the past two decades.[39] Partnering with consumers and the community is viewed as a basic element in discussions and decisions about the design, implementation and evaluation of health policies, programs and services.[40,89]

Since 2010, an increase in the volume and diversity of research conducted on consumer input into decision-making has strengthened the evidence base for the benefits of partnering with consumers in health service design and governance.[39]

A 2015 literature review conducted by the Consumers Health Forum of Australia concluded that there is a substantial body of research supporting the involvement of consumers in health decision-making, and consumer engagement can add value to the healthcare system by improving quality of care, efficiency of resource use, and community support for programs or services.[39]

Specific methods of partnership range from informal, one-off events or feedback through social media, through to formal and ongoing participation on boards and committees. Consumers can be engaged as individuals, or in small or large groups.[40]

Evidence on the benefits and sustainability of specific partnership approaches is lacking. When selecting methods to use locally, consider the diversity of the local community, and the organisation's design and governance needs. The use of mixed methods is common and supports the concept that not all consumers will engage with health services in the same way.[40]

In Australia, the concept of consumer partnership and the principles of person-centred care have gained broad support.[44] However, capacity, skill and resource limitations can challenge consumer partnerships in practice. Several well-established methodologies and resources can support health services to partner with consumers for design, governance and overall improvement activities.

Partnerships in healthcare governance planning, design, measurement and evaluation

Action 2.11

The health service organisation:

a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care

b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community

Intent

Consumers help shape the way the health service organisation operates to achieve mutually beneficial outcomes, and these consumers are reflective of the diversity of the people who use its services or, if relevant, the local community.

Key tasks

- Identify the diversity of consumers who use the services and who are part of the local community
- Implement a framework and systematic processes for partnering with consumers in the design, measurement and evaluation of healthcare services delivered by the organisation
- Implement a policy to ensure that the consumers involved in these partnerships represent the diversity of consumers who use the organisation's services.

Strategies for improvement

Consumers can make effective and meaningful contributions to health service planning and development through their involvement in organisational governance and decision-making.[41] To enable these contributions, integrate partnering with consumers into the governance systems of the organisation.

Review the diversity of consumers who use the organisation's services and make up the local community

Consumer partnership and engagement activities should truly reflect the diversity of consumers who use, or may use, the organisation's services. Gathering information about the type of consumers who use the organisation's services and comprise the local community can help identify specific consumer groups who should be involved in partnerships with the organisation.

Strategies may include[60,66,90]:

- Undertaking a community profiling project, which involves gathering information about the diversity within the community; its history, social and economic characteristics; the groups and networks within the community; and the social and infrastructure services that exist
- Administering surveys to identify diversity among current patients and carers
- Using demographic data from the Australian Bureau of Statistics, or local, state and territory government sources to understand the background of the organisation's consumers
- Networking with other organisations or individuals in the community such as culturally and linguistically diverse community groups, community participation managers, Primary Health Networks, Local Hospital Networks, local and state government organisations, and professional associations to share knowledge about community needs.

Review the current level of consumer partnerships

Identify the organisation's current levels of engagement with consumers. Assess consumer partnership and involvement in the organisation's:

- Governance
- Strategic and operational planning
- Health service design, redesign and evaluation
- Review of safety and quality performance.

Strategies may include:

- Conducting a self-assessment of the organisation's engagement with consumers
- Making a list of current committees or groups involved in strategic planning, health service design, and organisational safety and quality performance, and identifying the level of consumer involvement in these groups; interview consumers who currently take part in these committees or groups and find out whether they feel their voice is being heard
- Talking to the workforce involved in strategic planning, health service design, and reviewing organisational safety and quality performance information to find out how they work with consumers
- Reviewing policies or processes to identify whether there is currently a need for consumer involvement in the design, measurement and evaluation of healthcare services.

If consumer partnerships are already embedded within design, measurement and evaluation activities, use tools such as the Partnership Self-Assessment Tool[91] or the Patient Based Care Challenge[92] to assess the extent and effectiveness of those partnerships. Map the existing arrangements against the strategies suggested below to identify other systems or ideas.

If the organisation does not currently partner with consumers in its design, measurement and evaluation activities, establish a framework and associated processes to actively involve consumers.

Support consumer partnerships in governance and strategic leadership

Strategies to support, promote and improve consumer partnerships in governance and strategic leadership may include:

- Engaging organisational leaders to act as champions for consumer partnerships
- Creating meaningful positions for consumers on formal governance committees, such as boards, advisory groups and community councils[41,48,93]
- Creating consumer-only advisory groups that provide direct input to leadership and management structures[94]
- Developing a formal and consistent method for recruiting consumers to be involved in committees[95]
- Implementing a structured support program for consumers involved in governance and strategic leadership roles, which includes orientation and training for consumers to ensure that they feel equipped to provide valuable and meaningful input into discussions and decision-making[41]
- Employing a facilitator or coordinator to engage with, support, and build the confidence of, current and potential consumer partners[41,96]
- Providing a mentoring service between experienced and new consumer partners[41] – for example, the Consumer Buddy Program at the Walter and Eliza Hall Institute of Medical Research encourages long-term and meaningful engagement of consumers in medical research processes
- Educating the workforce to improve their understanding of the many potential roles for consumer partners in governance and strategic leadership[41]
- Creating a leadership position with responsibility for improving the organisation's commitment to consumer partnership – for example, the 'chief experience officer' at the Cleveland Clinic reports directly to the chief executive officer, and provides overall leadership for consumer partnerships within the organisation[97]
- Providing reimbursement and/or remuneration to consumers who take part in governance and leadership activities to ensure that consumer partners are not out of pocket, and to reflect the value and importance of their input.[41,98]

Support consumer partnerships in safety and quality activities

Strategies to support, promote and improve consumer partnerships in safety and quality activities may include:

- Providing multiple opportunities for consumers to provide feedback on the safety and quality of services; this may include surveys, suggestion boxes and opportunities for formal or informal consultation at multiple times throughout a patient's care[41]
- Engaging consumers in analysing organisational safety and quality performance[41,98]
- Engaging consumers in evaluating patient feedback data[41,98]
- Involving consumers in planning and implementing safety and quality improvement activities[41,98]
- Shaping the attitudes of the workforce so that there is greater acknowledgement, acceptance and understanding of the value of consumer feedback; consumers can provide a unique insight into safety and quality risks, which issues should have priority, and which solutions are acceptable[41]
- Regularly informing consumers and the wider community of adverse events or problems relating to care, and the corrective action that has been implemented[98]
- Involving consumers in developing consumer information about clinical safety issues, such as potential risks and side effects of care.[98]

Support consumer partnerships in performance and skills management

Strategies to support, promote and improve consumer partnerships in performance and skills management may include:

- Engaging consumers in workforce recruitment, potentially by including consumers on workforce selection panels[41]

- Involving consumers in workforce training about consumer participation (see Action 2.6).

Review existing policies and processes for engaging with consumers

Ensure that policies and processes include engaging with a diverse range of consumers who best represent the organisation's service users and local community. This includes 'hard-to-reach' consumer groups, such as Aboriginal and Torres Strait Islander people, or culturally and linguistically diverse communities. Talk to the workforce about how they involve these groups.

Connect with diverse and hard-to-reach consumers

If the organisation does not actively engage with diverse groups of consumers, develop or adapt a policy to engage with these consumers. Several strategies may be needed because different people will respond to different engagement methods.

Strategies for partnering with diverse and hard-to-reach consumers include:

- Engaging with community leaders, groups or liaison officers to determine the most appropriate engagement strategies for particular groups within the community; this will help identify any barriers to participation before approaching them
- Inviting representatives from these groups to join boards or be involved in consumer advisory groups.

More ideas for connecting with diverse and hard-to-reach consumers can be found in the *Health Care Providers' Guide to Engaging Multicultural Communities and Consumers*.[99]

Use consumer information respectfully

Ensure that, if feasible, the organisation acts on the information provided by consumers and feeds back information on changes that have occurred as a result of consumer advice.

Ensure that information provided by consumers or carers about their experiences is treated sensitively, that privacy and confidentiality are maintained, and that consumers and carers are supported to share their experiences and stories to the extent that they are comfortable.

Resources to help consider the consumer role include:

- Victorian Quality Council *Enabling the Consumer Role in Clinical Governance: A guide for health services*[100]
- Cancer Australia Consumer Involvement Toolkit.[101]

Action 2.12

The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation

Intent

Consumers partnering in organisational design and governance have the skills and knowledge they need to be able to contribute effectively.

Key task

- Develop (or adapt), and provide access to, orientation training and resources for consumers who take part in governance processes, or contribute to design, measurement or evaluation activities.

Strategies for improvement

Provide training and support for consumers involved in the organisation's governance process, and those who take part in design, measurement or evaluation activities. This gives these consumers the best opportunity to contribute meaningfully and effectively to the organisation. Training can be provided face to face, through take-home resources or through online portals, and may include[98]:

- Orientation to the health service organisation

- Orientation to health service decision-making processes for consumers
- Meeting procedures
- Communication skills.

Review existing processes for orienting consumers who have taken on a partnership role in organisational design and governance

This may involve identifying and reviewing the relevance, accessibility and applicability of induction processes and materials for consumers involved in organisational design and governance, including:

- Written information and resources on relevant subjects, required skills, roles and responsibilities
- Training and education
- Ongoing support.

Develop and facilitate access to orientation, training and resources

Develop and/or facilitate access to comprehensive orientation, training and resources for consumers partnering with the organisation.

Strategies may include:

- Facilitating access to external training programs for consumers who are partnering with the organisation, such as consumer representative training (see the Resources section at the end of this standard for state-based consumer organisations that may provide training, or see Australia's only accredited consumer representative training course, developed by the Health Issues Centre)[102]
- Adapting an existing consumer training program to the organisation's requirements, such as the *Guidelines for Consumer Representatives*[103] and *Getting the Healthcare You Need: An advocacy toolkit for people using the healthcare system in Queensland*[104]
- Adapting orientation resources for consumers and carer representatives, such as the *Guidelines for Consumer Representatives*[103], *Getting the Healthcare You Need: An advocacy toolkit for people using the healthcare system in Queensland*[104] and the consumer representatives checklist.[105]

Determine which consumers will gain the most benefit from participating in orientation and training. Training may be more applicable for consumers who are involved in formal partnerships with the organisation, such as members of boards or committees. It may not be feasible or appropriate to provide training for consumers who are involved in more informal partnerships, such as waiting room discussions or consultation processes.

Consider the needs of consumers involved in informal partnerships and ensure that they:

- Are aware that the information they provide is separate to the process of providing or receiving care, and will not affect their treatment
- Understand the process in which they are participating and how the information they provide will be used
- Have an opportunity to provide further comment later if they wish
- Have an opportunity to raise concerns about the process if they wish.

When looking for ways to support and train consumers and carers, look at similar organisations, speak to state-based consumer healthcare organisations, and think about how existing orientation training and resources could be adapted for consumers and carers.

Action 2.13

The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs

Intent

Aboriginal and Torres Strait Islander people receive health care that meets their needs.

Key tasks

- Implement (or adapt) a framework for partnering with local Aboriginal and Torres Strait Islander communities
- Adapt existing consumer resources or programs to be culturally appropriate for local Aboriginal and Torres Strait Islander communities
- Create a culturally safe environment for Aboriginal and Torres Strait Islander consumers who use the health service organisation.

Strategies for improvement

Review the current level of partnership with Aboriginal and Torres Strait Islander communities

This may involve reviewing:

- Policies or processes that aid access to culturally appropriate and safe health care for Aboriginal and Torres Strait Islander people in the community
- The involvement of Aboriginal and Torres Strait Islander people on boards or advisory committees involved in the design and evaluation of health care
- The presence of Aboriginal health workers or community liaison officers in the workforce
- Whether information for consumers is culturally appropriate, including the organisation's charter of rights and patient information brochures
- Linkages with local Aboriginal and Torres Strait Islander communities and consumer organisations.

Develop an approach to partnering with Aboriginal and Torres Strait Islander communities

If the organisation has an embedded approach for partnering with Aboriginal and Torres Strait Islander communities, review the framework and processes against the strategies recommended below to determine whether any changes are needed.

If the organisation does not have an embedded approach for partnering with Aboriginal and Torres Strait Islander communities, develop a framework and associated processes to ensure that Aboriginal and Torres Strait Islander people who use services receive health care that meets their needs.

Strategies for partnering with Aboriginal and Torres Strait Islander communities may include:

- Speaking with elders and other community leaders to understand the cultural considerations and healthcare needs of the local Aboriginal and Torres Strait Islander community; engaging and building long-term relationships with well-respected senior members of a community can increase service acceptance[106]
- Engaging with the broader community, rather than focusing on individual consumer engagement approaches; use engagement strategies that fit with Aboriginal and Torres Strait Islander community life, including informal gatherings such as yarning circles, bingo or sharing a meal[107]
- Employing Aboriginal and Torres Strait Islander people in positions such as Aboriginal health workers, liaison officers, family support workers, or education and training officers who can help engagement with local Aboriginal and Torres Strait Islander communities; if the organisation lacks the capacity to employ such positions, engage directly with members of the local Aboriginal and Torres Strait Islander communities to act as champions in support of building partnerships with the organisation[107,108]

- Developing specific policies or procedures to ensure Aboriginal and Torres Strait Islander representation in governance and planning activities
- Hosting culturally safe advisory groups or committees[106]
- Partnering with local Aboriginal and Torres Strait Islander organisations and agencies.

Adapt existing consumer programs and resources for Aboriginal and Torres Strait Islander people

English is not the first language of many Aboriginal and Torres Strait Islander people. These consumers may also face difficulties in understanding information provided by the organisation because of poor general and individual health literacy.

Strategies to adapt programs and resources include:

- Engaging with members of Aboriginal and Torres Strait Islander communities to review consumer programs and resources, and provide guidance on ways to adapt the material to be culturally safe and appropriate
- Reducing the amount of content in information brochures and resources, and supplementing this with culturally specific graphics or audiovisual aids to support understanding.

Create a culturally safe environment for Aboriginal and Torres Strait Islander people who use the organisation's services

Bringing together the cultures of a health service organisation and the local Aboriginal and Torres Strait Islander communities can improve access to health care for Aboriginal and Torres Strait Islander people.[109] Strategies for this may include:

- Providing cultural competency training so that all members of the workforce understand the historical and contemporary factors that may affect the willingness of Aboriginal and Torres Strait Islander people to partner with the organisation[107]; this is an important first step in understanding the cultural considerations of the local Aboriginal and Torres Strait Islander communities[106]
- Incorporating cultural symbols into the service setting, such as[110]:
  - flying the Aboriginal flag and the Torres Strait Islander flag in a prominent location
  - respectfully displaying cultural artwork or artefacts
  - mounting a plaque that recognises the traditional owners of the land on which the organisation is located
- Participating in and acknowledging major cultural events, such as National Aborigines and Islanders Day Observance Committee (NAIDOC) week or Reconciliation Day
- Allocating a space that can be used for the spiritual and cultural needs of Aboriginal and Torres Strait Islander patients, their families and communities.

Develop respectful relationships

In some Aboriginal and Torres Strait Islander communities, the cultural concept of health may be different from the biomedical model adopted by the organisation. Be aware of this when seeking consumer feedback and input into health service design.

Engaging with Aboriginal and Torres Strait Islander communities means developing a relationship built on trust and integrity. Allow enough time and resources to form this relationship.

Further strategies are available in *NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health*.

Action 2.14

The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce

Intent

The workforce has an understanding of health care from the consumer's perspective, and the value that consumers can bring to organisational design and governance.

Key tasks

- Implement a policy that involves consumers in the design and delivery of workforce training
- Consult regularly with consumers to seek their views and input for the development and delivery of workforce training.

Strategies for improvement

Develop or adapt policies or processes on workforce training to include consumer involvement

Consider the current processes for training and identify whether they can be used or modified to address this action. Strategies to involve consumers in the development of training could include[13,60,90]:

- Involving consumers in committees or advisory groups tasked with developing or reviewing training materials and resources
- Informally talking with consumers and carers in waiting areas about what they would include in person-centred care and partnership training for the clinical workforce
- Convening focus groups or workshops to seek consumers' advice on critical information, resources and strategies for training the clinical workforce in person-centred care and partnerships
- Approaching community groups or local consumer organisations to provide feedback and input into the development of training materials and resources
- Inviting consumers and carers to attend and review training sessions to ensure that the training reflects their needs and perspectives.

Involve consumers in the delivery of training on person-centred care, partnerships and consumer perspectives

Patient stories can provide a unique perspective of the consumer experience of the health service organisation. More so than other forms of research, patient stories can give a whole-of-system overview, highlighting what matters most to service users.[111]

Strategies to use patient stories may include:

- Inviting consumers or carers to present on their experiences
- Using video or audio recordings of personal stories from consumers or carers
- Undertaking exercises in which members of the workforce 'live in the patient's shoes' to gain an understanding of the experience of consumers (see *Patient-Centered Care Improvement Guide*).[71]

Manage consumer information

When involving consumers in the planning, delivery or review of workforce training, document the strategies used and the information collected from consumers in reports, diary entries, meeting agendas or minutes, or other equivalent records.

If consumer or carer stories are used in training, ensure that this information is treated sensitively, that privacy and confidentiality are maintained, and that consumers or carers are supported to share their experiences and stories to the extent that they are comfortable.

Information on collecting patient stories can be found in the Resources section at the end of this standard.

Resources

Partnerships at the individual and health service level

Agency for Healthcare Research and Quality – *Guide for Developing a Community-Based Patient Safety Advisory Council*

Cancer Australia – Consumer Involvement Toolkit

Health Consumers Queensland – *Consumer Representatives Program: Agency handbook*

Health Issues Centre – Getting Started toolkit

Institute for Patient- and Family-Centered Care – *Advancing the Practice of Patient- and Family-Centered Care in Hospitals: How to get started...*

NSW Agency for Clinical Innovation – Making change: designing change projects

NSW Clinical Excellence Commission – Partnering with patients

Planetree – *Patient-Centered Care Improvement Guide*

Point of Care Foundation – Experience-Based Co-Design toolkit

Point of Care Foundation – Patient and Family-Centred Care toolkit

SA Health – *Guide for Engaging with Consumers and the Community*

Scottish Health Council – *The Participation Toolkit*

Victorian Quality Council – *Enabling the Consumer Role in Clinical Governance: A guide for health services*

Waitemata District Health Board – Health Service Co-Design toolkit

Collecting patient stories

Cancer Australia – *Storytelling for Health Services*

Healthwatch Cambridgeshire – *Guidance for Collecting & Using People's Stories*

National Health Service Education for Scotland – *Making the Most of Patient Safety Stories*

NSW Agency for Clinical Innovation – Collect patient and carer stories

WA Health – *Patient Stories: A toolkit for collecting and using patient stories for service improvement in WA Health*

Health literacy

Agency for Healthcare Research and Quality – Health Literacy Universal Precautions Toolkit

Australian Commission on Safety and Quality in Health Care – Health literacy

Centers for Disease Control and Prevention – online health literacy training for health professionals

Centers for Disease Control and Prevention – *Simply Put: A guide for creating easy-to-understand materials*

Centre for Culture, Ethnicity and Health – Supportive systems for health literacy

Health Consumers Queensland – *Consumer Representatives Program: Agency handbook*

Health Literacy Consulting – Can they understand? Testing patient education materials with intended readers

National Health Service – DISCERN instrument

NSW Clinical Excellence Commission – *Health Literacy Guide*

PlainLanguage.gov

Communicating with patients

Eastern Health – Cue Cards in community languages

NPS MedicineWise – decision tools and resources

SA Health – *Guide for Engaging with Consumers and the Community*, Tool 3 – Tips for communicating clearly

Shared decision making

Agency for Healthcare Research and Quality – The SHARE approach

National Health Service – Shared decision making

NHS Institute for Innovation and Improvement – case studies

The Health Foundation – MAGIC: Shared decision making

Connecting with diverse and hard-to-reach consumers

Queensland Health – *Health Care Providers' Guide to Engaging Multicultural Communities and Consumers*

Partnerships with Aboriginal and Torres Strait Islander communities

Australian Human Rights Commission – *Aboriginal and Torres Strait Islander Peoples Engagement Toolkit*

Australian Indigenous Governance Institute – Indigenous Governance Toolkit

Oxfam Australia – *Aboriginal and Torres Strait Islander Cultural Protocols*

Queensland Government – *Protocols for Consultation and Negotiation with Torres Strait Islander People*

Reconciliation Australia – Respectful relationships

Assessment tools for established partnerships

National Collaborating Centre for Methods and Tools – *Partnership Self-Assessment Tool*

NSW Clinical Excellence Commission – Patient Based Care Challenge

Australian health consumer organisations and networks

Consumers Health Forum of Australia

Health Care Consumers' Association (ACT)

Health Consumers Alliance of SA Inc

Health Consumers' Council (WA) Inc.

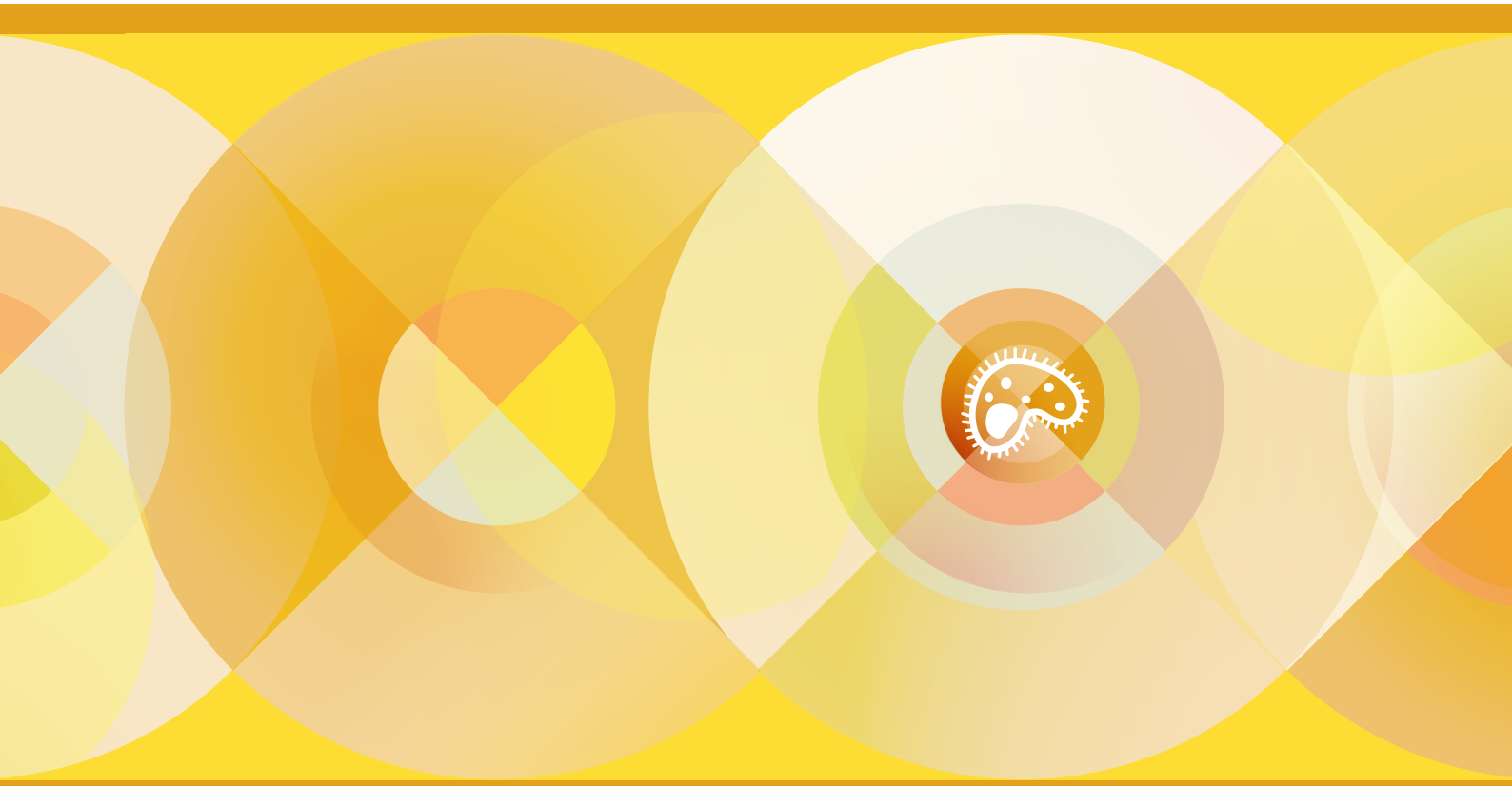
Health Consumers NSW

Health Consumers Queensland

Health Issues Centre (Vic)

3

Preventing and Controlling Healthcare-Associated Infection Standard



Preventing and Controlling Healthcare-Associated Infection Standard

Leaders of a health service organisation describe, implement and monitor systems to prevent, manage or control healthcare-associated infections and antimicrobial resistance, to reduce harm and achieve good health outcomes for patients. The workforce uses these systems.

Intention of this standard

To reduce the risk of patients acquiring preventable healthcare-associated infections, effectively manage infections if they occur, and limit the development of antimicrobial resistance through prudent use of antimicrobials as part of antimicrobial stewardship.

Criteria

Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

Infection prevention and control systems

Reprocessing of reusable medical devices

Antimicrobial stewardship

Introduction

Many healthcare-associated infections are thought to be preventable. Australian and overseas studies have demonstrated mechanisms to reduce the rate of infections associated with health care. Infection prevention and control practice aims to minimise the risk of transmission by identifying and isolating patients harbouring infectious agents and resistant organisms. However, just as there is no single cause of infection, there is no single solution to preventing infections. Successful infection prevention and control practice requires a variety of strategies across the healthcare system.

The Preventing and Controlling Healthcare-Associated Infection Standard has been developed in line with the recommendations and evidence in the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*.[112] This standard aims to prevent patients from acquiring preventable healthcare-associated infections, and to effectively manage these infections when they occur by using evidence-based strategies. It should be applied in conjunction with the other NSQHS Standards, particularly the Clinical Governance Standard, the Partnering with Consumers Standard and the Medication Safety Standard.

Although infection prevention and control programs have essential elements that must be considered, it is expected that programs will be tailored to reflect the local context and risk. Key tasks will be tailored to reflect the complexity of services offered and the risks associated with delivery of services in the organisation. Regardless of the size or type of the health service organisation, successful implementation of this standard depends on clinicians and executive leaders working together within a strong governance framework.

CRITERION: Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

> *Systems are in place to support and promote prevention and control of healthcare-associated infections, and improve antimicrobial stewardship.*

Antimicrobial stewardship is the ongoing effort by a health service organisation to optimise antimicrobial use to improve patient outcomes, ensure cost-effective therapy and reduce adverse impact of antimicrobial use, including antimicrobial resistance.[113]

This criterion requires organisation-wide governance, leadership and commitment to prevent and control healthcare-associated infections, and support antimicrobial stewardship.

To meet this criterion, health service organisations are required to:

- Apply safety and quality systems to prevent and control healthcare-associated infections, and support antimicrobial stewardship
- Use quality improvement systems to monitor, review and improve the systems to prevent and control healthcare-associated infections, and to support antimicrobial stewardship
- Apply principles of partnering with consumers when designing and implementing systems to prevent and control healthcare-associated infections, and support antimicrobial stewardship.

This criterion aligns with the Clinical Governance Standard and the Partnering with Consumers Standard.

Infection risk varies in each health service organisation, so there is no single risk management approach. However, the basic principles of risk management apply across all settings.

The principles of clinical governance apply regardless of the setting, but the management structure associated with infection control will differ with the size of the organisation, its context and the complexity of services delivered.

The governance framework and risk management principles for preventing and controlling healthcare-associated infections are outlined in the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*.[112]

Action 3.1

The workforce uses the safety and quality systems from the Clinical Governance Standard when:

a. Implementing policies and procedures for healthcare-associated infections and antimicrobial stewardship

b. Managing risks associated with healthcare-associated infections and antimicrobial stewardship

c. Identifying training requirements for preventing and controlling healthcare-associated infections, and antimicrobial stewardship

Intent

Safety and quality systems support clinicians in preventing and controlling healthcare-associated infections, and antimicrobial stewardship.

Key tasks

- Set up and implement governance structures for healthcare-associated infections and antimicrobial stewardship
- Develop and implement policies and procedures for healthcare-associated infections and antimicrobial stewardship
- Use organisation-wide risk management systems to identify, monitor, manage and review risks associated with healthcare-associated infections and antimicrobial stewardship
- Deliver or provide access to training on healthcare-associated infections and antimicrobial stewardship based on the specific needs of the clinical workforce.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' safety and quality systems.

Action 1.7 – policies and procedures

Action 1.10– risk management systems

Action 1.19, 1.20 and 1.21 – education and training

Health service organisations should:

- Use these and other established safety and quality systems to support policies and procedures, risk management and training for healthcare-associated infections and antimicrobial stewardship
- Ensure that current versions of all relevant policies and procedures are readily available and accessible to clinicians.

Policies may be developed or adapted at different levels within the organisation. However, all policy documents should be incorporated into a single, coherent set to maximise the effectiveness of the policy development process.

Implement policies and procedures

Ensure that current, readily available and accessible organisational policies and procedures are in place that cover priority areas for infection prevention and control, and antimicrobial stewardship, in the organisation, including:

- Standard and transmission-based precautions
- Environmental cleaning and disinfection
- Reprocessing of reusable medical devices
- Single-use items
- Insertion and maintenance of invasive devices
- Outbreaks or unusual clusters of infection or communicable disease
- Reporting requirements for communicable and notifiable diseases
- Antimicrobial prescribing and use
- Safe work practices for
  - use, handling and disposal of sharps
  - waste and linen management
  - workforce immunisation
  - exposure-prone procedures
  - prevention and management of occupational exposures to blood and body substances
- Product management and evaluation of new and existing products, equipment and devices
- Preventive maintenance, including repairs, refurbishment and upgrade of infrastructure, including buildings, equipment, fixtures and fittings.

Manage risks

Use established risk management systems (see Action 1.10) to identify, monitor, manage and review risks associated with preventing and controlling healthcare-associated infections. Develop processes to manage clinical risks for different populations served within the organisation, clinical and workplace risks for the workforce, and organisational risks.

Use information from measurement and quality improvement systems, adverse events, clinical outcomes and patient experiences to inform and update risk assessments and the risk management system. Consider the training the workforce may need to effectively use incident management and investigation systems to inform risk management, and to plan and implement quality improvement processes to mitigate these risks.

Health service organisations should manage the risk of infection and have local risk management strategies in place, regardless of where the governance for the organisation is located.

Identify training requirements

Assess the competency and training needs of the workforce in line with the requirements of Actions 1.19–1.21. Perform a risk assessment to inform the training schedule and set priorities for the members of the workforce who require training. Develop, or provide access to, training and education resources to meet the needs of the workforce regarding infection prevention and control activities, reprocessing of reusable medical devices, and antimicrobial prescribing and use.

Identify the processes used in the health service organisation to manage training requirements for infection prevention and control activities, reprocessing of reusable medical devices, and antimicrobial prescribing and use.

If appropriate, use a competency-based assessment process that is aligned with the organisation's policies, procedures and protocols for hand hygiene, aseptic technique, invasive device insertion and maintenance, putting on and removal of personal protective equipment, reprocessing of reusable medical devices, and environmental cleaning.

Competency-based assessment is the assessment of actual skills and knowledge that a person can demonstrate in the workplace. A workplace assessor reviews the evidence and verifies the person's competence in performing the assessed task.

Review the organisation's induction, and ongoing education and training programs to ensure that they include relevant information, tools and instructions on infection prevention and control policies and procedures for new and existing employees and contractors.

Develop, review or introduce an appraisal process for the workforce that incorporates:

- Awareness and understanding of relevant policies, procedures and protocols relating to infection risks in the workplace
- Use of infection prevention and control policies, procedures and protocols

- Education, training or competency assessment for relevant risk management processes, and incident management and investigation systems for infection prevention.

Related actions

In addition to these strategies, Actions 3.15 and 3.16 include specific strategies for the implementation, monitoring and evaluation of the organisation's antimicrobial stewardship program.

Applying quality improvement systems

Action 3.2

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:

a. Monitoring the performance of systems for prevention and control of healthcare-associated infections, and the effectiveness of the antimicrobial stewardship program

b. Implementing strategies to improve outcomes and associated processes of systems for prevention and control of healthcare-associated infections, and antimicrobial stewardship

c. Reporting on the outcomes of prevention and control of healthcare-associated infections, and the antimicrobial stewardship program

Intent

Quality improvement systems are used to support the prevention and control of healthcare-associated infections, and improvements in the antimicrobial stewardship program.

Key tasks

- Review, measure, and assess the effectiveness and performance of, organisational and clinical strategies for the prevention and control of healthcare-associated infections, and antimicrobial stewardship
- Implement quality improvement strategies for healthcare-associated infections and antimicrobial stewardship based on the outcomes of monitoring activities
- Provide information on the outcomes of quality improvement activities to the governing body, the workforce, consumers and other organisations.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' quality improvement systems.

- Action 1.8 – quality improvement systems
- Action 1.9 – reporting
- Action 1.11 – incident management and investigation systems

Health service organisations should use these and other established safety and quality systems to support monitoring, reporting and implementation of quality improvement strategies for healthcare-associated infections and antimicrobial stewardship.

Monitor effectiveness and performance

Use the organisation's quality improvement systems to identify, and set priorities for, organisational and clinical strategies to prevent healthcare-associated infections and manage the risks.

Review these systems to ensure that they include requirements for:

- Using the organisation's incident management and investigation system to identify and improve safety and quality activities
- Measuring performance and identifying opportunities for improvement
- Reporting outcomes to the organisation's leadership, workforce, consumers and (if appropriate) other health service organisations
- Engaging with consumers to review the performance of safety and quality activities
- Communicating the outcomes of quality improvement activities in newsletters and publications
- Maintaining and improving the effectiveness of the antimicrobial stewardship program.

Identify the key elements of an antimicrobial stewardship program that will both show performance and inform prescribing practice and use of antimicrobials in the organisation.

Identify how the organisation will evaluate compliance with policies, procedures and protocols relating to infection prevention and control, and antimicrobial stewardship (including hand hygiene, aseptic technique, invasive device insertion and maintenance, infection surveillance, environmental cleaning, workforce immunisation, standard and transmission-based precautions, reprocessing of reusable medical devices, and antimicrobial prescribing and use).

Review the results of annual evaluation of the organisation's quality improvement program for infection prevention and control, to acknowledge successes and identify opportunities for improvement.

Implement quality improvement strategies

Use the results of monitoring activities to show improvements or areas where improvement is required. Where appropriate, use quality improvement activities that are consistent and measurable across the corporate group, network or health service.

Use the results of the organisational risk assessment to identify gaps, plan, and set priorities for areas for investigation or action.

Identify where the organisation is performing well, including where infection risks have been minimised or eliminated.

Report outcomes

Report evaluation findings to the governing body and the workforce. Use the data to work with consumers, the workforce, clinical leaders and managers to identify and implement improvements.

Related actions

In addition to these strategies:

- Action 3.4 outlines surveillance strategies to support infection prevention and control activities, and the antimicrobial stewardship program; these strategies can be used to identify gaps and set priorities for actions to minimise risk in the prevention and control of healthcare-associated infections, and antimicrobial stewardship
- Action 3.16 includes specific strategies for ongoing monitoring, evaluation and improvement activities for the organisation's antimicrobial stewardship program.

Action 3.3

Clinicians use organisational processes from the Partnering with Consumers Standard when preventing and managing healthcare-associated infections, and implementing the antimicrobial stewardship program to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Intent

Clinicians partner with patients to prevent and manage healthcare-associated infections and implement an antimicrobial stewardship program.

Key tasks

- Review strategies in the Partnering with Consumers Standard to inform the implementation of actions in the Preventing and Controlling Healthcare-Associated Infection Standard
- Provide information to patients about healthcare-associated infections and antimicrobial stewardship tailored to their specific needs and level of health literacy.

Strategies for improvement

The Partnering with Consumers Standard has specific actions (Action 2.3–2.10) related to health service organisations' processes for involving patients in their own care, shared decision making, informed consent and effective communication.

Identify opportunities to improve the way that clinicians engage with patients in shared decision-making activities to reduce or manage the risk of healthcare-associated infections.

Review or develop resources to inform patients about infection prevention and control. Ensure that patients understand their own responsibilities in preventing and controlling healthcare-associated infections.

Ensure that patients and carers have enough information about treatment options to make informed choices about their medicines and adhere to treatment plans for antimicrobials. Action 4.11 includes specific strategies for providing information to patients on their individual medicines needs and risks.

Provide information in a format that is meaningful, easy to understand and use, and tailored to the diversity of the organisation's patient population. Consider the languages used in the local community when selecting and developing healthcare-associated infection resources for patients.

Surveillance

Action 3.4

The health service organisation has a surveillance strategy for healthcare-associated infections and antimicrobial use that:

a. Collects data on healthcare-associated infections and antimicrobial use relevant to the size and scope of the organisation

b. Monitors, assesses and uses surveillance data to reduce the risks associated with healthcare-associated infections and support appropriate antimicrobial prescribing

c. Reports surveillance data on healthcare-associated infections and antimicrobial use to the workforce, the governing body, consumers and other relevant groups

Intent

Surveillance activities provide data to support patient safety and governance decisions in preventing healthcare-associated infections, and antimicrobial stewardship.

Key tasks

- Use information from the organisational risk management system to decide appropriate surveillance activities for the size and scope of the organisation
- Review existing surveillance processes to identify any gaps, changes or variation in data
- Ensure that existing processes and supporting policies include reporting of infection and resistance data to the relevant workforce, the governing body, consumers and other relevant groups
- Ensure that surveillance activities use nationally agreed definitions (if available) and meet state or territory requirements
- Ensure that the workforce performing surveillance activities is adequately trained
- Develop new surveillance activities if there is a change in the services provided.

Strategies for improvement

Identify the types of surveillance activities to be used

Surveillance strategies should support infection prevention and control activities, and be used to identify gaps and set priorities for action to minimise the risk of preventable healthcare-associated infections. Surveillance activities are determined by the complexity of the health service organisation, the services it provides, and national and state or territory requirements. Surveillance activities may include continuous surveillance; targeted, process or signal surveillance; or unit-based activities based on local, national, and state or territory requirements.

Surveillance activities may be used to monitor:

- *Staphylococcus aureus* bacteraemia
- *Clostridium difficile* infection
- Central line-associated bloodstream infection
- Catheter-associated urinary tract infection
- Surgical site infection (for example, joint replacement, cardiac and maternity)
- Ventilator-associated complications
- Multidrug-resistant organisms of significance
- Compliance with outbreak management processes in the health service organisation
- Intravascular devices removed because of complications compared with those removed at the end of treatment

- Consistency of antimicrobial prescribing with evidence-based Australian therapeutic guidelines
- Post-discharge infection data from other health service organisations, clinicians or general practitioners.

The organisation may also take part in national surveillance activities relating to antimicrobial stewardship, such as the National Antimicrobial Prescribing Survey.

Review the organisation's services, and identify opportunities for monitoring infections and resistance of microorganisms based on risk, national and state or territory requirements, or changes in the services provided by the organisation.

Review validation and training requirements

Use nationally agreed surveillance definitions (if available) and validate data collected (if applicable). Undertaking surveillance activities and validating data require the workforce involved to be trained in these techniques.

Communicate results of surveillance

Use the results of surveillance activities to inform the risk management process, and to review or develop policies, procedures and protocols to reduce the risk of healthcare-associated infections.

Ensure that processes are in place to interpret surveillance results and provide results to the relevant workforce, the organisation's governing body (through the committee responsible for infection prevention and control), consumers and any other relevant groups.

Further resources on surveillance systems and infection surveillance definitions are available at the National Surveillance Initiative of the Australian Commission on Safety and Quality in Health Care (the Commission).

Related actions

In addition to these strategies, Action 3.16 includes specific strategies for the use of surveillance data on antimicrobial resistance and use to support appropriate prescribing.

CRITERION: Infection prevention and control systems

> *Evidence-based systems are used to prevent and control healthcare-associated infections. Patients presenting with, or with risk factors for, infection or colonisation with an organism of local, national or global significance are identified promptly, and receive the necessary management and treatment. The health service organisation is clean and hygienic.*

Infection control is a health and safety issue. All people working in the health service organisation are responsible for providing a safe environment for consumers and the workforce.

Infectious agents transmitted during provision of health care come primarily from human sources, including patients, clinicians and visitors. Successful infection prevention and control measures involve implementing work practices that prevent the transmission of infectious agents using a two-tiered approach: standard precautions and transmission-based precautions.

Standard precautions are basic infection prevention and control strategies that apply to everyone, regardless of their perceived or confirmed infectious status. Strategies include hand hygiene, personal protective equipment, cleaning, and appropriate handling and disposal of sharps. These are a first-line approach to infection prevention and control in health service organisations, and are routinely applied as an essential strategy for minimising the spread of infections. Standard precautions minimise the risk of transmission of infectious agents from one person or place to another, even in high-risk situations, and render and maintain objects and areas as free as possible from infectious agents.[112]

Transmission-based precautions are specific interventions to interrupt the mode of transmission of infectious agents. They are used to control infection risk with patients who are suspected or confirmed to be infected with agents transmitted by contact, droplet or airborne routes. Transmission-based precautions are recommended as extra work practices in situations when standard precautions alone may be insufficient to prevent transmission. Transmission-based precautions are also used during outbreaks to help contain the outbreak and prevent further infection. Transmission-based precautions should be tailored to the infectious agent involved and its mode of transmission – this may involve a combination of practices.

Hand hygiene is an essential infection prevention and control strategy. The current National Hand Hygiene Initiative states that hand hygiene must be performed according to the World Health Organization's My 5 Moments for Hand Hygiene approach to prevent patient colonisation and infection. Although the concept of hand hygiene is straightforward, improving hand hygiene practices involves changing attitudes and behaviour among clinicians.

Aseptic technique, use of invasive medical devices, workforce immunisation and environmental cleaning are included in this criterion because they are part of infection prevention and control systems. Health service organisation management is responsible for overseeing the systems and processes to maintain a clean, hygienic environment, including maintenance and upgrading of buildings and equipment; environmental cleaning of the buildings and infrastructure, new products or equipment; and linen handling and management.

For further information on implementing systems for standard and transmission-based precautions, refer to Section A1.2 in the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*.[112]

Action 3.5

The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[112], and jurisdictional requirements

Intent

The risk of infection to patients, the workforce and visitors is minimised by the routine application of basic infection prevention and control strategies.

Key tasks

- Use information from risk management systems to identify strategies to reduce the risks of healthcare-associated infections
- Review current policies, procedures and protocols to ensure that they align and comply with the *Australian Guidelines for the Prevention and Control of Infection in Healthcare* and state or territory requirements
- Provide access to the equipment, supplies and products required to comply with standard and transmission-based precautions
- Use the results of risk assessment processes to set priorities for assessment of workforce compliance with standard and transmission-based precautions
- Include the expectations of the workforce regarding infection prevention and control activities, including application of standard and transmission-based precautions, in the organisation's workforce orientation program.

Strategies for improvement

Ensure that the *Australian Guidelines for the Prevention and Control of Infection in Healthcare* and relevant state or territory requirements are available and accessible to the workforce when reviewing practice, policy and procedures.

Ensure that policies, procedures and protocols respond to areas in which there is the greatest risk of infection transmission. Work with individuals, services and committees to identify where risks have been identified, and where changes need to occur or improvements can be made to respond to risks.

Ensure that the equipment, supplies and products required by the workforce to work safely and minimise the risk of infection transmission are accessible, located where required and appropriate to the risks identified for that clinical area.

Based on information from the risk management systems, identify and set priorities for when, where and how compliance with standard and transmission-based precautions can be monitored, assessed and reviewed. Activities may include:

- Auditing hand hygiene
- Auditing putting on and removal of personal protective equipment
- Prioritising competency assessment for aseptic technique to members of the workforce who have been identified as high risk
- Assessing compliance with the requirements of transmission-based precautions when applied to a specific infection risk
- Reviewing surveillance data on healthcare-associated infections
- Reviewing incident reports relating to
  - infection prevention and control issues
  - intravascular devices
  - sharps and waste management
  - occupational exposures
  - biological spills and environmental cleaning.

Review or develop workforce education and orientation programs to include key aspects of standard and transmission-based precautions.

Evaluate attendance at, and content of, the orientation or induction programs for the workforce.

Develop or review signage, alert systems, and information/reminder systems and resources to raise awareness of standard and transmission-based precautions, and ensure consistency with the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*.

Have a management plan that can operate during localised outbreaks or periods when infections may be common (for example, seasonal influenza or local outbreaks of viral gastroenteritis) that:

- Identifies possible cases
- Implements other treatment options (for example, rescheduling procedures)
- Advises about exclusion periods for elective procedures
- Suggests management options for suspected or confirmed infections that may be transmissible
- Reduces impacts on treatment and recovery
- Addresses workforce occupational risk.

Action 3.6

Clinicians assess infection risks and use transmission-based precautions based on the risk of transmission of infectious agents, and consider:

a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated when clinically required during care

b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance

c. Accommodation needs to manage infection risks

d. The need to control the environment

e. Precautions required when the patient is moved within the facility or to external services

f. The need for additional environmental cleaning or disinfection

g. Equipment requirements

Intent

Exposure of other patients or the workforce to infectious agents that cannot be contained by standard precautions alone is minimised

Risk is assessed at all access opportunities to the health service organisation, and necessary precautions are implemented and maintained for as long as necessary.

Key tasks

- Use the results of the organisational risk assessment and gap analysis to identify priority areas for review, action or monitoring
- Review and use surveillance data to identify which communicable diseases, emerging risks, or infectious agents of local, national or international significance affect the health service organisation, patients and the workforce
- If available, use national systems and definitions to collect surveillance data on infectious agents

- Identify the systems that are already in place to manage the risk of transmission of these infectious agents
- Set up or review the processes for communicating risks and risk management strategies to clinical areas or units, services or facilities (internal and external) that may be involved in the care of the patient.

Strategies for improvement

Review and assess the organisation's processes that will inform risk management strategies to minimise exposure of patients, the workforce and the organisation to infectious agents. These include:

- How the risk of infection or communicable disease is assessed on admission, on referral or on presentation for care in the organisation
- What processes are in place to reassess the risks when clinically indicated during care
- How infection risks are acted on, if identified
- What processes are in place to inform the workforce or external services of a risk of an infectious agent or communicable disease
- How contracts and service performance of any external providers of goods and services are reviewed.

Information sources to help with this assessment may include:

- Data on waiting times for admission, movement through the emergency department and delays in patient placement because of a lack of appropriate accommodation, resources and equipment
- Pathology reports on infectious agents of local, national or international significance that require transmission-based precautions
- Surveillance data and reports from the organisation and other sources (for example, national, or state or territory surveillance reports) that have been gathered using national systems and definitions (if available)
- Incident reports relating to possible transmission of infectious agents
- Consumer feedback reports
- Maintenance or service history and pathology reports to identify appropriate monitoring of air-handling systems, water supply systems and other relevant equipment
- Data on cleaning and disinfection regimes.

Develop strategies to respond to any risks identified as part of the review, or any risks identified as part of a public health response or pandemic planning.

Include identified risks in the organisation's quality improvement program so that actions and outcomes are monitored, measured, assessed and reported to leadership, the workforce and consumers. If appropriate, report recommendations to external departments, facilities or services that may be involved in the care of the patient.

If the health service organisation is part of a larger organisation or corporate group, refer to their policies, procedures and protocols for managing and communicating risk of infectious agents of local, national and international significance.

The *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[112] provide detailed information about risk assessment processes for infection prevention and control.

Action 3.7

The health service organisation has processes for communicating relevant details of a patient's infectious status whenever responsibility for care is transferred between clinicians or health service organisations

Intent

A patient's known or suspected colonisation or infection risks are communicated to an admitting, transferring or referring facility to minimise exposure of patients, the workforce and visitors to infectious agents.

Key tasks

- Develop, review or implement a process to identify relevant pre-existing colonisation, infection or communicable diseases that will affect
  - patient placement while in the health service organisation
  - the risk to the workforce, other patients and consumers
  - transfer of care
- Review systems and processes used by managers and the workforce on admission, at entry points or when care is transitioning, including
  - pre-admission information
  - alerts, flags or risk identification processes
  - protocols for clinics, day surgery, emergency departments, community services and clinicians' rooms on how to assess patients for colonisation, infections or communicable diseases
  - processes for transporting patients within or outside the health service organisation.

Strategies for improvement

Review or develop processes to communicate relevant information relating to a patient's infection status whenever responsibility for care is transferred. This includes:

- Between members of the workforce
  - on admission
  - at every clinical handover
  - at any transition or transfer of care, including to other departments in the health service organisation (for example, radiology, operating theatre, rehabilitation)
  - during clinical review or consultation
  - during transport both within and outside the health service organisation
- To other relevant clinicians or care providers, including
  - general practitioners
  - community nurse services
  - allied health clinicians
  - carers and family on discharge
- To other heath service organisations, including rehabilitation and aged care services.

Develop or use relevant information systems and materials to inform clinicians about infection risks and the requirements to minimise the risks. Infection prevention and control risks should be included on:

- Requests for admission
- Referral documentation
- Transport requests
- Clinical handover reports
- Discharge or transfer summaries
- Notification, alert or flag systems for infection status, and precautions required for current and future care and treatment.

Develop or use resources to inform the workforce, patients and visitors of relevant infection risks, and infection prevention and control strategies to minimise risk to patients, visitors and the workforce.

Hand hygiene

Action 3.8

The health service organisation has a hand hygiene program that:

a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements

b. Addresses noncompliance or inconsistency with the current National Hand Hygiene Initiative

Intent

Implement and support a hand hygiene program that is consistent with the current National Hand Hygiene Initiative.

Key tasks

- Implement systems and processes to meet the National Hand Hygiene Initiative and state or territory requirements
- Measure and report program outcomes, including hand hygiene compliance, if appropriate, according to the National Hand Hygiene Initiative and state or territory requirements
- Identify how the organisation has responded to inconsistency or noncompliance with the current National Hand Hygiene Initiative.

Strategies for improvement

The current National Hand Hygiene Initiative is coordinated by Hand Hygiene Australia. Assess compliance of the organisation's overall hand hygiene program using one or more measures applicable to the organisation's scope, size and activities.

Ensure that a manager provides leadership, direction and support to the hand hygiene program by:

- Supporting the program to meet the requirements of the National Hand Hygiene Initiative and the state or territory
- Determining how the organisation's hand hygiene program will be resourced and managed.

The hand hygiene program in the health service organisation should include:

- Availability of alcohol-based hand sanitiser at the point of care
- Education of the workforce about hand hygiene
- Auditing of the hand hygiene program with performance feedback
- Development or review of a plan to respond to identified gaps, barriers and enablers that may help show improvement
- Identification of members of the workforce or work areas for which extra training and support are required (for example, medical officers, emergency department, anaesthetics department)
- Provision of feedback to clinicians on the overall performance of the program and results of hand hygiene activities, including hand hygiene compliance and other process audits

- Methods for evaluating the hand hygiene program when compliance auditing is not appropriate or not required – for example
  - review of the types of products used for hand hygiene
  - review of the availability of alcohol-based products at the point of care
  - evaluation of hand hygiene products used in the organisation
  - assessment of workforce knowledge of hand hygiene
  - completion of competency assessments for hand hygiene technique
  - completion of hand hygiene education and training
- Review or development of a process, policy or protocol to deal with issues of noncompliance or inconsistency with the National Hand Hygiene Initiative, which can include
  - identifying reasons for noncompliance and solutions to these issues
  - engaging with clinicians to identify possible solutions
  - modifying procedures, protocols or work practices to deal with issues of noncompliance or inconsistent practices in clinical services (for example, anaesthetic and emergency departments, phlebotomy services)
  - reviewing availability and workforce acceptance of equipment, supplies and products required for appropriate hand hygiene.

Aseptic technique

Action 3.9

The health service organisation has processes for aseptic technique that:

a. Identify the procedures where aseptic technique applies

b. Assess the competence of the workforce in performing aseptic technique

c. Provide training to address gaps in competency

d. Monitor compliance with the organisation's policies on aseptic technique

Intent

A risk-based process is implemented that will prevent or minimise the risk of introducing infectious agents during clinical procedures and activities.

Key tasks

- Use risk management tools to identify the procedures for which aseptic technique is required
- Identify gaps where aseptic technique is not applied appropriately
- Provide training to reduce gaps in competence
- Give priority to compliance assessment and auditing for aseptic technique in the areas of highest risk and most frequent use.

Strategies for improvement

Identify procedures and risks

Identify the clinical procedures and activities for which aseptic technique needs to be assessed, such as:

- Surgical procedures, including invasive procedures performed in the operating room, procedure room or clinical areas
- Venepuncture
- Insertion of vascular access devices such as peripheral or central lines

- Maintenance of vascular access devices, including line or dressing changes, or medicine administration through these devices
- Urinary catheterisation
- Simple dressings
- Complex or large dressings
- Gowning and gloving
- Collecting of swabs and other specimens.

Conduct a risk assessment to identify the areas of the organisation with the highest risk when performing these procedures. Risks relate to the clinical environment, the patient and the frequency at which the procedure is performed.

Provide the workforce with current policies, procedures and protocols that provide guidance on aseptic technique and that have been developed or reviewed by members of the workforce who are competent in aseptic technique.

Assess training and competence

Identify the training needs of members of the workforce who perform procedures requiring aseptic technique. Consider the validity, currency and scope of previous training, and how often training should be repeated to maintain competence.

Assess the competence of members of the workforce who are required to perform aseptic technique and provide training to address gaps in competence. Set priorities for training based on risk assessment.

Identify opportunities to review practice to improve aseptic technique in specialised units such as emergency and anaesthetic departments, interventional radiology, dialysis, outpatient clinics (for example, wound care; ear, nose and throat; ophthalmic) and phlebotomy.

Use surveillance data, if available, for healthcare-associated infections, results of hand hygiene compliance audits and incident reports to help set priorities for assessment and training needs.

Support practice improvement

Consider technological advances to support improving aseptic technique in practice, such as:

- Equipment bundles
- Sterile 'starter' packs
- Dedicated trolleys (for example, intravenous, dressing and urinary catheter trolleys).

Invasive medical devices

Action 3.10

The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[112]

Intent

Infections are minimised by the appropriate selection, safe insertion and maintenance, and timely removal of invasive medical devices.

Key tasks

- Review the organisation's compliance with relevant regulations, guidelines and state or territory requirements covering invasive medical devices
- Review, develop or implement processes to cover introduction, use, management and removal of invasive medical devices used in the organisation.

Strategies for improvement

As part of the organisational risk assessment, determine:

- Which invasive medical devices are used in the health service organisation
- Where they are used
- Which clinicians are using them
- Escalation pathways to manage difficult insertion of invasive devices
- Whether clinicians have been trained and assessed in appropriate selection, management and removal of the invasive medical devices they use
- Consistency with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[112]
- Compliance with relevant regulations, guidelines and state or territory requirements covering invasive medical devices.

Assess risks relating to indications for use, insertion and management of invasive medical devices in clinical and procedural areas, such as:

- Medical and surgical inpatient areas
- Interventional radiology
- Emergency departments
- Anaesthetic departments
- Operating theatres and recovery
- Special care units, including intensive care units, paediatric intensive care units and high-dependency units
- Outpatient clinics.

Develop or review policies, procedures and protocols relating to the choice, insertion, maintenance and removal of invasive medical devices to cover:

- Product selection and evaluation, including cost, cost-effectiveness and patient preferences
- Supply and procurement
- Introduction into the organisation
- Education, training and competency assessments required before use
- Any requirements for reassessment of competence
- Strategies for individual inserters and departments to track their own complication rates
- Scope of use
- Reuse
- Disposal
- Storage
- Transportation from storage to place of use, including
  - maintaining integrity and sterility
  - transport safety and time frames
  - temperature and moisture control
  - disposal considerations
- Fault management
- Recall
- Evaluation of devices
- Documentation in the patient's healthcare record of time frames and reasons for insertion, management and removal of invasive medical devices, and patient assessment (including feedback and actions taken).

Identify the risks associated with the use and maintenance of invasive medical devices. This could include documenting:

- Criteria for insertion, and selection of the best device for patient indications and purpose
- Indications for the device to be left in place once inserted
- Assessment of aseptic technique used at insertion and for maintenance activities
- Use of evidence-based safety engineered technology
- Evaluation of how clinicians choose the most appropriate device
- Physical environment issues that affect insertion and maintenance of devices
- Patient monitoring activities to identify infections relating to invasive medical devices
- Use of the organisation's incident reporting process
- Review of incident reports relating to invasive medical devices for appropriateness, infection, referral, inconsistency or noncompliance with organisational policy, equipment failure and other adverse events
- Patient engagement and education about use and maintenance of invasive medical devices
- Indications for removal, evidence-based removal procedure and post-removal assessment of possible complications (for example, air emboli, bleeding from removal site).

Action 3.11

The health service organisation has processes to maintain a clean and hygienic environment – in line with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[112], and jurisdictional requirements – that:

a. Respond to environmental risks

b. Require cleaning and disinfection in line with recommended cleaning frequencies

c. Include training in the appropriate use of specialised personal protective equipment for the workforce

Intent

Health service organisations identify and respond to environmental and infection risks by providing a clean environment for patients and the workforce.

Key tasks

- Identify the environmental cleaning hazards in the organisation and include these in the organisation's risk management strategies
- Review or develop policies, procedures and protocols to include effective strategies to provide a clean environment in the organisation
- Use the implementation and evaluation strategies for environmental cleaning to ensure that cleaning and disinfection processes are in line with recommended cleaning frequencies appropriate to the health service organisation
- Provide training to the workforce undertaking environmental cleaning activities and include the use of specialised personal protective equipment, if required
- Evaluate environmental cleaning practices for compliance with policies, procedures and protocols, and measure outcomes of cleaning processes
- Review duty lists, position descriptions or contract specifications as part of the appraisal or contract review process, and provide feedback to the relevant person or group on achievements or areas for improvement.

Strategies for improvement

Include environmental cleaning risks in the organisation's risk management strategies, and ensure that cleaning processes have the support of the governing body and executive.

Implementation strategies for a clean environment should be evidence based and have a risk management focus. Strategies may include:

- Workforce and contractor education
- Version control and standardised formats for
  - policies
  - procedures
  - position descriptions
  - duty lists
  - contract specifications (for contracted cleaning services)
- Processes to assess effectiveness
- Evaluation of the cleaning program.

The governing body is responsible for overseeing contracted cleaning services. Contract development, documentation and record keeping should include consultation with key groups, including:

- The cleaning manager
- Infection prevention and control
- Corporate services
- Governance.

Develop cleaning and disinfection schedules that meet the requirements outlined in the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[112] and relevant state or territory requirements. These schedules should include:

- Frequency and type of activity
- Product and equipment to be used
- Specialised personal protective equipment, if required
- Safety instructions.

Ensure that position descriptions and duty lists are current, and consistent with the environmental cleaning and disinfection schedules used in the organisation.

Monitor performance

Identify areas that require audit and evaluation of environmental cleaning and disinfection processes, and use audit and evaluation tools that effectively assess compliance with policies, procedures and protocols used in the organisation. Report to the governing body on improvements achieved and areas in which further improvement is needed as part of the quality improvement program.

Include environmental cleaning and a process to deal with any identified issues in the organisation's incident management and investigation system. Review the incident management and investigation system to identify any incidents relating to environmental cleaning activities and act to prevent incidents recurring.

Action 3.12

The health service organisation has processes to evaluate and respond to infection risks for:

a. New and existing equipment, devices and products used in the organisation

b. Maintaining, repairing and upgrading buildings, equipment, furnishings and fittings

c. Handling, transporting and storing linen

Intent

The health service organisation minimises infection risks to patients and the workforce from equipment, device, product and environmental hazards.

Key tasks

- Develop or review the organisation's processes for introducing new technologies, devices, products or equipment
- Develop or review the organisation's risk management processes to include the need to identify and respond to infection risks that may be associated with repairs, refurbishment or upgrade of infrastructure, including during the planning stage
- Set up or review the processes for handling, transporting and storing linen used in the organisation.

Strategies for improvement

Develop processes for new products

Ensure that processes are in place to assess infection risks when introducing new devices, products or equipment into the organisation. This could be included in the role of a products committee, and may be coordinated by the health service organisation or at a group, corporate, or network or district level. Processes for introducing new technologies, devices, products or equipment should also consider:

- How new products will be trialled
- How new products will be introduced
- What training is required
- Whether items need to be removed or decommissioned

- Whether the maintenance program considers infection risks that need to be managed (for example, by using specialised personal protective equipment, extra cleaning or disinfection to reduce biofilm or microbial contamination, physical barriers)
- How product recalls will be coordinated
- How alerts will be managed and responded to
- How the introduction of a new product or technology aligns with the organisation's risk management system.

Consult with relevant services

Ensure that the organisation's risk management program includes the need to consult with relevant services, such as engineering, environmental cleaning, reprocessing of reusable medical devices, and infection prevention and control services:

- At the planning stage for any repairs, renovations, refurbishment or redevelopment within the organisation
- At each stage during any repairs, renovations, refurbishment or redevelopment to minimise or manage risks to patients, the workforce, departments and contractors involved both directly and indirectly.

Infection risks to be considered may include:

- Access
- Dust
- Aerosols
- Air handling
- Filters and filtration
- Water quality, biofilms and supply
- Sewerage and wastewater
- Infectious agents
- Waste materials
- Disruption of services and utilities
- Patient and workforce safety
- Extra cleaning and reprocessing requirements.

Review processes for linen handling

Review the movement, supply and handling of clean and used linen in the health service organisation to minimise infection risks associated with linen for both patients and the workforce. This includes linen used for patient care, environmental linen (for example, privacy screens), and linen used by the workforce (for example, theatre scrubs, uniforms). Consider how to:

- Minimise excess handling
- Ensure effective containment and storage
- Optimise traffic flows to minimise contamination of clean linen
- Reprocess used linen (methods used, and whether this is done by the health service organisation or an external service).

Ensure that any external services are part of the systems for quality improvement and contracts review addressed in the Clinical Governance Standard.

Workforce immunisation

Action 3.13

The health service organisation has a risk-based workforce immunisation program that:

a. Is consistent with the current edition of the *Australian Immunisation Handbook*[114]

b. Is consistent with jurisdictional requirements for vaccine-preventable diseases

c. Addresses specific risks to the workforce and patients

Intent

The health service organisation has a risk-based immunisation program to protect the workforce and patients.

Key tasks

- Review the organisation's immunisation program to ensure that it is consistent with the current edition of the *Australian Immunisation Handbook*[114] and state or territory requirements for vaccination
- Ensure that policies, procedures and protocols are in place to cover employer and employee responsibilities for managing occupational risks for vaccine-preventable diseases.

Strategies for improvement

Conduct a risk assessment to establish consistency of the organisation's workforce immunisation program with the current edition of the *Australian Immunisation Handbook* and state or territory requirements.

Ensure that the policies, procedures and protocols for workforce immunisation include:

- Employer and employee responsibilities for managing occupational risks for vaccine-preventable diseases
- Relevant aspects relating to the organisation's infection prevention and control program
- A statement of the risks in the organisation and how the risks are to be managed, including identifying high-risk areas and at-risk members of the workforce
- How the program aligns with the organisation's workplace health and safety program
- Identification of appropriately qualified or trained personnel to manage the program
- Vaccination requirements for the workforce (including students and contractors) before they start work in the organisation
- The need to maintain current vaccination records for the workforce and a process to view these records, if required
- How information about relevant vaccine-preventable diseases is provided to the workforce and patients
- A documented management process for vaccine refusal that includes reducing the risk to members of the workforce, and reducing the risk of a healthcare worker transmitting disease to vulnerable patients.

CRITERION: Reprocessing of reusable medical devices

> *Reprocessing of reusable equipment, instruments and devices is consistent with relevant current national standards, and meets current best practice.*

This criterion includes cleaning, disinfection and sterilisation of reusable medical devices, equipment and instrumentation used in the health service organisation.

Reprocessing of reusable medical devices, equipment and instruments should be consistent with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[112], and meet current relevant national and international standards.

Reprocessing of reusable devices

Action 3.14

Where reusable equipment, instruments and devices are used, the health service organisation has:

a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines

b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying
   - the patient
   - the procedure
   - the reusable equipment, instruments and devices that were used for the procedure

Intent

Where reusable equipment, instruments and devices are used, the health service organisation minimises infection risks to patients and the workforce by ensuring adequate identification of, and procedures for reprocessing, reusable medical equipment.

Key tasks

- Identify the organisation's need for reusable critical and semi-critical equipment, instruments and devices
- Review the organisation's infrastructure for reprocessing services, and workforce capacity to reprocess reusable equipment, instruments and devices
- Review policies, procedures and protocols used in sterilising services for reprocessing reusable equipment, instruments and devices
- Review policies, procedures and protocols for decontamination of reusable devices at the point of use before reprocessing
- Review the methods used to reprocess reusable equipment, instruments and devices to ensure that these processes are consistent with relevant national and international standards
- Implement or review processes for traceability or tracking of critical and semi-critical equipment, instruments and devices, and assess the processes' ability to identify the patient, the procedure, and the equipment, instrument or device that was used for the procedure.

Strategies for improvement

Identify requirements and processes

Identify the organisation's requirements for reusable equipment, instruments and devices (and associated consumables) as part of the organisational risk assessment.

Identify the organisation's infrastructure and workforce capacity to safely reprocess reusable equipment, instruments and devices.

If reusable equipment, instruments and devices are required, assess the processes used to provide appropriately reprocessed items to the workforce and patients, and ensure that these processes are covered in the organisation's policies, procedures and protocols. Questions to consider include:

- Does the organisation have the facilities and ability to reprocess the required reusable medical equipment, instruments and devices?
- Can sterilising services be centralised where there are several health service organisations under one administration?
- Are specialised reprocessing techniques required for some reusable medical devices (for example, low-temperature sterilisation, ethylene oxide) and are processes in place to achieve this?
- Should the organisation purchase commercial, pre-sterilised single-use items to meet its needs?
- Could an external sterilising service be contracted to provide reprocessing services for critical or semi-critical equipment, instruments or devices?
- If services are contracted, are contract development, documentation and record keeping conducted in consultation with key groups, including:
  - sterilising services manager
  - hospital theatre manager or endoscopy unit manager
  - infection prevention and control
  - corporate services
  - governance.

Review policies, procedures, protocols and systems

Develop or review policies, procedures and protocols that are consistent with relevant national or international standards to cover:

- Governance responsibility for the sterilising service
- Infrastructure, including
  - enough dedicated space for all required steps for reprocessing
  - reprocessing equipment requirements and replacement schedules
  - appropriate storage to maintain the integrity of reprocessed equipment, instruments and devices before use, in all areas where they are stored
  - decontamination and safe packaging for transporting reusable equipment, instruments and devices from clinical areas that may be located away from the sterilising services (for example, wards, interventional radiology, outpatient clinics, other facilities)
- Quality improvement systems, which should include
  - appropriate storage requirements for reusable medical equipment, instruments and devices
  - a fault or variance reporting process that includes responsibility, actions and risk management strategies
  - document control and record-keeping processes that allow data to be retrieved at any time
  - environmental controls, including water quality, air handling, access, maintenance schedules and cleaning activities
  - consumables, including packaging materials and personal protective equipment
  - suitably trained members of the workforce who are available in sterilising services, and wherever decontamination of used reusable equipment, instruments or devices is undertaken.

Use incident management and investigation system to report any incidents relating to the reprocessing of reusable equipment, instruments and devices. Review the incident management and investigation system in the organisation to identify any variation between practice and policy, procedure or protocol, and act to rectify the risks.

Review systems for identification and tracking

Review the existing quality improvement systems used to identify and track reusable equipment, instruments and devices during reprocessing and use. Consider how the following are identified:

- Batch numbers
- Individual items or sets of items
- Patients
- Date of reprocessing
- Type of reprocessing undertaken
- Identification details of the steriliser or disinfector used
- Process cycle details
- Results of chemical and biological monitoring undertaken
- Operator responsible for the reprocessing and release of the items for use
- Documentation, quality monitoring and tracking or traceability systems for reusable equipment, instruments and devices received from an external provider (for example, loan sets, clinicians' own reusable medical devices).

Evaluate the quality improvement systems used to identify and track reusable equipment, instruments and devices to check that processes are adequate to identify any items and affected patients in the event of a fault or recall.

CRITERION: Antimicrobial stewardship

> *The health service organisation implements systems for the safe and appropriate prescribing and use of antimicrobials as part of an antimicrobial stewardship program.*

Safe and appropriate antimicrobial prescribing is a strategic goal of the clinical governance system.

Antimicrobial stewardship (AMS) is defined as an ongoing effort by a health service organisation to optimise antimicrobial use among patients 'to improve patient outcomes, ensure cost-effective therapy and reduce adverse sequelae of antimicrobial use (including antimicrobial resistance).[113] An AMS program involves strategies and interventions that aim to reduce unnecessary antimicrobial use and promote the use of agents that are less likely to select for resistant microorganisms. This is done in line with treatment guidelines and with consideration of local susceptibility patterns.[115]

Effective AMS programs reduce inappropriate antimicrobial use, improve patient outcomes and reduce adverse consequences of antimicrobial use (including antimicrobial resistance, toxicity and unnecessary costs).[116] Along with infection control, hand hygiene and surveillance, AMS programs are a key strategy in preventing antimicrobial resistance and decreasing preventable healthcare-associated infections.

The emergence of antimicrobial-resistant bacteria is closely linked with inappropriate antimicrobial use. Studies show that up to 50% of antimicrobial regimens prescribed for patients in hospitals, including Australian hospitals, are considered inappropriate. Comparison with data from northern Europe shows that Australian hospitals have a higher overall rate of inpatient antimicrobial use, and further work is required to optimise the use of antimicrobials in Australian hospitals.

The intent of this criterion is to ensure appropriate prescribing of antimicrobials, as part of the broader systems within a health service organisation to prevent and manage healthcare-associated infections and improve patient safety and quality of care.

This criterion, and the actions and strategies outlined in this guide should be considered in conjunction with the requirements of the Medication Safety Standard.

The content and implementation strategies for this criterion have been drawn from *Antimicrobial Stewardship in Australian Hospitals*[116], which summarises the evidence about AMS programs, and details strategies for implementing and sustaining these programs. It is recommended that health service organisations consult this publication when planning and implementing an AMS program. This publication is currently under revision; the second edition is expected to be published in 2018.

AMS programs may need to be tailored in each organisation. The types of strategies and activities used depend on the specific organisational context, and factors such as the complexity, size and resources available for implementation, monitoring and evaluation.

The *Options for Implementing Antimicrobial Stewardship in Different Facilities* resource provides examples of how strategies to support AMS might be implemented in different contexts. These examples can be used as a starting point for health service organisations and AMS teams to consider ways in which different strategies can be applied to their own settings. This resource can be downloaded from the Commission's website.

Action 3.15

The health service organisation has an antimicrobial stewardship program that:

a. Includes an antimicrobial stewardship policy

b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing

c. Has an antimicrobial formulary that includes restriction rules and approval processes

d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard[117]

Intent

Appropriate prescribing and use of antimicrobials are part of the broader systems to improve patient safety and quality of care, and prevent and manage infections associated with multidrug-resistant organisms.

Key tasks

- Review the current AMS program to identify what is working well; identify gaps, risks and areas for improvement; set priorities; and inform review of the AMS program plan – use the results of this review to set priorities for AMS
- Identify the key membership of the AMS committee and the AMS team
- Develop or review an AMS policy that specifies that clinicians should follow current, evidence-based Australian therapeutic guidelines on antimicrobial prescribing, or evidence-based guidelines that have been endorsed by a state or territory AMS committee, and incorporates the principles of the Antimicrobial Stewardship Clinical Care Standard
- Develop, review and maintain antimicrobial prescribing policies and a formulary for specific infections to reflect current resistance patterns
- Create or review an antimicrobial formulary and guidelines for treatment and prophylaxis that align with current, evidence-based Australian therapeutic guidelines
- Review policies, clinical pathways, point-of-care tools and education programs to ensure that they incorporate the principles of the Antimicrobial Stewardship Clinical Care Standard.

Strategies for improvement

Review the AMS program

All health service organisations should have an overarching AMS program. Review the current AMS program to identify what is working well, and gaps and areas for improvement. This includes:

- Assessing current antimicrobial use, results of prescribing audits, available incident data, current AMS activities and resources to support AMS strategies
- Mapping current governance structures, systems and processes that currently support AMS, or could be further developed
- Using the results of this evaluation to identify risks, gaps and priorities for AMS, and to inform the AMS program plan.

Review the AMS committee and team

The AMS committee is multidisciplinary and oversees the effective implementation and ongoing function of the AMS program. Membership includes:

- A member of the executive as an executive sponsor, who can enable change
- Clinicians with technical expertise (for example, an infectious diseases physician, pharmacist, clinical microbiologist or infection control nurse) and other individuals who can provide day-to-day leadership and support implementation.

Check that the AMS committee has endorsement from the organisation's executive or governing body for formal structural alignment.

Ensure that there are links between the AMS committee and the existing clinical governance framework and quality improvement systems, including having the committee represented on both the drug and therapeutics committee, and the infection prevention and control committee. These links should be clearly articulated (for example, in the organisational chart or terms of reference).

Incorporate AMS within the organisation's safety and quality improvement systems (see Actions 1.10 and 3.2).

The AMS team is the effector arm of the AMS program. Core membership includes:

- An infectious diseases physician or clinical microbiologist
- A nominated clinician (for example, lead doctor)
- A clinical pharmacist.

In larger health service organisations, the team would be on site; in smaller facilities, the pharmacist position may be part of a broader network or group of health service organisations, or support may be provided using telehealth systems. The responsibility to ensure that the AMS team is adequately resourced should be clearly outlined in organisational policies.

Implement an AMS policy

Write or review, and implement, an AMS policy that:

- Specifies that prescribers must follow current, evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing, or evidence-based guidelines that have been endorsed by a state or territory AMS committee, and incorporates processes for informing prescribers about prescribing requirements
- Incorporates the quality statements from the Antimicrobial Stewardship Clinical Care Standard
- Lists restricted antimicrobials and procedures for obtaining approval for use of these agents
- Specifies processes for monitoring antimicrobial use, resistance and appropriateness of prescribing, and providing feedback to prescribers
- References the health service organisation's policy on liaising with the pharmaceutical industry (see Action 4.1)
- Outlines systems for obtaining specialist advice for complex clinical conditions
- Incorporates an audit and evaluation strategy for managing the policy's effectiveness, including assessment of AMS indicators that are relevant to the organisation, such as those suggested in the Antimicrobial Stewardship Clinical Care Standard
- Details governance arrangements; communication lines; and roles and responsibilities of facility leaders, the AMS committee and the AMS team
- Reflects the AMS program's integration within the organisation's safety and quality systems.

Decide on, and document, procedures for managing noncompliance with the policy.

Review policies relating to antimicrobial prescribing at least annually, or as changes in evidence or recommended practices are notified.

Plan the AMS program

The strategies below align with those listed in Action 3.16.

Develop an AMS program plan based on the risks, gaps and priorities identified in the initial assessment and gap analysis. Ensure that the plan details:

- Procedures for prescription review and feedback to prescribers (for example, AMS rounds or pharmacy rounds)
- Goals, actions, time frames, and measurement and reporting activities
- Frequency of review and monitoring activities
- Process and outcome indicators or measures to monitor program effectiveness
- Roles, responsibilities and time frames for reporting on policy compliance, antimicrobial use and resistance, and prescribing according to guidelines
- Roles and responsibilities of governance, executive, leaders, managers and clinicians for meeting and evaluating identified priorities
- Resource allocation (for example, workforce, time, infrastructure) to support planned activities.

Ensure that clinicians who prescribe, dispense or administer antimicrobials are educated about the AMS program policy and plan at the start of their employment and at least annually.

Ensure that prescribing clinicians have access to, and follow, current guidelines and the local antimicrobial formulary for treatment and prophylaxis for common infections relevant to the patient population, the procedures performed and the local antimicrobial resistance profile. *Therapeutic Guidelines: Antibiotic*[118] is recognised as a national guideline for antimicrobial prescribing in Australia.

Provide clinicians with ready access to the current version of *Therapeutic Guidelines: Antibiotic* and the local antimicrobial formulary. To promote uptake, make guidelines available in print or online formats.

Ensure that any local clinical and prescribing guidelines are consistent with recommendations in the current version of *Therapeutic Guidelines: Antibiotic*, and consider local microbial susceptibility patterns.

Review prescribing guidelines at least annually, or as changes are notified.

Review formulary, approval and restriction

Establish or review an antimicrobial formulary that aligns with recommendations in current evidence-based Australian therapeutic guidelines.

Ensure that the formulary specifies procedures for obtaining approval for use of restricted agents, and that systems are in place to inform prescribers of these procedures.

Incorporate the principles of the Antimicrobial Stewardship Clinical Care Standard into the AMS program

Review relevant clinical pathways to ensure that review of antimicrobial therapy and patient condition is included in the pathway. Set benchmarks for documenting in the patient's healthcare record the clinical reason; the medicine name, dose, route of administration and intended duration; and the treatment review plan.

Implement or review the process for reporting adverse events, incidents and near misses relating to antimicrobial use, including assessment and management of reported antibiotic–allergy mismatch.

Educate patients and carers about safe and appropriate use of antimicrobials, including potential adverse reactions and what to do in the event of a reaction.

Use process measures to monitor implementation of the AMS program, and to identify opportunities for improvement. Possible measures include Antimicrobial Stewardship Clinical Care Standard indicators[117] and quality use of medicines indicators.

The Antimicrobial Stewardship Clinical Care Standard is available on the Commission's website.[117]

Action 3.16

The antimicrobial stewardship program will:

a. Review antimicrobial prescribing and use

b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing

c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use

d. Report to clinicians and the governing body regarding
   - compliance with the antimicrobial stewardship policy
   - antimicrobial use and resistance
   - appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing

Intent

The AMS program promotes safe and appropriate antimicrobial prescribing and use through ongoing monitoring, evaluation and improvement activities.

Key tasks

- Collect and regularly review data on antimicrobial use (volume and appropriateness) and local resistance to identify areas for improvement and ascertain the effectiveness of AMS interventions
- Monitor quality indicators to assess prescribing practice and AMS program effectiveness
- Use the results of monitoring activities to decide on priorities and actions for improvement
- Set up a system that ensures that feedback is provided to prescribers on results of monitoring and assessment activity
- Report routinely to the organisational governing body and the chief executive on AMS processes and outcomes.

Strategies for improvement

Monitoring and analysing antimicrobial use are critical to understanding patterns of prescribing, the impact on patient safety and antimicrobial resistance, as well as to measure the effectiveness of, and identify means to improve, the AMS program. Antimicrobial use can be measured in terms of quantity, quality (that is, appropriateness of prescribing according to guidelines) or expenditure.

Decide on areas for monitoring and improvement

Map current data collection systems across all departments to identify those that can be used to support monitoring and evaluation of AMS (note that a lot of data are routinely collected throughout health service organisations and it is important to identify what is already available to avoid duplication of effort). Examples include:

- Pharmacy data collection systems – for information about trends in antimicrobial use
- Data collected as part of performance monitoring for sepsis
- Emergency department indicators reviewing time to first dose of antibiotics
- Healthcare record systems
- Electronic medication management systems
- Pathology department audits
- Data on the incidence of surgical site infections.

Use the risk assessment principles outlined in Action 3.1 to decide on priority areas for monitoring and improvement. Ensure that antimicrobial use monitoring includes intensive care units and oncology units, as the control of resistance in these areas can affect other areas of a health service organisation. Other priorities for monitoring may include conditions commonly associated with high antimicrobial use (for example, sepsis, urinary

tract infections, respiratory tract infections, surgical prophylaxis) or high-risk antimicrobials (for example, third-generation cephalosporins, carbapenems).

Take part in state or territory, or national programs to monitor antimicrobial use and appropriateness that provide readily accessible audit and monitoring tools. Examples are:

- National Antimicrobial Utilisation Surveillance Program (NAUSP), which measures volume of antimicrobial use
- National Antimicrobial Prescribing Survey (NAPS), which measures appropriateness of prescribing.

Work with clinical microbiology services to ensure reporting of selective susceptibilities, and review antimicrobial use data in association with resistance data to identify any patterns.

Act to improve prescribing

Support the AMS team to provide an AMS service that:

- Uses data from audits of prescribing and antimicrobial use to give feedback to clinicians on prescribing appropriateness, as part of AMS team or pharmacy review
- Publishes reports on antimicrobial use and appropriateness; this could be whole-of-organisation data or broken down into individual ward or division information.

To engage individual clinicians and focus efforts, present data and feedback focused on specific clinical conditions and appropriateness of therapy.

To inform local empirical therapy recommendations and formulary management, make antimicrobial susceptibility tables (antibiograms) available to clinicians and groups responsible for local antimicrobial therapy guidelines. Because antibiograms can be difficult to interpret, ensure appropriate expertise from clinical microbiologists or infectious diseases specialists to help analyse the antibiogram and plan appropriate actions. If antibiograms are used, they should be consistent with the national specifications for a hospital-level cumulative antibiogram.[119]

Provide resources and tools at the point of care to promote appropriate antimicrobial prescribing, such as:

- Posters targeting both prescribers and patients
- Laminated cards that can be placed in medication rooms or be developed as pocket cards as a quick reference
- Stickers or electronic prompts that can be used as reminders to review patients and treatment.

Implement or review clinical pathways for specific infections or conditions. Ensure that clinical pathways include steps to allow appropriate investigations, routine review of therapy, de-escalation, intravenous-to-oral switch and limiting the duration of therapy.

Establish clinical pathways for common, high-volume and high-risk conditions; examples might include *Staphylococcus aureus* bacteraemia, bone and joint infections, community-acquired pneumonia, surgical prophylaxis, sepsis and antimicrobial-related allergy.

Use state or territory, or national guidelines or resources to implement a formal intravenous-to-oral switch program.

Require all new prescribers to complete the NPS MedicineWise antimicrobial modules.

Communicate about safe and appropriate use of antimicrobials:

- Provide regular updates about the AMS program to members of the clinical workforce using different methods, such as newsletters, screensavers, meetings and posters
- Take part in annual Antibiotic Awareness Week activities
- Ensure that patients and carers receive current Australian education materials on safe and appropriate use of antimicrobials.

Set up systems for communication with other clinicians about antimicrobial management. This is especially important for transitions of care, and includes internal communication, and external communication with general practitioners, members of the aged care workforce and other prescribers.

Monitor and evaluate the AMS program

Use the quality improvement framework outlined in Action 3.2 to evaluate the program, and identify opportunities and actions for improvement.

Use process and outcome measures to monitor and evaluate the program. Possible process measures include:

- Antimicrobial Stewardship Clinical Care Standard indicators[117]
- Quality use of medicines indicators
- Infection- or antimicrobial-related incidents (for example, sentinel events such as *Staphylococcus aureus* bacteraemia, or adverse events relating to antimicrobial administration or dosing).

Possible outcome measures include:

- *S. aureus* bacteraemia–related mortality
- Infection-related length of stay (for example, central line-related sepsis, ventilator-related complications, multidrug-resistant organism infections)
- Infection-related readmissions (for example, joint replacement surgery)
- Reduced antimicrobial expenditure.

Contribute data on antimicrobial use and appropriateness to relevant state or territory, or national programs (for example, NAPS and NAUSP) to enable benchmarking as part of program evaluation.

Report on AMS program processes and outcomes

Responsibility for monitoring the effectiveness of the AMS program and ensuring accountability for actions lies with the governing body of the organisation. The governing body also has a role in allocating resources to achieve program goals and outcomes.

Provide a report every year to the chief executive and governance units that summarises:

- Current AMS resources
- AMS team activity
- Performance against process and outcome indicators for antimicrobial use, appropriateness and resistance
- Key areas of improvement
- Areas for further improvement or priority
- Areas in which guidance or support from chief executive and governance units is needed.

Refer to the *Options for Implementing Antimicrobial Stewardship in Different Facilities* resource for examples of monitoring and reporting activities in different settings.

Resources

Healthcare-associated infection

Australian Commission on Safety and Quality in Health Care – National Surveillance Initiative

Hand Hygiene Australia

National Health and Medical Research Council – *Australian Guidelines for the Prevention and Control of Infection in Healthcare*

National Health and Medical Research Council – *The Australian Immunisation Handbook*

Antimicrobial stewardship

Australian Commission on Safety and Quality in Health Care – Antimicrobial Stewardship Clinical Care Standard

Australian Commission on Safety and Quality in Health Care – *Antimicrobial Stewardship in Australian Hospitals*

Australian Commission on Safety and Quality in Health Care – *Options for Implementing Antimicrobial Stewardship in Different Facilities*

National Antimicrobial Prescribing Survey (NAPS) and Surgical National Antimicrobial Prescribing Survey (SNAPS)

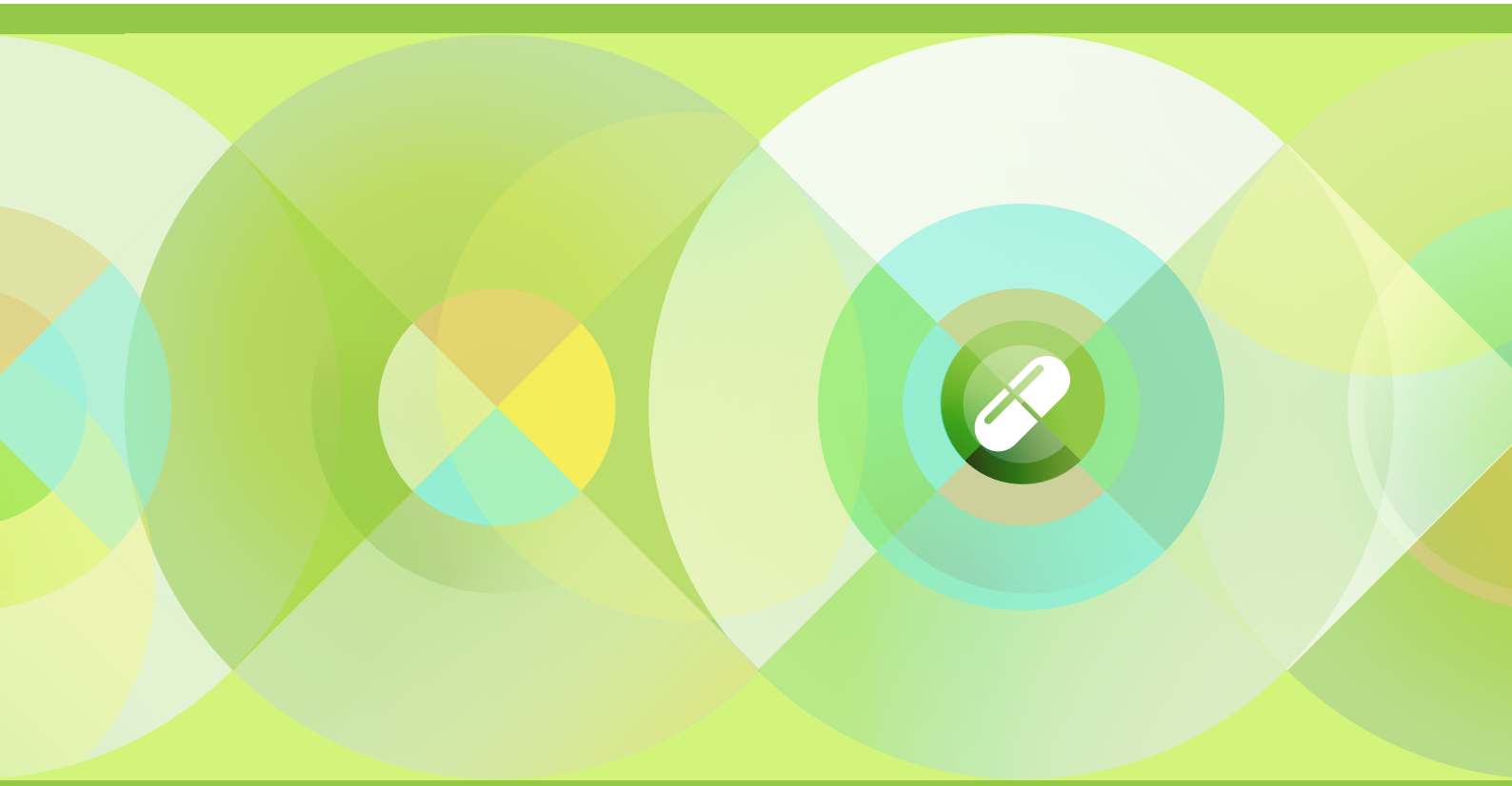
NPS antimicrobial modules

SA Health – National Antimicrobial Utilisation Surveillance Program (NAUSP)

Therapeutic Guidelines Limited – *Therapeutic Guidelines: Antibiotic*

4

Medication Safety Standard



Medication Safety Standard

Leaders of a health service organisation describe, implement and monitor systems to reduce the occurrence of medication incidents, and improve the safety and quality of medication use. The workforce uses these systems.

Intention of this standard

To ensure clinicians are competent to safely prescribe, dispense and administer appropriate medicines and to monitor medicine use. To ensure consumers are informed about medicines and understand their individual medicine needs and risks.

Criteria

Clinical governance and quality improvement to support medication management

Documentation of patient information

Continuity of medication management

Medication management processes

Introduction

Medicines are the most common treatment used in health care. Although appropriate use of medicines contributes to substantial improvements in health, medicines can also be associated with harm.[120] Because they are so commonly used, medicines are associated with a higher incidence of errors and adverse events than other healthcare interventions. Some of these events are costly, in terms of morbidity, mortality and resources. Up to 50% are potentially avoidable.[121]

Scope of this standard

The Medication Safety Standard addresses areas of medication management that have a known risk of error, often as a result of unsafe processes and variation in clinician practices.

The Medication Safety Standard requires health service organisations to assess medication management and implement processes and practices that:

- Provide for sound governance for the safe and quality use of medicines
- Minimise the occurrence of medicine-related incidents and the potential for patient harm from medicines
- Ensure that competent clinicians safely prescribe, dispense and administer medicines, and monitor their effects
- Inform patients about their medicines and involve them in decision-making.

Key links with other standards

The Medication Safety Standard should be applied in conjunction with other NSQHS Standards, including the Clinical Governance Standard and the Partnering with Consumers Standard.

Synergies with other NSQHS Standards will also need to be identified. This will ensure that medication safety and quality systems, and policies and processes for medication management are integrated, to reduce duplication of effort.

Medication management pathway

Medication management involves prescribing, dispensing, administering and monitoring medicines. Medication management is complex and involves several different clinicians. Often referred to as the medication management pathway, it comprises multiple activities and three system processes to manage the safe and effective use of medicines for patients at each episode of care (Figure 1).[122,123]

Safe processes and practices are required for all activities in the medication management pathway. These activities include procuring, supplying, storing, compounding, manufacturing, prescribing, dispensing, administering and monitoring the effects of medicines.

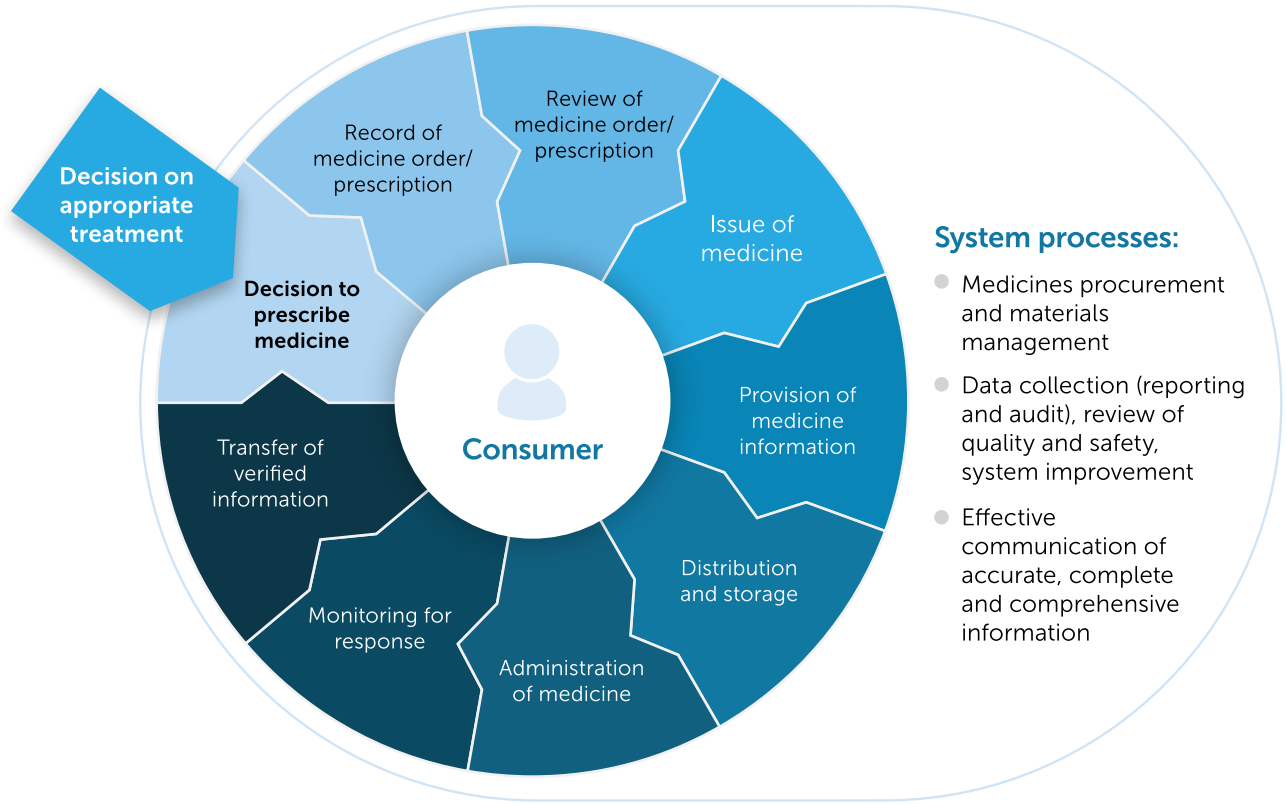
The consumer is the central focus of the medication management pathway. Health service organisations should apply the principles of partnering with consumers, health literacy and shared decision making when developing, reviewing and implementing processes or practices within the medication management pathway.

The pathway provides a framework for:

- Identifying when there is potential for errors or risk of harm
- Responding with strategies to reduce the opportunity for error.

To ensure safe and effective use of medicines within the health service organisation, identify opportunities for patient harm and implement strategies to prevent medicine-related errors. Steps taken early in the medication management pathway can prevent adverse events occurring later in the pathway.

Figure 1: Medication management pathway



Source: Adapted from Australian Pharmaceutical Advisory Council[82]

CRITERION: Clinical governance and quality improvement to support medication management

> *Organisation-wide systems are used to support and promote safety for procuring, supplying, storing, compounding, manufacturing, prescribing, dispensing, administering and monitoring the effects of medicines.*

This criterion requires organisation-wide governance, leadership and commitment to support the safe and effective use of medicines.

To meet this criterion, health service organisations are required to:

- Apply safety and quality systems to support medication management
- Use quality improvement systems to monitor, review and improve medication management
- Apply principles of partnering with consumers when designing and implementing systems for medication management
- Define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians
- Train, educate and support clinicians to understand their roles and accountabilities in delivering safe and effective use of medicines.

This criterion aligns closely with the Clinical Governance Standard and the Partnering with Consumers Standard.

Meeting the Medication Safety Standard may require the organisation to introduce new processes, or modify existing processes and practices to reduce the risk of medication error. This may require

local project teams to oversee, plan and coordinate assessment, implementation and evaluation.

Project teams should be multidisciplinary and include clinicians responsible for various medication management activities. Partnering with patients and carers in these processes can result in improved services and a higher level of satisfaction.[124]

Ongoing monitoring and evaluation of the safety, quality and performance of medication management systems are also necessary to track changes over time, ensure that systems continue to operate effectively[125] and identify areas for improvement. Data from evaluation of medication management should be communicated back to clinicians. They can focus clinicians on areas that need improvement, and motivate them to change practice and take part in improvement activities.[125-127] Feedback processes also contribute to a culture of transparency and accountability.

Integrating clinical governance

Action 4.1

Clinicians use the safety and quality systems from the Clinical Governance Standard when:

a. Implementing policies and procedures for medication management

b. Managing risks associated with medication management

c. Identifying training requirements for medication management

Intent

Safety and quality systems support clinicians in the safe and effective use of medicines and reduce medicine-related risk.

Key tasks

- Set up and implement governance structures for medication management
- Develop and implement policies and procedures for medication management
- Use organisation-wide risk management systems to identify, monitor, manage and review risks associated with medication management
- Provide access to training on medication management based on the specific needs of the workforce, including medicine-related information and decision support tools.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' safety and quality systems.

- Action 1.7 – policies and procedures
- Action 1.10 – risk management systems
- Actions 1.19, 1.20 and 1.21 – education and training

Health service organisations should:

- Use these and other established safety and quality systems to support policies and procedures, risk management, and training for medication management
- Ensure that current versions of all relevant policies and procedures are readily available and accessible to clinicians.

Policies may be developed or adapted at different levels within the organisation. However, all policy documents should be incorporated into a single, coherent set to maximise the effectiveness of the policy development process.

Establish and implement medication management governance

Health service organisations are expected to have a governance group with responsibility for medication management, including formally reporting to the organisation's clinical governance or managers. This is usually a drug and therapeutics committee, or a committee with a similar name and intent (for example, quality use of medicines committee, medication safety committee, medication advisory committee).

The drug and therapeutics committee should:

- Be multidisciplinary
- Have membership that reflects the size of the organisation and the services provided
- Have consumer representation or membership[128,129]
- Be established at the level of the individual hospital, Local Hospital Network or hospital group (public or private).

Drug and therapeutics committees have an important role in:

- Developing, reviewing and overseeing medicine-related policy
- Developing the organisation's medication safety and quality improvement strategies
- Monitoring quality improvement activities.

Drug and therapeutics committees (and their subcommittees) should work with the organisation's safety and quality unit, clinical governance and executive to oversee organisation-wide safe and quality use of medicines, including:

- Monitoring occurrence of medicine-related incidents
- Implementing risk reduction strategies
- Implementing technology such as electronic medication management, 'smart' infusion pumps and drug libraries
- Managing contract arrangements, including those with external organisations that provide medication management services.

Resources such as *Achieving Effective Medicines Governance: Guiding principles for the roles and responsibilities of drug and therapeutics committees in Australian public hospitals*[129] provide guidance for establishing and reviewing the structure, operation and processes (that is, the terms of reference); communications; and resources for an effective governance group responsible for medication management.

Review existing governance arrangements for medication management. Ensure that responsibility for implementing and monitoring the decisions of the drug and therapeutics committee and subcommittee is clearly defined (this is usually delegated to the pharmacy or organisation management).

High-risk medicines, and high-risk procedures involving medicines, pose considerable risk to patient safety. Consider designating a member of the workforce as the medication safety officer or 'patient safety champion' in high-risk procedural areas (for example, operating theatres, anaesthesia departments) to liaise with the pharmacy department on medicine-purchasing decisions and issues relating to presentation of anaesthetic products.

Implement policies and procedures

Policies, procedures and guidelines for medication management should be built on the National Medicines Policy[130] and *Guiding Principles to Achieve Continuity in Medication Management*.[123] Policies and procedures should be consistent with legislative and evidence-based documentation as it relates to safe medicine:

- Procurement, supply, storage and disposal
- Prescribing, dispensing and administration
- Reconciliation, review and monitoring of effects
- Compounding and manufacturing.

Other policies, procedures and guidelines may include:

- Medicine evaluation and list of approved medicines (formulary)

- Procedures for managing high-risk medicines (for example, administration of medicines in high-risk domains such as paediatrics, anaesthetics and chemotherapy)
- Recording of a best possible medication history (BPMH)
- Using standard forms such as the national inpatient medication chart (NIMC) or Pharmaceutical Benefits Scheme hospital medication chart (PBS HMC)
- Provision of information about medicines to patients
- Liaison with the pharmaceutical industry
- Use of oral dispensers for administering oral medicines
- User-applied labelling
- Avoiding use of abbreviations
- Safe implementation and use of electronic medication management
- Use of standardised electronic display of clinical medicines information
- Management and reporting of medication incidents and suspected adverse drug reactions (ADRs)
- Management of services contracted with external pharmacy providers.

Ensure that current versions of all medicine-related policies, procedures and protocols are readily available and accessible to clinicians.

Manage risks

Use established risk management systems (see Action 1.10) to identify, monitor, manage and review risks associated with medication management. Develop processes to manage clinical risks for different populations served by the organisation, clinical and workplace risks for the workforce, and organisational risks. Ensure that medication safety risks are recorded and can be identified in the organisation's risk management system.

Use information from measurement and quality improvement systems, adverse events, clinical outcomes and patient experiences to inform and update risk assessments and the risk management system. Consider the training the workforce may need to effectively use incident management and investigation systems to inform risk management, and to plan and implement quality improvement processes to mitigate these risks.

The medication management pathway (Figure 1) provides a framework for:

- Identifying where there is potential for errors or risk of harm
- Responding with strategies to reduce the opportunity for error.

To ensure safe and effective use of medicines within the health service organisation, implement strategies to prevent medicine-related errors and the potential risk of patient harm. Steps taken early in the medication management pathway can prevent adverse events occurring later in the pathway.

Identify training requirements

Assess the competency and training needs of the workforce in line with the requirements of Actions 1.9, 1.20 and 1.21. Perform a risk assessment to inform the training schedule and to set priorities for the members of the workforce who require training. This will include clinicians and any other employed or contracted members of the workforce who are involved in medication management (for example, medicines procurement workforce). Develop or provide access to training and education resources to meet the needs of the workforce regarding medication management.

Training the workforce in risk identification, incident management and investigation systems, and quality improvement will support safe use of medicines.

Use ongoing education programs to supplement existing knowledge and skills to inform clinicians about:

- Medication safety risks identified from incident monitoring, risk assessments, or national, state or territory medication safety directives, alerts and information
- Strategies to reduce the risks.

Ongoing education could cover medication safety topics and known risk mitigation strategies, such as:

- Using national standard medication charts
- Taking a BPMH and reconciling medicines
- Managing high-risk medicines
- Checking procedures (for example, independent double-check)

- Documenting known and new allergies and ADRs
- Preventing medication errors or incidents
- Safely preparing and administering medicines, including labelling of injectable medicines, fluids and lines.

Review training programs for clinicians that relate to safe medication management practices. Ensure that training includes:

- Education on the common causes of medication incidents and how to make medicine use safer
- The different levels of knowledge and skills required by different clinicians
- How and where to access evidence-based medicine-related information and decision support tools
- Training on medication safety during orientation of new clinicians (for example, medical, nursing and pharmacy)
- Competency assessment.

See the Resources section at the end of this standard for links to further information.

Applying quality improvement systems

Action 4.2

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:

a. Monitoring the effectiveness and performance of medication management

b. Implementing strategies to improve medication management outcomes and associated processes

c. Reporting on outcomes for medication management

Intent

Quality improvement systems are used to support effective medication management and reduce medicine-related risks.

Key tasks

- Review, measure, and assess the effectiveness and performance of, medication management strategies and practices
- Implement quality improvement strategies for medication management based on the outcomes of monitoring activities
- Provide information on the outcomes of quality improvement activities to the governing body, the workforce, consumers and other organisations.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' quality improvement systems.

- Action 1.8 – quality improvement systems
- Action 1.9 – reporting
- Action 1.11 – incident management and investigation systems

Health service organisations should use these and other established safety and quality systems to support monitoring, reporting and implementation of quality improvement strategies for medication management.

Safe medicine use requires:

- An understanding of the risks and barriers in the medication management pathway (Figure 1)
- Routine collection and monitoring of data to measure the performance of the medication management pathway, and act if required
- Mechanisms for learning from medication incidents and from identified risks in the medication management pathway that could jeopardise patient safety
- Mechanisms to show that the risk reduction strategies in place improve the safety and performance of medication management
- Careful planning when introducing new technology (for example, electronic medication management).

Monitor effectiveness and performance

Medication safety self-assessments are an important monitoring activity to identify structure, system and communication opportunities to proactively reduce harm and target risk mitigation strategies. Use the organisation's quality improvement systems to identify and prioritise the organisational and clinical strategies for medication management. Use assessment tools such as Medication Safety Self Assessment® for Australian Hospitals, or other internationally or locally developed (and endorsed) tools, to self-assess all or part of the organisation's medication management pathway. Medication Safety Self Assessment® tools are also available in specialist domains such as oncology and antithrombotic therapy, two areas of high risk for medication error and adverse events (linked to Action 4.15).

Areas to assess may include:

- Practices associated with procurement through to storage and destruction of unwanted medicines (including high-risk medicines – Action 4.15)
- Quality of, and access to, medicine-related information resources, decision support tools and documentation (for example, BPMH – Action 4.5)
- Information for patients (Action 4.3, 4.11 and 4.12).

Use a multidisciplinary team that includes frontline members of the workforce to conduct the assessment and obtain information on barriers to managing medicines safely. Review the results and compare them with any previous baseline assessments or audits to assess the impact of medication safety strategies.

Involve patients or consumers in these self-assessments by using surveys or focus groups, or including these in the organisation's processes for monitoring and responding to medicine-related complaints.

Other monitoring actions may include:

- Establishing a list of medicine-related indicators that reflect the organisation's usual range of medicines and their risk, along with the performance of medication management; use validated indicators such as the National Quality Use of Medicines Indicators for Australian Hospitals
- Using failure mode and effects analysis as a (prospective) proactive and 'preventive' process (see information from the Institute for Safe Medication Practices and the Institute for Healthcare Improvement)
- Auditing compliance with medication safety policies and procedures – for example, the use of cognitive impairment, delirium and falls assessment tools with respect to medicine use; or completion of venous thromboembolism risk assessment
- Conducting observation audits and walk-arounds to identify where corrective action might be required when breaches, violations or practice variations are observed
- Assessing the use of technology (for example, electronic medication management)
- Monitoring the occurrence of, analysing the frequency and causes of, and reporting on, medicine-related incidents, including ADRs (related to Actions 4.7–4.9)
- Capturing pharmacist interventions and using the data to identify further opportunities to improve medication management processes
- Collating feedback (including complaints) from surveys or focus groups, and the organisation's feedback and complaints management systems
- Seeking feedback on the quality, suitability and range of the medicine-related information provided to patients (for example, leaflets, brochures, medicines lists)
- Reassessing the system (or relevant components) regularly according to local, state or territory, or national requirements.

Implement quality improvement strategies

Use local, state or territory, national and international resources to identify solutions or risk mitigation strategies that might be useful, transferable and adaptable (links to Action 4.1).

Review strategies for medication management to ensure that:

- Risks identified using the various assessment, audit, survey and feedback mechanisms are logged in the risk management system
- Actions required to deal with any problems have been developed and included
- Responsibilities have been assigned.

Tools such as *Pathways for Medication Safety: Leading a strategic planning effort*[131] provide guidance on a model strategic plan for medication safety.

Eliminating error is a challenge. Strategies to reduce risks are detailed in Selecting the best error-prevention 'tools' for the job.[132]

Report outcomes

Report evaluation findings, adverse events and quality improvement activities to the governing body and the workforce. Use the data to work with consumers, the workforce, clinical leaders and managers to identify and implement improvements to the system for medication management.

Report on trend analysis (frequency and causes) of medicine-related incidents, including ADRs.

Partnering with consumers

Action 4.3

Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Intent

Clinicians partner with patients to minimise medicine-related risks.

Key tasks

- Review strategies in the Partnering with Consumers Standard to inform the implementation of actions in the Medication Safety Standard
- Provide information to patients about medication management tailored to their specific needs and level of health literacy.

Strategies for improvement

The Partnering with Consumers Standard has specific actions (Actions 2.3–2.10) relating to health service organisations' processes for involving patients in their own care, shared decision making, informed consent and effective communication.

The patient is the focus of the medication management pathway (Figure 1). Health service organisations should apply the principles of partnering with consumers, health literacy and shared decision making when developing, reviewing and implementing processes or practices within the medication management pathway.

Health service organisations should use established processes to partner with patients at key points in the medication management pathway, including when:

- Taking a BPMH (Action 4.5)
- Documenting a patient's history of medicine allergies and ADRs (Action 4.7)
- Assessing a patient's clinical needs for medication review (Action 4.10)
- Providing information to patients on their individual medicines needs and risks (Action 4.11)
- Providing patients with a current medicines list on discharge (Action 4.2).

Refer to the implementation strategies under each relevant action for more details.

Provide information for patients

Ensure that patients and carers have enough information about treatment options to make informed choices about their medicines and to adhere to medicine-related treatment plans. Providing patient information is the responsibility of everyone involved in the administration and prescribing processes, and when a medicine is dispensed. Provision of medicine-related information to a patient should be recorded in the patient's healthcare record.

Provide information in a form that is meaningful, easy to understand and use, and tailored to the diversity of the organisation's patient population. Consider the different languages used in the local community when selecting and developing medicine-related information for patients.

Action 4.11 contains specific strategies relating to the provision of information to patients on their individual medicines needs and risks. Organisations should refer to strategies in Action 4.11 when implementing Action 4.3.

Support shared decision making

Shared decision making can only occur when a patient understands what medicines are being proposed, the need for a new medicine, or why a change to therapy (including a dose change or ceasing a medicine) is being recommended.

Patients need to be involved in setting treatment goals and supported to understand the proposed outcomes of treatment.

Discussion about medicines should include:

- Duration of treatment
- Whether the medicine will cure their illness, or is required to control the symptoms of their chronic illness
- Untoward effects (for example, side effects, pain on administration) that the medicine may have.

Use the strategies outlined in Action 2.5 to identify and support patients who do not have the capacity to understand the risks of medicine use or make decisions about their care.

Medicines scope of clinical practice

Action 4.4

The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians

Intent

Clinicians work within their scope of clinical practice, and have the knowledge, skills, competence and delegated authority to safely manage, use and handle medicines.

Key tasks

- Identify all areas where specific authorisation is required to prescribe, dispense or administer medicines
- Use organisation-wide credentialing and scope of clinical practice processes to ensure that only authorised members of the workforce can prescribe, dispense or administer medicines
- Regularly assess qualifications, credentials and competence of the clinical workforce to safely prescribe, dispense and administer medicines.

Strategies for improvement

Credentialing and scope of clinical practice processes are key elements in ensuring patient safety. The aim is to ensure that only health practitioners who are suitably experienced, trained and qualified to practise in a competent and ethical manner can practise in health service organisations.[27]

The Clinical Governance Standard has specific actions for credentialing and scope of clinical practice.

- Action 1.23 – scope of clinical practice
- Action 1.24 – credentialing

Health service organisations should use these established systems and processes to support the implementation of this action.

Processes must be in place to ensure that only clinicians with the requisite authority prescribe, dispense and administer medicines. This authority is defined by both national and state or territory legislation. For many clinicians, this authority will be registration with the Australian Health Practitioner Regulation Agency (AHPRA). In some circumstances, the authority to administer medicines may be given by a state or territory. For example, registered nurses might be able to initiate and administer a limited selection of medicines without a prescription as part of a nurse-initiated medicines list.

The health service organisation may be responsible for establishing the qualifications and competence required by the clinicians and other members of the workforce working in extended roles – for example, nurses qualified to administer chemotherapy, clinicians authorised to administer intrathecal injection of chemotherapy, and nurses authorised to administer medicines against standing orders.

Clinicians' scope of clinical practice is likely to be defined by their professional background, qualifications, credentials or authority, acknowledged through AHPRA registration or endorsement.

An endorsement of registration recognises that a person has extra qualifications and expertise in an approved area of practice, and/or is provided for scheduled medicines.[133] See the AHPRA *Endorsement of Registration* fact sheet for more information.

Use organisation-wide credentialing and scope of clinical practice processes to support:

- Identification and description of all areas where specific authorisation is required to prescribe, dispense or administer medicines
- Assessment of qualifications and competencies at recruitment
- Inclusion of a clear definition of scope of clinical practice in job descriptions and contracts of employment
- Development and maintenance of a log or register for individual professions or positions for which an authority is required to prescribe, administer or dispense medicines.

Review organisational policies, procedures and guidelines to ensure regular assessment of qualifications and competence of clinicians to safely prescribe, dispense and administer medicines.

Consider strategies such as:

- Providing extra training and competency assessment when new medicines or formulations are introduced and when implementing electronic medication management
- Using simulation training for members of the workforce when they start work or if they are required to work under supervision.

CRITERION: Documentation of patient information

> *A patient's BPMH is recorded when commencing an episode of care. The BPMH, and information relating to medicine allergies and ADRs are available to clinicians.*

Ideally, all patients will receive a comprehensive medicines assessment before any decision to prescribe a new medicine.

Best possible medication history and medication reconciliation

A key component of this assessment is obtaining a thorough medication history, or a BPMH.

The BPMH is a snapshot of the patient's actual medication use, which may be different from information in their healthcare record, in the medicines list held by the patient, or provided by the patient's general practitioner. It is vital that the patient (or carer) is actively involved and that the health service organisation has a formal, systematic process in place for obtaining a BPMH.[134]

A BPMH is essential for:

- Ensuring continuity of medication management
- Identifying medicine-related problems
- Identifying potential medicine-related discrepancies
- Informing the decision-making process
- Optimising the use of medicines.

Medication histories are often incomplete, with medicines, strengths and doses missing, and over-the-counter and complementary medicines often omitted. Instituting a formal, systematic process for obtaining a BPMH on admission, and reconciling this history against the patient's medicines ordered on the medication chart reduces medication errors on admission by more than 50%.[135]

Reconciling medicines at care transition points has been shown to reduce medication errors by 50–94%.[136,137]

If not corrected, the errors can persist throughout the episode of care and after discharge. Inaccurate medication histories can lead to discontinuation of therapy, recommencement of medicines that have been ceased, inappropriate orders and failure to identify a medicine-related problem.

For planned admissions, the BPMH can be documented as part of the pre-admission process.

The medication management plan (MMP) is designed to document the BPMH and record the key steps of medication reconciliation. It is suitable for use in both adult and paediatric settings. The 'Medicines taken prior to presentation to hospital' section on the front of the NIMC and the PBS HMC may also be used to record the BPMH. Health service organisations may also develop alternative hard-copy or electronic forms – for example, within an electronic medication management system.

The MMP or equivalent form should be stored with the current NIMC throughout the episode of care.

Medicine allergies and adverse drug reactions

Medicine allergies and ADRs can be classified as:

- Known – those that have been previously experienced by the patient before their episode of care
- New – those that are experienced by patients during their episode of care and have not been previously experienced or documented.

The administration of medicines to patients with a known medicine allergy or previous ADR can be prevented by having mechanisms in place for alerting clinicians who prescribe, dispense and administer medicines. Information on a patient's known medicine allergies and ADRs can be collected on presentation to the health service organisation and recorded in the BPMH. Any new medicine allergies or ADRs should be recorded in the same place.

If there is any doubt about the nature of a medicine allergy (for example, an allergy to an antibiotic), there must be a process for clinicians to challenge and verify the diagnosis of true allergies. If a patient is not allergic, the patient's history and healthcare record will need to be modified, including removal of allergy alerts.[138]

Medicine allergies and ADRs are included in the definition of an adverse drug event. If a patient is given a medicine that is contraindicated (that is, there is a known allergy or ADR), they are at risk of experiencing preventable harm.[139]

To minimise the risk of preventable harm from adverse drug events, it is critical to ensure that clinicians understand their responsibility to refer to a patient's medicine allergy and ADR history before, or at the point of, decision-making when prescribing, dispensing or administering medicines.

All adverse drug events are expected to be reported using the organisation's incident monitoring system. Clinicians are also expected to report new suspected ADRs to the Therapeutic Goods Administration (TGA) – this provides important information about possible adverse effects for the TGA's safety monitoring program.

Medication reconciliation

Action 4.5

Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care

Intent

Patients and carers are actively involved in taking a BPMH as the first step in the process of medication reconciliation.

Key task

- Implement a systematic process for obtaining the patient's actual medicine use and recording a BPMH.

Strategies for improvement

Complete a BPMH as early as possible on admission – this is the key first step of a formal process of medication reconciliation. At least two sources of information are needed to obtain and then confirm the patient's BPMH – for example, the patient and their nominated general practitioner or community pharmacist.

A BPMH should be completed, or the process supervised, by a clinician with the required skills and expertise. Policies, procedures and guidelines for obtaining a BPMH should include:

- A structured interview process
- The key steps of the process
- Documentation requirements (where and what should be documented, such as use of the MMP or equivalent; paper or electronic)
- Roles and responsibilities of clinicians
- Training requirements for clinicians
- Involvement of patients and carers (links to Action 4.3).

Use a standard form for recording the BPMH. This may be the MMP, the section for medicines taken before presentation to hospital on the front of the NIMC or PBS HMC, or an electronic or paper-based equivalent. This creates 'one source of truth', and acts as an aid to reconciliation on admission, clinical handover, transfer and discharge.

Consider training requirements to ensure that clinicians with responsibility for obtaining a BPMH are sufficiently competent. Learning modules and instructional videos are available from various state, national and international organisations – links are provided in the Resources section at the end of this standard. These can guide clinicians on using a systematic approach to obtain and record an accurate and complete history of the medicines taken by patients at home, noting that specific techniques for taking a BPMH can influence its accuracy.

The BPMH and associated information should be easily accessible to all clinicians involved in managing the patient's medicines, and used to reconcile against medication orders on admission, at transfers of care and on discharge. At the end of an episode of care, verified information should be transferred and communicated effectively to the next health service organisation to ensure continuity of medication management.[140]

Action 4.6

Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care

Intent

A formal, structured, multidisciplinary and timely process is in place for reconciling medicines against the BPMH and treatment plan, which involves patients and carers.

Key task

- Implement a formal, structured process to ensure that all patients admitted to the health service organisation receive accurate and timely medication reconciliation on admission, at transfer of care and on discharge.

Strategies for improvement

Although specific aspects of medication reconciliation may be attributable to one professional group, medication reconciliation is everybody's business, and a multidisciplinary approach is crucial to success.

Medication reconciliation may occur:

- On admission – matching the current medicine orders with the BPMH, ideally within 24 hours of admission
- During the episode of care – verifying that the current list of medicines is accurately communicated each time care is transferred and when medicines are recharted
- On discharge – checking that medicines ordered on the discharge prescription match those on the discharge plan and the medicines list, and confirming that changes have been documented.

Prioritise medication reconciliation in patients who have a higher risk of experiencing medicine-related problems or ADRs, in a similar manner to prioritising or risk assessing patients for medication review (see Actions 4.10 and 4.12).

Review organisational policies, procedures and guidelines on medication reconciliation. These should include key steps of the medication reconciliation process and when these should occur (including at transfer of care and on discharge), roles and responsibilities of clinicians, training requirements for clinicians who are responsible for reconciling medicines, the involvement of patients and carers (links to Action 4.3), and documentation requirements, including where and what should be documented.

Review existing risk assessment criteria for patients who might benefit from medication reconciliation (links to Action 4.12).

Skills and training

Only clinicians with the requisite knowledge, skills and expertise should conduct medication reconciliation. These clinicians should be able to show competence in each of the steps of the medication reconciliation process.

Consider training requirements for clinicians who are responsible for reconciling medicines.

Action 4.7

The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation

Intent

Medicine-related risks for patients are minimised by documenting and referring to the patient's history of medicine allergies and ADRs.

Key task

- Document known patient medicine allergies and ADRs on presentation, and make this information available when clinicians prescribe, dispense and administer medicines.

Strategies for improvement

As part of a BPMH, clinicians must elicit and document known medicine allergies and ADRs experienced by a patient before their current admission (see Actions 4.4 and 4.6).

Review organisational policies, procedures and guidelines on recording known medicine allergies and ADRs in the patient's healthcare record. These should:

- Identify the clinician responsible for recording information on known medicine allergies and ADRs
- Outline what information to include (for example, type of reaction experienced, its severity, how it was managed)
- Describe what action should be taken if the nature of the documented reaction needs to be challenged or verified (for example, as a result of immunologist consultation), including instances of allergy mismatch
- Include criteria for the appropriate use of a coloured (red) patient allergy/ADR wristband
- Describe where and when it is appropriate to record a known allergy or adverse reaction to substances other than medicines, such as food, in the patient's medicine allergy and ADR history.

Ensure that known medicine allergies and ADRs are recorded:

- In the medication history (paper or electronic)
- On all forms on which medicines are ordered, such as national standard medication charts, ancillary charts and the anaesthesia record
- In electronic medication management and dispensing systems
- On ADR summary sheets or similar
- By using an alert sticker on hard-copy healthcare records
- By using electronic allergy/ADR alerts in digital healthcare records.

Provide orientation, training and education to clinicians, and review clinician work practices for:

- Determining and documenting known medicine allergies and ADRs in the patient's medicine allergy/ADR history, including the type of reaction, the severity and how it was managed
- Referring to a patient's medicine allergy/ADR history before, or at the point of, decision-making when prescribing, dispensing or administering medicines.

Conduct audits of documentation on medicine allergies and ADRs. These may focus on patients who have experienced previous medicine allergies or ADRs, the information that has been documented and where it has been documented (for example, in the medication chart, MMP or equivalent, discharge summary, medicines list, electronic medication management system). Data could be collected during an audit of the NIMC (linked to Action 4.8).

Collate and review audit trends, and provide information to clinicians through medication safety bulletins, in-service orientation sessions, case reports or grand rounds.

Action 4.8

The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system

Intent

Medicine allergies and ADRs experienced by patients while in the health service organisation are documented in the patient's medicine allergy/ADR history, and in incident management and investigation systems.

Key task

- Document and report medicine allergies and ADRs experienced by patients during their episode of care (see Actions 4.1 and 4.2).

Strategies for improvement

Document all new medicine allergies and ADRs by including them in the patient's existing history of medicine allergies and ADRs, to ensure that clinicians are alerted and can refer to this information when medicines are being prescribed, dispensed or administered.

Review organisational policies, procedures and guidelines on recording new medicine allergies and ADRs in the patient's healthcare record. These should:

- Identify the clinician responsible for managing and recording information on new medicine allergies and ADRs
- Ensure that all new medicine allergies and ADRs are reported within the organisation's incident management and investigation system
- Include criteria for the appropriate use of a coloured (red) patient allergy/ADR wristband
- Emphasise the importance of informing the patient about all new medicine allergies and ADRs, and informing other prescribers and members of their healthcare team
- Incorporate information on new allergies and ADRs at care transfer and handover
- Update the patient's medicines list (linked to Action 4.12)
- Inform the patient's general practitioner and other members of the patient's healthcare team (for example, community pharmacist) of all new medicine allergies and ADRs in the patient's transfer or discharge summary.

Ensure that new medicine allergies and ADRs are recorded in the organisation's incident reporting system and:

- In the medication history (paper or electronic)
- On all forms on which medicines are ordered, such as national standard medication charts, ancillary charts and the anaesthesia record
- In electronic medication management and dispensing systems
- On ADR summary sheets or similar
- By using an alert sticker on hard-copy healthcare records
- By using electronic allergy/ADR alerts in digital healthcare records.

Provide orientation, training and education to clinicians, and review clinician work practices for:

- Documenting new medicine allergies and ADRs in the patient's medicine allergy/ADR history, including the type of reaction, the severity and how it was managed
- Referring to a patient's medicine allergy/ADR history before, or at the point of, decision-making when prescribing, dispensing or administering medicines.

Audit documentation on medicine allergies and ADRs. These may include the medication chart, the MMP or equivalent, or the electronic medication management system. Data could be collected during an audit of the NIMC (linked to Action 4.7).

Collate and review trends in reported medicine allergies and audit results, and provide information to clinicians through medication safety bulletins, in-service orientation sessions, case reports or grand rounds.

Action 4.9

The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements

Intent

All new suspected ADRs experienced by patients during their episode of care are reported to the TGA.

Key task

- Report all new suspected ADRs experienced by patients to the TGA.

Strategies for improvement

Any adverse event that may have been caused by a medicine is a suspected ADR. Suspected ADRs that patients experience during their episode of care that have not been previously experienced or documented are considered to be new. Report these new suspected ADRs to the TGA's adverse event reporting system via the TGA website.

Assist communication and feedback about ADR reports by enrolling the health service organisation as a registered user when completing and submitting a report to the TGA's adverse event reporting system.

Registered organisations have access to information about their own reports through the TGA website or by contacting the TGA directly. Reports sent by email will only be accessible if the organisation's name and address are included in the report, and the reporter type is designated as 'hospital'.

Review current information and training

Review current organisational policies, procedures and guidelines to ensure that all suspected ADRs that patients experience during their episode of care are reported to the TGA. Include or refer to specific TGA information about:

- What to report
- How to report suspected ADRs
- How to maintain a record of the suspected ADR in the patient's healthcare record
- The process for a copy of the report to be sent to the organisation's pharmacy department, drug committee or equivalent, or medication safety governance group.

The health service organisation can include the capability to report suspected ADRs online to the TGA as part of its strategy for electronic medication management.

Provide orientation, training and education to clinicians on reporting suspected ADRs to the TGA. This should include the importance of providing comprehensive information about the patient, the medicine that is suspected of causing the reaction, the patient's concurrent medicines, the reaction they experienced and the organisation at which it was experienced.

Health service organisations can use online learning modules developed by the TGA for health professionals on reporting adverse events with medicines and vaccines.

Assess the quality, content and timeliness of ADR reports. Reports are most useful for detecting new safety issues if they are made soon after the reaction has occurred. Encourage clinicians to report ADRs by using awareness campaigns.

Access information on ADRs and medication safety issues by:

- Reading the Database of Adverse Event Notifications
- Reading the bimonthly Medicine Safety Updates publication
- Subscribing to the Medicine Safety Update email list
- Subscribing to the TGA Safety Information email list.

Communicate about ADRs

Collate and review ADRs that have been experienced and reported, and circulate information to clinicians through medication safety bulletins, in-service orientation sessions, case reports or grand rounds.

Include ADR reports for the relevant governance committee to consider as part of the review of the safety of the medication management pathway.

Provide patients with information about ADRs, how to recognise symptoms and how to self-report to the TGA. Both the TGA and NPS MedicineWise have information on their websites that is suitable for consumers.

CRITERION: Continuity of medication management

> *A patient's medicines are reviewed, and information is provided to them about their medicines needs and risks. A medicines list is provided to the patient and the receiving clinician when handing over care.*

There are multiple points of vulnerability in the medication management pathway when communication and focused partnership with the patient and/or their carer can contribute to achieving the best treatment outcome.

Medication review

Health service organisations need to consider how medication review, including medication reconciliation, can be built into existing work practices.

Medication review is a multidisciplinary responsibility and should be person centred. It ensures ongoing safe and effective use of medicines at all stages of the medication management pathway, including at the point of prescribing, dispensing and administering a medicine. Clinicians need to have the skill and expertise to conduct medication review, and have sound practices and processes for communication to implement recommended changes.

A well-structured medication review will minimise medicine-related problems and optimise the intended therapeutic outcomes for patients. Delivery models will vary across health service organisations. Medication review may need to be given a higher priority for patients with a higher risk of experiencing a medicine-related problem.

Medication review includes[141]:

- Prescription review – a technical review of a patient's medicines (for example, anomalies with medicine orders or prescriptions)
- Concordance and compliance review – a structured review to consider issues relating to a patient's medicines-taking behaviour (also called review of medicines use)[142]
- Clinical medication review – a structured review of medicines and clinical 'condition' with the patient (and/or their carer); an outcome of review could be cessation (or 'deprescribing') of a medicine.

Some reviews of a patient's medicines may be unstructured and opportunistic, with or without the patient's or carer's involvement.[142] These might include an isolated question or issue raised by a patient or clinician; clarification about a dose, formulation or name of a medicine; or monitoring requirements of a medicine.

Medication review provides a mechanism to partner with patients to optimise medicine use. This can help patients to:

- State their preferences and consider options to make fully informed decisions (links to Action 4.3)
- Manage their condition
- Improve their functional ability (for patients with long-term conditions)
- Reduce the time they spend in the health service organisation or the likelihood of readmission
- Enhance their quality of life, such as for patients with mental illness.

Information for patients

Patients and carers should be provided with enough information about medicine-related treatment options. This information needs to be in a form that is easy to understand and useful to patients.

Appropriate education and provision of written medicine-related information to patients are essential to encourage safe and effective medicine use, and promote adherence to treatment regimens. This may include the supply of a medicines list (or profile), education about the medicines and any changes, and consumer medicine information (CMI) leaflets.

When provided with quality information and education about medicines, many patients are able to:

- Be involved in decision-making, and consider the options, benefits and risks of the proposed treatment
- Make informed choices about their medicines – this is especially important when informed consent is required

- Assist in medication reconciliation and prevention of errors by identifying medicine-related problems
- Alert clinicians to suspected ADRs.

Providing information to patients is a multidisciplinary (medical, nursing and pharmacy) responsibility to ensure continuity of medication management.

Medicines list

Transfer of patients between clinicians, health service organisations and units within organisations provides opportunity for medication error if the communication of the patient's medicine-related information is incomplete or inaccurate.

More than 50% of medicine-related incidents occur at transitions of care, and around one-third of these have the potential to cause harm.[143,144] Omitting one or more medicines from a patient's discharge summary exposes patients to nearly 2.5 times the usual risk of readmission to hospital.[145]

All clinicians, including doctors, nurses and pharmacists, have a role and shared responsibility to ensure that accurate and complete medicine-related information, in the form of a medicines list, is communicated whenever care is transferred.

The medicines charted on the NIMC are considered a current list (as long as this information is based on a BPMH that has been verified; see Actions 4.5 and 4.6), and any changes to medicines are documented during the episode of care. These changes may be part of the clinician's decision-making process, or may be as a result of a recommendation following medication review (see Action 4.10).

Partnering with patients throughout the episode of care and providing a medicines list (accompanied by counselling) on discharge will:

- Help patients adhere to their medicines
- Empower patients and provide an opportunity to challenge the prescribing, dispensing or administration of potentially incorrect medicines
- Reduce the risk of patients taking incorrect medicines when they are discharged to the community or when their care is transferred.

Medication review

Action 4.10

The health service organisation has processes:

a. To perform medication reviews for patients, in line with evidence and best practice

b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems

c. That specify the requirements for documentation of medication reviews, including actions taken as a result

Intent

Medicines use is optimised and medicine-related problems are minimised by conducting medication reviews and documenting the outcomes in partnership with patients.

Key tasks

- Conduct evidence-based medication reviews on existing and newly prescribed medicines to optimise therapy for patients

- Set up processes for
  - determining who is responsible at each point in the medication management pathway
  - prioritising medication reviews for, and in partnership with, patients who are most at risk of a medicine-related problem
  - documenting any recommendations and action taken as a result of a medication review
  - identifying and monitoring trends in medicine-related problems, including those that have been prevented.

Strategies for improvement

Conduct evidence-based medication reviews

Ensure that medication reviews are conducted or supervised by a clinician with the appropriate skills and expertise, acting as part of a multidisciplinary team.[146] In large health service organisations, pharmacists may be the main provider of medication review services (often referred to as a clinical pharmacy service).[147] Although medication review is considered an inherent role of a pharmacist, medicines should also be reviewed by clinicians whenever decisions are being made about prescribing, dispensing and administering medicines.

For each medicine being reviewed, consider the clarity, validity and appropriateness of the medicine order, as well as the expected treatment outcomes. A patient's experience of using medicines and their needs may change over time, especially during an admission to a health service organisation. This means that medicines may be reviewed more than once during an episode of care.

Use medication reviews to understand the patient's experience with their current medicines and any newly prescribed medicines, and ensure that their medicine use is as safe as possible. This might include discussion of:

- When, how and whether the patient has been taking their prescribed medicines before admission to the health service organisation
- The patient's satisfaction with the outcomes from their medicines (including those newly prescribed), as well as a positive care experience – for example, no avoidable medicine-related problems[139]
- The patient's quality of life and life expectancy (for patients with long-term conditions).

Medication review should include assessment of current (existing and newly prescribed) medicines; the history of all medicine-related orders and administration records, including oral and parenteral, and multiple- and single-dose medicines; anaesthetic and operative records; and ceased medicine orders.

When conducting a medication review, consider the following:

- Is there a documented reason or evidence base for use of a medicine?
- Does the patient still need the medicine?
- Is the medicine still working?
- What risks are associated with use of the medicine, and what monitoring is required?
- Are there any patient-specific issues that will affect use of the medicine?

Guidance on conducting structured medication review includes:

- Society of Hospital Pharmacists of Australia *Quick Guide: Assessment of current medication management*
- National Institute for Health and Care Excellence *Medicines Optimisation: The safe and effective use of medicines to enable the best possible outcomes*
- National Prescribing Centre *A Guide to Medication Review 2008*.

Assess individual patient risk

Review the organisation's risk assessment criteria for patients admitted who might be at risk of a medicine-related adverse event. Include consideration of the patient's capacity to understand the risks of medicine use and make decisions about their medicines, and the need to involve carers or interpreters.

Assessment criteria for patients will depend on the patient casemix and services delivered by the organisation. For example, priority might need to be given to patients with a higher risk of experiencing a medicine-related adverse event.

Ensure that these criteria target patients who are most at risk, such as patients who:

- Are admitted as a result of a medicine-related problem
- Are taking multiple medicines or high-risk medicines
- Are taking medicines prescribed by multiple clinicians
- Have known or suspected adherence problems
- Have a chronic disease
- Have, or potentially have, a disability or impairment (for example, cognitive impairment)
- Are over 65 years old
- Have known allergies or ADRs.

Monitor the effectiveness of the organisation's risk assessment tool(s) by conducting audits using indicators.

Guidance for developing medicine-related risk assessment criteria includes:

- Society of Hospital Pharmacists of Australia's fact sheet *Risk Factors for Medication-Related Problems*[148]
- National Prescribing Centre's *A Guide to Medication Review 2008* (page 33).

Set up processes to set priorities for, and document, medication reviews

For medication review to be effective, health service organisations need to have a formal, structured process in place for medication review that is conducted in partnership with the patient, carer or family member, and in collaboration with relevant clinicians involved in the patient's care. Processes will depend on the infrastructure and resources available. A structured medication review will minimise medicine-related problems and optimise patients' therapeutic outcomes. Electronic medication management with integrated clinical decision support is useful in screening for at-risk patients (for example, those with medicine-related problems).

Review organisational policies, procedures and guidelines to ensure that they outline:

- When a medication review is warranted
- The roles and responsibilities of clinicians in the process
- Training requirements for clinicians responsible for medication review
- Involvement of patients and carers (see Action 4.3 and the Partnering with Consumers Standard)
- Documentation requirements for recommendations or requests as a result of the medication review, and any subsequent action taken
- The role of electronic medication management, if available, in integrated clinical decision support
- How trends in medicine-related problems within the health service organisation are monitored
- Discharge referral processes for those patients who did not receive a medication review while in the health service organisation (for example, refer to residential medication management review, home medicines review or non-admitted clinical pharmacy review; see the Independent Hospital Pricing Authority website for definitions).

Review risk assessment criteria for patients admitted to the health service organisation who might benefit from a structured medication review. Ensure that priority is given to patients with a higher risk of experiencing medicine-related problems or adverse drug events.

Guidance on developing risk assessment criteria includes the Society of Hospital Pharmacists of Australia's fact sheet *Risk Factors for Medication-Related Problems*.[148]

Use quality improvement methodology to monitor and implement change. This can be achieved by auditing and evaluating medication review processes using national, state or territory, or local indicators. Use validated indicators such as the National Quality Use of Medicines Indicators for Australian Hospitals (indicators 1.5 and 6.2).

Action 4.11

The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks

Intent

Clinicians are supported to provide information to their patients about medicines options, benefits and risks.

Key tasks

- Provide patients and carers with enough information about treatment options for them to make informed choices about their medicines, and to adhere to medicine-related treatment plans
- Support clinicians to provide medicine-related information when treatment options are discussed and when treatment decisions have been made.

Strategies for improvement

Actions 2.3–2.10 and Action 4.3 include requirements for organisation-wide processes for involving patients in their own care, shared decision making, informed consent and effective communication.

Refer to the strategies outlined for each of these actions when implementing Action 4.11.

Provide patients and carers with enough information

Providing medicine-related information is a multidisciplinary responsibility.

Provide medicine-related information in a form that can be used and understood by patients, and is sensitive to individual patients' needs (for example, culturally appropriate). This includes providing a package to patients and carers on discharge that contains relevant medicine-related information (Action 4.12). Discuss the benefits and associated risks of any medicines, and use patient-specific written information (such as CMI) to help inform the patient about the medicine.

Include a section on medicines in patient information brochures about general health service organisation care and services, and in patient charter documents. This will help to inform patients that medicine-related treatment options will be discussed and information will be provided about medicines prescribed.

Refer patients and carers to education programs that include medicine-related information, such as cardiac rehabilitation programs, or chemotherapy education sessions for oncology or haematology patients and carers.

Review policies, procedures and guidelines

Ensure that organisational policies, procedures and guidelines include the requirement to:

- Provide medicines information to patients and carers as part of the clinical consultation, using written information, if relevant, to help inform the patient about any new medicine
- Document in the healthcare record that patients and carers have been informed about the medicine; documentation may occur as a component of the consent process, within the patient's healthcare record (hard copy or digital), on the NIMC or on the MMP (or equivalent).

Review policies governing patient consent (Action 2.4) to include specific situations that require informed consent for treatment with a medicine (for example, Special Access Scheme medicines, off-label use of medicines).

Ensure that medicine-related information is available to clinicians

Ensure that clinicians have access to relevant, up-to-date medicine-related information (including reference materials and information tailored for patients) that is evidence based, at all stages of the medication management pathway (Action 4.13). This includes:

- When clinicians discuss associated risks of any medicines, as well as treatment options, with patients (for example, before making a decision to prescribe or deprescribe)
- When clinicians are counselling patients on the use of their prescribed medicines (for example, on discharge)
- When medicines are being dispensed (for example, provide patients with CMI)
- When medicines are being administered (for example, to educate patients on self-administration techniques, such as for inhalers or subcutaneous injections).

Use medicine-related information that has been tailored for patients, which has either been developed locally or sourced from reliable sites. Medicine-related information and materials that have been developed locally to meet a specific need must be endorsed by the organisation's medication safety governance group.

Patient-specific medicine-related information can be accessed from:

- Medicines.org.au, which provides access to up-to-date CMI, as well as product information for medicines available in Australia
- NPS MedicineWise Consumer medicine information (CMI) explained, which includes information about how to use CMI.

Guidance for producing locally developed information includes:

- The Australian Self-Medication Industry *Writing About Medicines for People: Usability guidelines for consumer product information, 3rd edition*
- The Australian Commission on Safety and Quality in Health Care (the Commission) *Tip Sheet 5: Preparing written information for consumers that is clear, understandable and easy to use*
- Medline Plus How to write easy-to-read health materials.

Promote the availability and use of consumer-specific medicine-related information, tools and resources to clinicians using communication strategies such as newsletters, presentations, in-service education sessions and awareness campaigns.

Evaluate medicines information

Evaluate the content and usefulness of locally developed consumer-specific resources by obtaining feedback from consumers and clinicians.

Audit healthcare records to determine whether provision of medicine-related information has been documented, and provide feedback to clinicians. This evaluation could target specific medicines or at-risk patient groups. Resources for guidance include:

- National Quality Use of Medicines Indicators for Australian Hospitals (in particular, indicators 5.4, 5.5 and 5.6)
- Local, or state or territory indicators.

Provision of a medicines list

Action 4.12

The health service organisation has processes to:

a. Generate a current medicines list and the reasons for any changes

b. Distribute the current medicines list to receiving clinicians at transitions of care

c. Provide patients on discharge with a current medicines list and the reasons for any changes

Intent

Medicine-related problems and risk of patient harm are minimised by maintaining a current medicines list with reasons for any changes, and providing it in a suitable format for clinicians at transfer of care and patients on discharge.

Key tasks

- Implement processes that support clinicians to generate and maintain current medicines lists throughout an episode of care
- Incorporate the use of medicines lists into clinical handover procedures
- Implement a process to provide current medicines lists and the reasons for any changes to patients on discharge.

Strategies for improvement

Implement processes to generate and maintain current medicines lists

Provide access to the system that supports medication management (including documenting medicines lists) in all clinical areas within the health service organisation to create 'one source of truth'. This reduces the risk of miscommunication and errors as the patient moves through the health service organisation. It also improves the quality of medicine-related information that accompanies the patient and ensures that it is available for clinical decision-making.

The system may be paper based (for example, the medicines list section in a manually prepared discharge summary) or electronic; however, paper-based systems provide greater opportunity for error and can be resource intensive.

Introduce work practices and service delivery models that link the production of medicines lists with prescribing processes and medication supply systems, to improve communication when transferring care.

Review organisational policies, procedures and guidelines for medication management and medication reconciliation (linked to Action 4.6) to include generating and maintaining a current medicines list on admission, and updating it when necessary during the episode of care and when transferring care. Consider:

- How and where the list will be accessed and maintained
- The minimum information to be documented (refer to the definition in the Glossary)
- The roles, responsibilities and accountabilities of clinicians
- Reconciling discrepancies and communicating updates or changes to the medicines list
- Assessing and managing the risks associated with maintaining and generating medicines lists
- Auditing the documentation on admission, and provision on discharge, of medicines lists using relevant indicators.

Review work practices for documenting a patient's current medicines when the patient is admitted to the health service organisation, and for maintaining a record in a standard format and in a consistent place, such as:

- On the PBS HMC
- On the MMP or equivalent
- On the NIMC
- In the electronic medication management system
- In the pharmacy's dispensing system
- In an alternative standalone electronic module, such as those developed and used by some states or territories (for example, Queensland Health's Enterprise-wide Liaison Medication System).

A standard procedure for transferring current medicines lists that contain at least the minimum requirements could include an electronic transfer summary, a copy of the current NIMC and MMP (or equivalent record), or an event summary in the patient's digital healthcare record.

Incorporate medicines lists into clinical handover procedures

Continuity of medication management includes generating, maintaining and communicating a current list of medicines and the reasons for changes at clinical handover (including shift changes and movement between clinical areas/wards; see Actions 6.7 and 6.8).

It is critical to communicate the patient's current medicines list, along with any medicine-related problems or adverse drug events that have occurred during a shift or episode of care (see Action 4.6). A medicine-related problem may include a patient refusing or missing a dose of medicine, or withholding a medicine.

Ensure that clinical handover training includes the principles of continuity of medication management, and the construction of a current medicines list and the reasons for changes, tailored for communicating to the intended audience (for example, clinicians or patients).

Ensure that policies, procedures and guidelines for clinical handover include communicating issues relating to a patient's medication management during their episode of care, and the roles, responsibilities and accountabilities of clinicians.

Establish a set of key elements relating to medication management in clinical handover, such as identifying high-risk patients, high-risk medicines, and the priorities for maintaining treatment and achieving patient treatment goals (see Action 4.3).

Rather than developing a separate handover tool, and in the absence of integrated electronic medication management, health service organisations may use the MMP (or equivalent form) along with the current NIMC to support the transfer of critical medicines information at clinical handover or when the patient is transferred, reinforcing the concept of 'one source of truth'.

Monitor and evaluate the process for communicating critical medicines information during clinical handover. Consider:

- Medicine-related incidents relating to inadequate information transfer
- Content and the quality of content
- Feedback and evaluation of information transfer tools.

Provide current medicines lists and reasons for any changes to receiving clinicians at transfer or on discharge

To improve communication about medicines and continuity of medication management, minimise delays, and reduce the risk of medicine-related problems after transfer or discharge:

- Provide a current reconciled medicines list, in a standard format (discharge summary, either paper or electronic), that includes the essential elements of the medicines list and an explanation of any changes made to therapy during the episode of care
- Prepare the medicines list in partnership with the patient
- Provide clear instructions for ongoing care and follow-up requirements, if relevant
- Ensure consistency between medicines lists that are
  - provided to the patient
  - in the discharge summary
  - in the patient healthcare record
- Resolve any discrepancies with prescriptions written on discharge before finalising the discharge medicines list

- If possible, transfer the medicines list electronically along with other discharge information to the patient's general practitioner and community pharmacy, and to the patient's digital healthcare record
- Incorporate the process of obtaining informed consent for transfer of medicines information to general practitioners and community pharmacists into standard work practices.

When transferring patients to other organisations, implement a standard procedure for transferring an updated medicines list and reasons for any changes. This could be an electronic transfer summary, or a copy of the current NIMC and MMP (or equivalent record).

Tailor the discharge format of the medicines list to the needs of the recipient (for example, the general practitioner, community pharmacist or other clinicians, as well as any organisation that the patient is being transferred to).

Extra documentation may be provided in specific situations, such as transfer to residential care facilities. This should be outlined in the relevant policies, procedures and guidelines.

Provide current medicines lists and reasons for any changes to patients on discharge

Provide information for patients and carers that explains the medicines list and its purpose as leaflets, brochures, posters or the health service organisation's patient information handbook (see Action 4.11 for other medicine-related information that would be expected to be provided on discharge). Tailor the discharge format of the medicines list to the needs of the patient.

Review organisational discharge policies, procedures and guidelines to include the requirement for a current medicines list to enable continuity of medication management.

Ensure that policies, procedures and guidelines outline:

- Who is responsible for preparing the medicines list and reconciling the content and its accuracy (for example, alignment with the discharge summary and medicines dispensed on discharge)
- The patients who should receive medicines lists; consider determining a priority for those patients most at risk of medicine-related problems, using existing or locally developed risk assessment tools that also consider health literacy and cognitive ability
- How patients and carers are involved in the process, and how their individual needs and risks are considered in the preparation of medicines lists (for example, consider a patient's usual medicine-taking routine or their ability to manage, including cognitive or physical impairment, or language barriers)
- The format of the list, which should be tailored to the patient's needs
- Incorporation of the medicines list into counselling of patients and carers (see Action 4.11).

Ensure that multidisciplinary discharge planning and work practices:

- Enable gaining of consent to supply a copy of the medicines list, reasons for changes, and any other essential medicine-related information to the patient's nominated community care providers, such as their general practitioner, community pharmacy, residential care provider or other clinician
- Include the practice of reconciling medicines
- Encourage preparation of medicines lists in partnership with patients
- Enable timely generation to ensure that patients and carers receive the updated medicines list on discharge
- Include discussion between the patient and the responsible clinician (for example, discharge counselling provided by a pharmacist) about the purpose and use of the medicines list, the need to keep it up to date, and the need to take it with them each time they visit a health service organisation, including whenever they go to hospital
- Make provision for an event summary to be loaded into the patient's digital healthcare record.

CRITERION: Medication management processes

> *Health service organisations procure medicines for safety. Clinicians are supported to supply, store, compound, manufacture, prescribe, dispense, administer, monitor and safely dispose of medicines.*

Many of the risks associated with each part of the medication management pathway can be avoided by using systems and processes that are designed to improve safety and are based on evidence from initiatives that have demonstrated significant benefit. These initiatives focus on addressing the common contributing factors in medication errors, which include[149]:

- Lack of knowledge of the medicine
- Lack of information about the patient
- Slips and memory lapses
- Transcription errors
- Failure in communication
- Lack of patient education
- Poor medicines distribution practices.

Medication safety initiatives should focus on systems and standardisation to reduce unnecessary variation, coupled with judicious use of tools and resources that improve knowledge and skills.

The actions and strategies described in this criterion aim to achieve safe and effective medicines use through:

- Best use of information and decision support tools in clinical decision-making
- Compliance and safety in medicines distribution and storage systems
- Targeting known risk areas (for example, high-risk medicines), and embedding processes, practices and tools within the organisation to prevent error
- Integration of work practices that underpin safe medication management (such as standardisation, monitoring and risk assessment)
- Using medication safety strategies and tools to create an environment for the best communication of medicine-related information (for example, using an MMP).

Actions within this criterion require health service organisations to:

- Make a variety of up-to-date and evidence-based medicine-related information and decision support tools available to clinicians
- Ensure the effectiveness of the supply chain in the safe delivery of medicines
- Ensure compliance with relevant requirements for maintaining the integrity of medicines, minimising wastage and disposing of medicines appropriately
- Implement strategies for safe and secure storage and selection of medicines, including high-risk medicines.

Information and decision support tools for medicines

Action 4.13

The health service organisation ensures that information and decision support tools for medicines are available to clinicians

Intent

Medication management is supported by providing relevant, up-to-date and evidence-based medicine-related information and decision support tools to the clinical workforce.

Key tasks

- Maintain a variety of up-to-date and evidence-based medicine-related information and decision support tools that assist clinicians with their responsibilities to provide safe and effective medication management
- Make up-to-date and evidence-based medicine-related information and decision support tools available to clinicians.

Strategies for improvement

Maintain a variety of up-to-date and evidence-based medicine-related information and decision support tools

Ensure that the content of medicine-related information and decision support tools is:

- Current, and consistent with evidence-based prescribing, dispensing, compounding and administration of medicines
- Suitable for the organisation's patient casemix, care delivery work practices and workflows
- Consistent with the organisation's policies, procedures and guidelines
- Available in several formats
- Integrated within the organisation's digital or electronic systems.

Decision support includes any functionality or resource that helps clinicians make the most appropriate decisions for patient care and provides guidance (for example, a medicine-related protocol) or incorporates knowledge (for example, an electronic database of medicine–medicine interactions).

Review the organisation's range of medicine-related information and decision support tools, including guidelines and protocols. Ensure that they are relevant to the organisation's range of clinicians, including those who prescribe medicines, dispense (and compound) medicines or administer medicines.

This review should be undertaken by the organisation's governance group responsible for medication safety, in consultation with clinicians. Any amendments to the existing range of resources could be recommended as a change at the state or territory level.

Ensure that processes are in place for maintaining up-to-date, evidence-based medicine-related information and decision support tools, and making available medicine-related information that is mandated by legislation. Ensure that these processes consider requirements for clinician training and education.

A minimum standard set of medicine-related reference materials could include current versions of:

- *Australian Medicines Handbook (AMH)* and *AMH Children's Dosing Companion*
- *Therapeutic Guidelines*
- *The Australian Immunisation Handbook*
- Australian product information and CMI, such as MIMS and AusDI
- Medicine interactions references, such as Micromedex or *Stockley's Drug Interactions*
- References on complementary and alternative medicines, such as MedlinePlus Drugs, herbs and supplements
- *Australian Injectable Drugs Handbook* or local injectable medicines administration guidelines
- *Don't Rush to Crush* handbook or local guidelines.

Examples of decision support tools are:

- Formulary information, prescribing requirements and approval systems
- Policy directives, protocols, guidelines and authorised standing orders
- Dosing calculators and medicine-interaction databases
- Reference texts, and telephone-based medicines information and advice services
- Guidelines for safe administration of specific medicines (for example, administering medicines via enteral tubes)
- Selection of treatment in specific clinical situations (for example, appropriate choice of antimicrobial).

Make up-to-date and evidence-based medicine-related information and decision support tools available to clinicians

Access to relevant, up-to-date, evidence-based medicine-related information (reference materials) and decision support tools is essential at all stages of the medication management pathway. It improves

clinical practice, improves work practice and workflow efficiencies, supports clinician learning and assists with the provision of information to patients.

A standard set of evidence-based reference materials may be available online through a centralised portal at the state or territory level and at the point of decision-making, including within clinicians' specialty areas of practice.

Explore and implement suitable technologies to deliver medicine-related information and decision support tools in clinical areas where medicines are prescribed, dispensed and administered – for example, smartphone apps, bedside/desktop computers, tablets and computers-on-wheels.

Include clinical decision support functionality when implementing electronic medication management systems. Comprehensive guidance on electronic decision support can be found in *Electronic Medication Management Systems: A guide to safe implementation*.

Implement electronic decision support tools as standalone modules when complete electronic medication management systems are not in place (for example, antibiotic approvals and antibiograms as components of antimicrobial stewardship) (see Actions 3.15 and 3.16).

Promote the availability and use of information sources (including how to contact medicines information services) and decision support tools using education and communication strategies, including newsletters, presentations, in-house education sessions, awareness campaigns and desktop icons.

Safe and secure storage and distribution of medicines

Action 4.14

The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the:

a. Safe and secure storage and distribution of medicines

b. Storage of temperature-sensitive medicines and cold chain management

c. Disposal of unused, unwanted or expired medicines

Intent

Medicines are safely stored and distributed with minimal waste, and disposed of appropriately.

Key tasks

- Identify risks associated with medicines handling, storage and distribution across the organisation, and develop and implement evidence-based strategies aimed at reducing these risks
- Implement systems and equipment that continuously monitor, and maintain the integrity of, temperature-sensitive medicines
- Implement policies, procedures and guidelines for the disposal of unused, unwanted or expired medicines.

Strategies for improvement

Identify and reduce risks

Review the effectiveness of the supply chain to deliver medicines in a way that is timely and secure, and that complies with manufacturer's instructions, and legislative and state or territory requirements for medicines.

Establish appropriate governance and oversight to ensure that medicine storage systems are safe and

inaccessible to the public, and the opportunity for diversion or theft is minimised (linked to Action 4.1).

Incorporate factors that reduce opportunity for 'look-alike, sound-alike' selection errors when considering (linked to Action 4.15):

- Product labelling, packaging and storage
- Listing of new medicines in the formulary
- Situations of temporary replacement of a formulary medicine (for example, when medicine shortages or supply chain interruptions occur)
- Contract specification and safe procurement (for example, anaesthetic medicines)
- Availability of medicines (review of ward stock or imprest lists)
- Design and layout (including workflow and safe access) of the dispensary and ward stock rooms or cupboards, their proximity (high- or low-traffic areas), and the labelling requirements in these areas.

Ensure that specific recommendations for the safe procurement and storage of anaesthetic medicines are included in any policies, procedures or protocols, to minimise risks from these medicines (linked to Action 4.15; also see *Guidelines for the Safe Management and Use of Medications in Anaesthesia*[150]).

Evaluate the use and implementation of storage or delivery systems (including automated systems) for safety, quality and security risks, including:

- 'End-to-end' delivery of accountable medicines, such as Schedule 8 medicines
- Automated dispensing cabinets (check these against essential requirements, such as those of the Institute for Safe Medication Practices in *Medication Safety Self Assessment® for Automated Dispensing Cabinets*
- Limiting the range of medicines suitable for pneumatic tube delivery.

Ensure that policies, procedures and protocols for safe handling, storage and distribution of medicines are evidence based and comply with legislative requirements, state or territory directives and professional guidelines. See the Society of Hospital Pharmacists of Australia's website for useful resources.

Perform a risk assessment of the processes in place for the handling, storage and distribution of medicines using validated or locally endorsed audit and risk tools (or relevant components), such as the Medication Safety Self Assessment® for Australian Hospitals.

Monitor and evaluate processes

Perform audits of compliance with policies, procedures and protocols for handling, storage and distribution of medicines. In particular, consider temperature-sensitive medicines and safety controls, such as separating look-alike packaging or electronic alerts.

Monitor usage patterns of medicines to identify unusual fluctuations.

Conduct observation audits and walk-arounds to review security, workflow, workforce access, and approval processes for access to medicine storage areas. Take corrective action when breaches, violations or practice variations are observed.

Review incident reports for incidents associated with handling (including procurement), storage and distribution of medicines.

Review the potential for increased risk of error when changes to product labelling, packaging or storage requirements are introduced as a result of changes to procurement arrangements and contracts, product shortages, recalls or substitution. Review and implement work practices that ensure safe and secure handling (including procurement), storage and distribution of medicines (including high-risk, investigational and clinical trial medicines) – for example (also see Action 4.15):

- Making opioids available only to clinicians with authorised access
- Providing clinicians with timely access to required medicines, given the casemix and acuity of the health service organisation.

Maintain the integrity of temperature-sensitive medicines

Having effective processes in place will ensure that problems are detected early, responded to promptly, and managed before the integrity (safety, quality, potency and efficacy) of temperature-sensitive medicines is compromised.

Effective storage and response requirements will prevent the risk of ineffective vaccines or medicines being administered. Specific guidance is included in the latest edition of *National Vaccine Storage Guidelines: Strive for 5*.

Develop guidance on effective processes to ensure the integrity of the cold chain that includes:

- Audits of temperature control of storage facilities, including room temperature, refrigeration and frozen storage
- Regular testing and maintenance schedules for temperature alarms and temperature recording devices
- Transportation or transfer of temperature-sensitive medicines between storage areas or facilities
- Workforce orientation and training on cold chain management
- Action required in the event of a cold chain breach or temperature excursion.

Review organisational policies, procedures and guidelines to ensure that the integrity of temperature-sensitive medicines is maintained.

Ensure that refrigerators (or coolrooms) of adequate size are available for the exclusive storage of vaccines or medicines that require storage between 2 °C and 8 °C.

Install alarms to monitor refrigerators and coolrooms, as well as medicine storage areas (including pharmacy departments), where temperatures would ideally be maintained below 25 °C (according to the manufacturer's instructions).

Install audible temperature alarms on refrigerators (or coolrooms) within pharmacy departments, clinical areas or as a 'back-to-base' mechanism to provide an early warning in the event of a temperature excursion.

Maintain power to all refrigerators and coolrooms within the health service organisation at all times.

Implement policies, procedures and guidelines for disposal of unused, unwanted or expired medicines

Review and implement work practices and distribution systems that minimise wastage of medicines, such as by regular checking of stock expiry dates and stock rotation.

Set up inventory management practices to eliminate wastage of medicines. Take a proactive and planned approach to changes to formulary listing, and conduct routine reviews of medicines use.

Review and implement work practices (for example, compounding of high-risk medicines such as multiple doses of cytotoxic chemotherapy) that minimise waste, ensure safe handling and promote the efficient use of medicines.

Review organisational policies, procedures and protocols for disposal of unused, unwanted or expired medicines to ensure:

- Minimal risk to the workforce and the environment (for example, cytotoxic chemotherapy, vaccines, hazardous substances)
- Consistency with legislative, health and safety, and state or territory requirements (for example, secure disposal of recordable [Schedule 8] medicines only by those with the relevant authority)
- Assignment of responsibility and accountability
- Consideration of situations when only part of a tablet, capsule, ampoule or infusion is required
- Appropriate waste segregation (for example, use of purpose-designed disposal bins).

Obtain patient consent for disposal of patients' own medicines brought into the health service organisation that are not prescribed, required, or returned to patients at transfer of care or on discharge.

Include specific requirements for waste segregation and disposal of medicines in the organisation's waste management policies and contracts. For instance, special arrangements must be made for handling and disposal of cytotoxic chemotherapy and radiopharmaceuticals.

Action 4.15

The health service organisation:

a. Identifies high-risk medicines used within the organisation

b. Has a system to store, prescribe, dispense and administer high-risk medicines safely

Intent

Medicine-related risks are minimised by identifying and safely managing processes relating to high-risk medicines.

Key tasks

- Regularly assess the use and misuse of high-risk medicines, relating to storage, prescribing, dispensing and administration
- Develop and implement evidence-based risk reduction strategies for high-risk medicines.

Strategies for improvement

Regularly assess use and misuse of high-risk medicines

Set up a structured framework for monitoring and review of high-risk medicines (and the frequency of these reviews) as part of routine governance of medication management (see Action 4.1). This could include:

- Monitoring and analysis of incident reports and logs
- Monitoring occurrence and reporting of ADRs (see Actions 4.7–4.9)
- Monitoring of published literature, including websites and bulletins from medication safety and patient safety organisations such as the Institute for Safe Medication Practices (which offers subscriptions to a regular bulletin)
- Assessing local situations regarding alerts, advisories and reports
- Conducting risk assessments and audits
- Conducting a failure mode and effects analysis on, for example, a new high-risk medicine or a high-risk process associated with medicine use.

Use validated indicators, such as the National Quality Use of Medicines Indicators for Australian Hospitals (indicators 1.3, 1.4, 1.5, 2.3, 3.6, 4.1, 4.2, 5.4, 6.1, 7.1, 7.2 and 7.4) and local, or state or territory indicators.

Perform audit and risk assessment of high-risk medicines using validated or locally endorsed audit and risk tools (or relevant components), such as:

- Medication Safety Self Assessment® for Australian hospitals
- Medication Safety Self Assessment® for antithrombotic therapy in Australian hospitals
- International Medication Safety Self Assessment® for oncology.

Refer to and adapt existing international assessments, audit tools or indicators that might be suitable for the health service organisation, such as those from the Institute for Safe Medication Practices, the National Health Service (NHS) National Patient Safety Agency, NHS Trusts and the Institute for Healthcare Improvement.

Perform audits of compliance with:

- Policies, procedures and protocols for storing, prescribing, dispensing, administering and monitoring specific high-risk medicines such as anticoagulants, aminoglycosides, chemotherapy, opioids, concentrated electrolytes and insulin
- Recommendations from national alerts on high-risk medicines (for example, potassium chloride, vincristine)

- Specific storage requirements for high-risk medicines, such as safety controls or segregation of concentrated electrolytes (for example, injectable potassium chloride) and physical security restricting access to opioids
- Documentation and records retention requirements (for example, drugs and poisons legislation)
- Procedures for labelling injectable medicines, fluids and lines.

Review and implement work practices relating to high-risk medicines that ensure:

- Appropriate storage and safe delivery systems for medicines such as anaesthetics, neuromuscular blocking agents, anticoagulants, aminoglycosides, cytotoxic chemotherapy (for example, vincristine), opioids and insulin
- Storage of, and access to, high-risk medicines comply with legislative requirements (for example, opioids only available to clinicians with authorised access)
- Safe prescribing (for example, standardised or specialised charts, using protocols or standard sets, electronic prescribing, dose-calculating tools)
- Accuracy in medicine selection and dispensing (for example, using barcode or similar product scanning technology, using Tall Man lettering)
- Appropriate controls are in place for compounding high-risk medicines (for example, using commercially available products or ready-to-administer preloaded syringes, standardised single concentrations for infusions, adhering to good manufacturing practices, using National Association of Testing Authorities–certified cytotoxic containment cabinets or similar, spill containment procedures)
- Safe procurement practices (for example, avoiding look-alike packaging for high-risk medicines, especially those used in high-risk procedures such as sedation)
- Safe administration (for example, appropriate use of equipment such as infusion pump drug libraries, oral liquid dispensers, line labelling for routes of administration, epidural lines without injection ports, standardised premixed solutions, independent double checks, principles of 'time out').

Develop and implement evidence-based risk-reduction strategies

Use or adapt tools that have been developed to identify the organisation's list of high-risk medicines, and make the list available to clinicians. Tools include the NSW Health High-risk Medicines Management Policy and the Institute for Safe Medication Practices List of High-Alert Medications in Acute Care Settings.

Determine which contributing factors (environmental, task, individual, team) underlie high-risk medicine-related incidents to assist the development of strategies and policies specific to the health service organisation that can be used to deal with these factors on several levels (see Action 4.2).

Implement a combination of risk reduction strategies that includes low-leverage (education) and high-leverage (NIMC, decision support software) standardisation processes[132], practices and products for medication management (for example, implementation of Tall Man lettering, use of smart infusion pumps).

Develop policies, procedures and guidelines

Implement high-risk medicine-related policies, procedures, guidelines and safe work practices that are evidence based, have been developed in collaboration with relevant clinicians, and include:

- Identifying and regularly reviewing a high-risk medicines list (which can be class or medicine specific) that reflects a subset of the organisation's usual range of medicines
- Assessing and rating risks for individual high-risk medicines, their class and system risk(s), and how these risks are to be mitigated (for example, how to avoid medicine misuse for aminoglycosides or opioids, which is likely to be associated with devastating patient outcomes)
- Training requirements (for example, for the prescribing and administration of cytotoxic chemotherapy), including orientation and ongoing education on medication safety (for example, training and assessment of competence using simulation)

- Labelling and storage requirements (for example, implementing the *National Standard for User-Applied Labelling of Injectable Medicines, Fluids and Lines*, separate storage of highly concentrated electrolyte solutions such as injectable potassium chloride or magnesium)
- Patient-specific protocols for monitoring requirements that will ensure a prompt response to adverse events or side effects associated with treatment
- Availability of antidotes and reversal agents, and rescue protocols
- Work practice restrictions and access authorities, as necessary
- Incident reporting requirements
- Managment of breaches, violations or practice variations.

Incorporate factors that contribute to safer use of high-risk medicines, or that reduce the opportunity for misuse or error, when considering:

- Medicines on the formulary (for example, listing a new medicine, contract specification and procurement, temporary replacement during a shortage)
- Availability of medicines (prescribing restrictions, review of ward stock or imprest lists and stock levels)
- Design and layout of the dispensary and ward stockrooms or cupboards, and labelling requirements in these areas, including selection of medicine distribution system (individual dispensing, bedside locked drawers, automated medicine cabinets)
- Alerts in electronic medication management systems.

Consider protocols for vulnerable populations, including patients who are older or obese, or children.

Analyse incidents

Investigate incidents involving high-risk medicines, analyse the frequency and causal factors, and implement strategies to mitigate risks associated with high-risk medicine-related incidents.

Use recommendations from high-risk medicine-related incident analysis to make relevant system-wide changes within the organisation.

Apply safe and robust design principles to processes. Ensure that recommendations from national, state or territory and local policies, alerts, incident reports and audits are actioned.

Communicate about high-risk medicines

Provide feedback for clinicians on high-risk medicine-related incidents and risk prevention strategies.

Promote medication safety awareness of high-risk medicines through regular communication to clinicians via memos, alerts, fact sheets, email broadcasts, newsletters, posters, presentations, in-house education sessions, awareness campaigns, lanyards or screensavers.

Tailor communications on high-risk medicines for patients and carers, which might include instructions on monitoring symptoms or side effects, and when to ask a clinician for assistance.

Monitor effectiveness and performance

Re-audit as necessary to show that recommended strategies for improvement have been implemented and outcomes sustained.

When assessing the effectiveness of strategies, establish both outcome and process measures, and routinely collect data to assess the effectiveness of risk reduction strategies for high-risk medicines. Share results as part of the governance of medication management (see Action 4.1 and 4.2).

Resources

Governance, policies and procedures

Australian Government Department of Health – National Medicines Policy

Australian Pharmaceutical Advisory Council – *Guiding Principles to Achieve Continuity in Medication Management*

Council of Australian Therapeutic Advisory Groups – *Achieving Effective Medicines Governance: Guiding principles for the roles and responsibilities of drug and therapeutics committees in Australian public hospitals*

SA Health – Continuity in medication management

Training

Australian Commission on Safety and Quality in Health Care – *National Patient Safety Education Framework*

Australian Commission on Safety and Quality in Health Care – National standard medication charts course

NPS MedicineWise – Prescribing Competencies Framework

World Health Organization – *Patient Safety Curriculum Guide: Multi-professional edition*, Topic 11: Improving medication safety

State and territory medication safety sites

NSW Clinical Excellence Commission – Medication safety and quality

Queensland Health – Medication safety

SA Health – Medication safety

Tasmanian Department of Health and Human Services – *Medication Systems and Management Policy*

Victorian Department of Health and Human Services – Quality use of medicines

Western Australian Department of Health – Medication safety alerts

Assessment and performance of the medication management pathway

Australian Commission on Safety and Quality in Health Care, and NSW Therapeutic Advisory Group – *National Quality Use of Medicine Indicators for Australian Hospitals*

Institute for Healthcare Improvement – Failure Modes and Effects Analysis Tool

NSW Clinical Excellence Commission – Medication Safety Self Assessment® for Australian Hospitals

Reducing medicine-related risks

American Hospital Association, Health Research and Educational Trust, Institute for Safe Medication Practices – *Pathways for Medication Safety: Leading a strategic planning effort*

Institute for Safe Medication Practices – Selecting the best error-prevention 'tools' for the job

Society of Hospital Pharmacists of Australia – *Fact Sheet: Risk factors for medication-related problems*

Scope of clinical practice and credentialing

NPS MedicineWise – Prescribing Competencies Framework

Nursing and Midwifery Board of Australia – Framework for assessing standards for practice for registered nurses, enrolled nurses and midwives

Pharmaceutical Society of Australia – *National Competency Standards Framework for Pharmacists in Australia*

Information for consumers

Medicines.org.au

NPS MedicineWise – Medical info

Pharmaceutical Society of Australia – *Guide to Providing Pharmacy Services to Aboriginal and Torres Strait Islander People*

Society of Hospital Pharmacists of Australia – SHPA Standards of Practice for Medicines Information Services

Medication reconciliation

Agency for Healthcare Research and Quality – *Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation*

Australian Commission on Safety and Quality in Health Care – Medication reconciliation

Institute for Safe Medication Practices Canada – Medication reconciliation

NPS MedicineWise – Get it right! Taking a bestpossible medication history

NSW Clinical Excellence Commission – Comprehensive Audit Tool

Society of Hospital Pharmacists of Australia – *Quick Guide: Facilitating the continuity of medication management on transition between care settings*

Society of Hospital Pharmacists of Australia – *Quick Guide: Medication reconciliation*

Victorian Department of Health – Medication reconciliation

World Health Organization – *High 5s Fact Sheet: The High 5s assuring medication accuracy at transitions of care – medication reconciliation standard operating protocol*

Assessment and monitoring of allergy and ADR recording

Australian Commission on Safety and Quality in Health Care – medication charts and user guides

NPS MedicineWise – Safety through adverse event reporting

Society of Hospital Pharmacists of Australia – *Quick Guide: Clinical review, therapeutic drug monitoring (TDM) and adverse drug reactions (ADRs)*

Sydney Children's Hospitals Network – *Adverse Drug Reaction Practice Guideline*

Therapeutic Goods Administration – Database of Adverse Event Notifications

Therapeutic Goods Administration – Reporting adverse drug reactions

Medication review

National Health Service – *A Guide to Medication Review 2008*

SA Health – *Continuity in Medication Management: A handbook for South Australian hospitals*, Principle 5: Medication review and reconciliation

Society of Hospital Pharmacists of Australia – *Quick Guide: Assessment of current medication management*

Society of Hospital Pharmacists of Australia – Standards of Practice for Clinical Pharmacy Services, Chapter 1: Medication reconciliation

Western Australian Department of Health – Pharmaceutical review

Medicines list

Australian Commission on Safety and Quality in Health Care – National Medication Management Plan

NPS MedicineWise – Keeping a medicines list

Information for clinicians and decision support tools

Australian Commission on Safety and Quality in Health Care – Electronic medication management (EMM) resources

Australian Government Department of Health – *The Australian Immunisation Handbook*

Institute for Safe Medication Practices Canada and Canadian Patient Safety Institute – *Paper to Electronic MedRec Implementation Toolkit*

Royal Australian College of General Practitioners, Pharmaceutical Society of Australia, and Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists – *Australian Medicines Handbook*

Therapeutic Guidelines Limited – *Therapeutic Guidelines*

Storage, distribution and disposal

Australian and New Zealand College of Anaesthetists – *Guidelines for the Safe Management and Use of Medications in Anaesthesia*

Australian Commission on Safety and Quality in Health Care – *National Standard for User-Applied Labelling of Injectable Medicines, Fluids and Lines*

Australian Commission on Safety and Quality in Health Care – *National Tall Man Lettering List*

Australian Government Department of Health and Ageing – *National Vaccine Storage Guidelines: Strive for 5*

Institute for Safe Medication Practices – *Medication Safety Self Assessment for Automated Dispensing Cabinets*

Western Australian Department of Health – Safe storage of medications

High-risk medicines

Australian Commission on Safety and Quality in Health Care – High-risk medicines

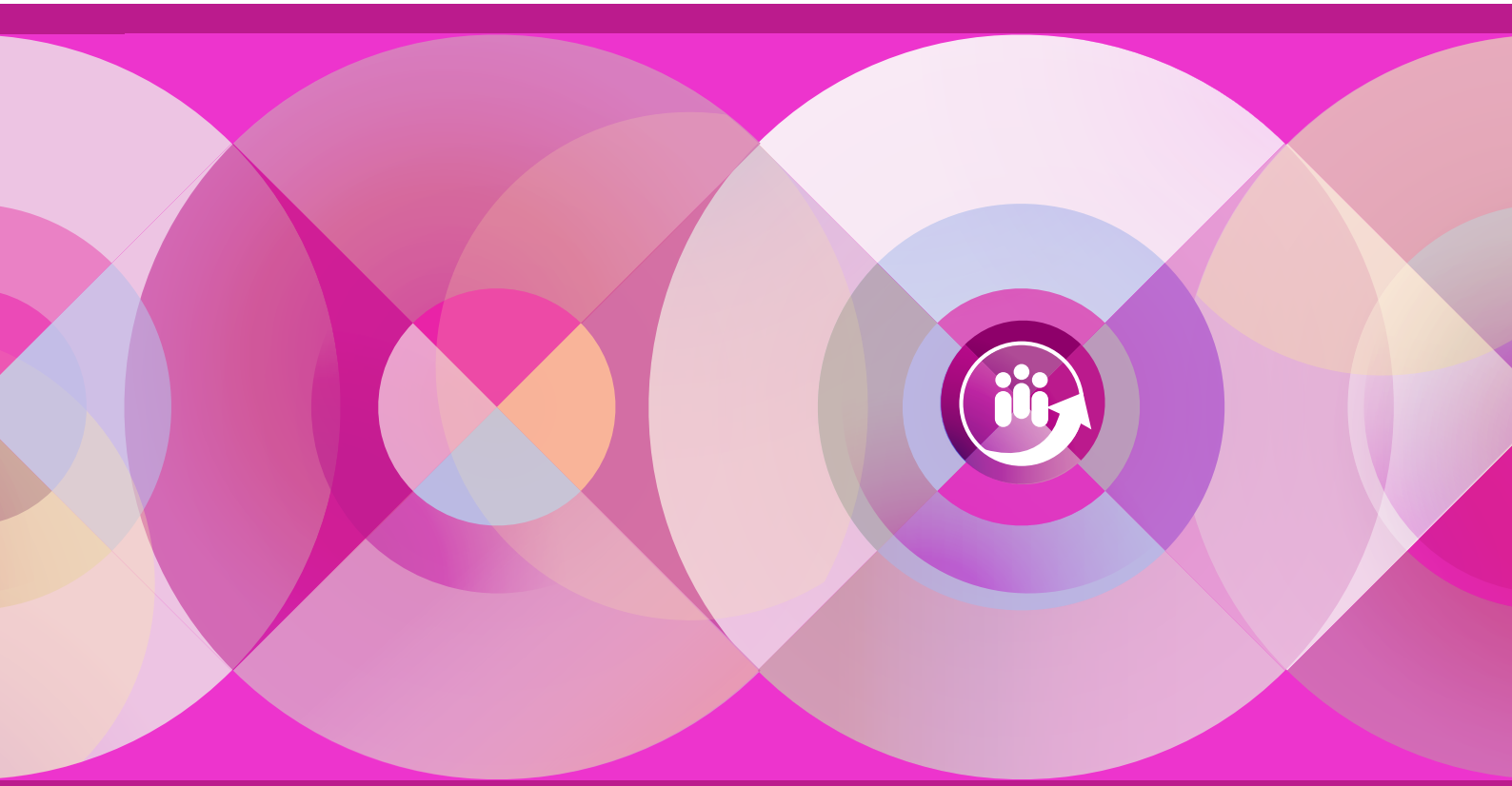
Institute for Safe Medication Practices – ISMP high-alert medications

NSW Clinical Excellence Commission – Medication safety and quality: high-risk medicines

Victorian Department of Health – High-risk medicines

5

Comprehensive Care Standard



Comprehensive Care Standard

Leaders of a health service organisation set up and maintain systems and processes to support clinicians to deliver comprehensive care. They also set up and maintain systems to prevent and manage specific risks of harm to patients during the delivery of health care. The workforce uses the systems to deliver comprehensive care and manage risk.

Intention of this standard

To ensure that patients receive comprehensive care – that is, coordinated delivery of the total health care required or requested by a patient. This care is aligned with the patient's expressed goals of care and healthcare needs, considers the effect of the patient's health issues on their life and wellbeing, and is clinically appropriate.

To ensure that risks of harm for patients during health care are prevented and managed. Clinicians identify patients at risk of specific harm during health care by applying the screening and assessment processes required in this standard.

Criteria

Clinical governance and quality improvement to support comprehensive care

Developing the comprehensive care plan

Delivering comprehensive care

Minimising patient harm

Introduction

Safety and quality gaps are often reported as failures to provide adequate care for specific conditions, or in specific situations or settings, or to achieve expected outcomes in certain populations. The purpose of this standard is to address the cross-cutting issues underlying many adverse events. These issues often include failures to:

- Provide continuous and collaborative care
- Work in partnership with patients, carers and families to adequately identify, assess and manage patients' clinical risks, and find out their preferences for care
- Communicate and work as a team (that is, between members of the healthcare team).

Processes for delivering comprehensive care will vary, even within a health service organisation. Take a flexible approach to standardisation so that safety and quality systems support local implementation and innovation. Target screening, assessment, comprehensive care planning and delivery processes to improve the safety and quality of care delivered to the population that the organisation serves.

Although this standard refers to actions needed within a single episode of patient care, it is essential that each single episode or period of care is considered as part of the continuum of care for a patient. Meaningful implementation of this standard requires attention to the processes for partnering with patients in their own care and for safely managing transitions between episodes of care. This requires that the systems and processes necessary to meet the requirements of this standard also meet the requirements of the Partnering with Consumers Standard and the Communicating for Safety Standard.

Minimising patient harm

Implement targeted, best-practice strategies to prevent and minimise the risk of specific harms identified in this standard.

Pressure injuries

Pressure injuries can occur in patients of any age who have one or more of the following risk factors: immobility, older age, lack of sensory perception, poor nutrition or hydration, excess moisture or dryness, poor skin integrity, reduced blood flow, limited alertness or muscle spasms.[151] Evidence-based strategies to prevent pressure injuries should be used if screening identifies that a patient is at risk.

Falls

Falls also occur in all age groups. However, the risk of falls and the harm from falls vary between individuals as a result of differences in factors such as eyesight, balance, cognitive impairment, muscle strength, bone density and medicine use. The Australian Commission on Safety and Quality in Health Care (the Commission) has developed evidence-based guidelines for older people.[152-154] Policies and procedures for other age groups need to be based on available evidence and best practice.

Poor nutrition

Patients with poor nutrition, including malnutrition, are at greater risk of pressure injuries, and their pressure injuries are more severe.[155,156] They are also at greater risk of healthcare-associated infections and mortality in hospital, and for up to three years following discharge.[157-161] Malnutrition substantially increases length of hospital stay and unplanned readmissions.[159,160,162] Ensure that patients at risk of poor nutrition are identified and that strategies are put in place to reduce these risks.

Cognitive impairment

People with cognitive impairment who are admitted to hospital are at a significantly increased risk of preventable complications such as falls, pressure injuries, delirium and failure to return to premorbid function, as well as adverse outcomes such as unexpected death, or early and unplanned entry into residential care.[163] People with cognitive impairment may also experience distress in unfamiliar and busy environments. Although cognitive impairment is a common condition experienced by people in health service organisations, it is often not detected, or is dismissed or misdiagnosed. Delirium can be prevented with the right care[164], and harm can be minimised if systems are in place to identify cognitive impairment and the risk of delirium, so that strategies can be incorporated in the comprehensive care plan and implemented.

Unpredictable behaviour

People in healthcare settings can exhibit unpredictable behaviours that may lead to harm. Health service organisations need systems to identify situations that have higher risk of harm, and strategies to mitigate or prevent these risks. They also need systems to manage situations in which harm relating to unpredictable behaviour occurs. In this standard, unpredictable behaviours include self-harm, suicide, aggression and violence. It is important that systems designed to respond to the risks of unpredictable behaviour minimise further trauma to patients and others. This relates to both the material practices and the attitude with which care is delivered.

Processes to manage people who have thoughts of harming themselves, with or without suicidal intent, or who have harmed themselves are needed. These processes need to provide physical safety, and support to manage psychological and other issues contributing to self-harm. The health service organisation is responsible for ensuring that follow-up services are arranged before the person leaves the health service because of the known risks of self-harm after discharge.[165]

Some people are at higher risk of aggressive behaviour as a result of impaired coping skills relating to intoxication, acute physical deterioration or mental illness. Healthcare-related situations, such as waiting times, crowded or high-stimulus environments and conflicts about treatment decisions, can precipitate aggression. Members of the workforce need skills to identify the risk of aggression, and strategies to safely manage aggression and violence when they do occur.

Restrictive practices

Minimising or, if possible, eliminating the use of restrictive practices (including restraint and seclusion) is a key part of national mental health policy.[166,167] Minimising the use of restraint in other healthcare settings besides mental health has also been identified as a clinical priority. Identifying risks relating to unpredictable behaviour early and using tailored response strategies can reduce the use of restrictive practices. Restrictive practices must only be implemented by members of the workforce who have been trained in their safe use. The health service organisation needs processes to benchmark and review the use of restrictive practices.

Key links with other standards

To implement systems that meet the requirements of the Comprehensive Care Standard, identify areas of synergy with the other NSQHS Standards. This will help to ensure that the organisation's safety and quality systems, policies and processes are integrated, and will reduce duplication of effort.

CRITERION: Clinical governance and quality improvement to support comprehensive care

> *Systems are in place to support clinicians to deliver comprehensive care.*

Taking an organisation-wide and systematic approach to the delivery of comprehensive care will help to ensure consistent experiences of comprehensive care for patients, and consistent expectations for clinicians and other members of the workforce about how to deliver comprehensive care.

This criterion requires organisation-wide governance, leadership and commitment to support delivery of comprehensive care and minimise patient harm.

To meet this criterion, health service organisations are required to:

- Integrate clinical governance and apply quality improvement systems
- Apply principles of partnering with consumers, health literacy and shared decision making when developing and implementing organisational processes for comprehensive care and minimising patient harm
- Implement organisational systems and processes to support effective delivery of comprehensive care and minimise patient harm.

This criterion aligns closely with the Clinical Governance Standard and the Partnering with Consumers Standard.

Integrating clinical governance

Action 5.1

Clinicians use the safety and quality systems from the Clinical Governance Standard when:

a. Implementing policies and procedures for comprehensive care

b. Managing risks associated with comprehensive care

c. Identifying training requirements to deliver comprehensive care

Intent

Safety and quality systems support clinicians in the delivery of comprehensive care and minimising patient harm.

Key tasks

- Establish and implement governance structures for comprehensive care and minimising patient harm
- Develop and implement policies and procedures for comprehensive care and minimising patient harm
- Use organisation-wide risk management systems to identify, monitor, manage and review risks associated with comprehensive care and minimising patient harm
- Deliver or provide access to training on comprehensive care and minimising patient harm based on the patient population and the specific needs of the workforce.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' safety and quality systems.

- Action 1.7 – policies and procedures
- Action 1.10 – risk management systems
- Actions 1.19, 1.20 and 1.21 – education and training

Health service organisations should:

- Use these and other established safety and quality systems to support the policies and procedures, risk management and training for comprehensive care and minimising patient harm
- Ensure that current versions of all relevant policies and procedures are readily available and accessible to clinicians.

Policies may be developed or adapted at different levels within the organisation. However, all policy documents should be incorporated into a single, coherent set to maximise the effectiveness of the policy development process.

Implement policies and procedures

Provide guidance about aspects of comprehensive care in policies and procedures, such as:

- Performing a risk assessment of the population served and the services provided to inform decisions about required screening and assessment processes
- Using organisation-wide integrated screening and assessment processes
- Ensuring shared decision making in the context of comprehensive care planning, and in making decisions about end-of-life care
- Documenting screening and assessment findings, the outcome of shared decision making processes, agreed goals of care and comprehensive care plans
- Outlining the roles, responsibilities and accountabilities of multidisciplinary team members in developing, documenting, evaluating and reviewing comprehensive care plans, and delivering comprehensive care
- Using processes for identifying patients with end-of-life care needs; receiving, documenting and using advance care plans; accessing supervision and support; and reviewing the safety and quality of end-of-life care
- Using processes relating to the specific harms identified in the 'Minimising patient harm' criterion of this standard.

Manage risks

Use established risk management systems (see Action 1.10) to identify, monitor, manage and review risks associated with comprehensive care. Develop processes to manage clinical risks for different populations served within the organisation, clinical and workplace risks for the workforce, and organisational risks.

Use information from measurement and quality improvement systems, adverse events, clinical outcomes and patient experiences to inform and update risk assessments and the risk management system.

Identify training requirements

Assess the competency and training needs of the workforce in line with the requirements of Actions 1.19, 1.20 and 1.21. Perform a risk assessment to inform the training schedule and to set priorities for the members of the workforce who require training. Develop or provide access to training and education resources to meet the needs of the workforce in relation to comprehensive care.

Consider the training the workforce may need to effectively use the clinical incident management and investigation system to inform risk management, and to plan and implement quality improvement processes to mitigate risks.

Action 5.2

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:

a. Monitoring the delivery of comprehensive care

b. Implementing strategies to improve the outcomes from comprehensive care and associated processes

c. Reporting on delivery of comprehensive care

Intent

Quality improvement systems are used to support the delivery of comprehensive care and minimise patient harm.

Key tasks

- Review, measure, and assess the effectiveness and performance of, organisational and clinical strategies to deliver comprehensive care and minimise patient harm
- Implement quality improvement strategies for comprehensive care and minimising patient harm based on the outcomes of monitoring activities
- Provide information on the outcomes of quality improvement activities to the governing body, the workforce, consumers and other organisations.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' quality improvement systems.

- Action 1.8 – quality improvement systems
- Action 1.9 – reporting
- Action 1.11 – incident management and investigation systems

Health service organisations should use these and other established safety and quality systems to support monitoring, reporting and implementation of quality improvement strategies for comprehensive care.

Monitor effectiveness and performance

Use the organisation's quality improvement systems to identify and set priorities for the organisational and clinical strategies to deliver comprehensive care and minimise patient harm.

Review these systems to ensure that they include requirements for:

- Intermittent audits of documentation on screening and assessment processes, patient preferences and goals, and shared decision making
- Ongoing data collection about processes such as patient admission and discharge, hourly rounding, multidisciplinary team rounds and meetings, clinical handover, and discharge planning
- Ongoing data collection about outcomes such as length of stay, the alignment of documented patient preferences with actual care, patient experiences, and the prevalence of adverse events associated with this standard (for example, falls, pressure injuries, delirium, restraint)
- Periodic surveys of workforce attitudes and patient experiences of using the system for comprehensive care

- Regular, informal quality checks of patient, carer and family experiences and perspectives (for example, conducting five-minute interviews at the bedside or in the waiting room).

Implement quality improvement strategies

Use the results of monitoring activities to show improvements or areas in which improvement is required. If appropriate, use quality improvement activities that are consistent and measurable across the corporate group, network or health service.

Use the results of organisational risk assessments to identify gaps, plan, and set priorities for areas for investigation or action.

When adverse events occur, specifically investigate to identify any issues in the performance or use of the system for comprehensive care. Use this information to make improvements.

Report outcomes

Report evaluation findings to the governing body and the workforce. Use the data to work with consumers, the workforce, clinical leaders and managers to identify and implement improvements to the system for comprehensive care.

Strategies for monitoring, preventing and minimising specific risks of harm can be found in the 'Minimising patient harm' criterion of this standard.

Partnering with consumers

Action 5.3

Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Intent

Clinicians partner with patients when providing comprehensive care and minimising patient harm.

Key tasks

- Review strategies in the Partnering with Consumers Standard to inform the implementation of actions in the Comprehensive Care Standard
- Provide information to patients about comprehensive care and minimising patient harm tailored to their specific needs and level of health literacy.

Strategies for improvement

The Partnering with Consumers Standard has specific actions (Actions 2.3–2.10) relating to health service organisations' processes for involving patients in their own care, shared decision making, informed consent and effective communication.

Use patient experience data to evaluate whether clinicians are actively involving patients in their own care, meeting patient information needs and making shared decisions when providing comprehensive care. If a patient has impaired capacity for making decisions about their own care,

then decision-making support or the involvement of a substitute decision-maker may be required.

Actions in the 'Minimising patient harm' criterion of this standard require specific strategies for partnering with patients in their care including:

- Providing information to patients, carers and families about preventing pressure injuries (Action 5.23) and falls (Action 5.26)
- Collaborating with patients, carers and families to manage or minimise risks of
  - delirium (Action 5.30)
  - self-harm and suicide (Action 5.31)
  - aggressive or violent behaviour (Action 5.34).

Designing systems to deliver comprehensive care

Action 5.4

The health service organisation has systems for comprehensive care that:

a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment

b. Provide care to patients in the setting that best meets their clinical needs

c. Ensure timely referral of patients with specialist healthcare needs to relevant services

d. Identify, at all times, the clinician with overall accountability for a patient's care

Intent

The health service organisation provides systems to enable and support the delivery of comprehensive care to patients.

Key tasks

- Work with clinicians and consumers to design and implement systems for developing, documenting and communicating comprehensive care plans
- Implement systems to ensure that patients receive care in the setting that best meets their clinical needs
- Work with internal and external services to implement timely referral processes
- Develop processes for ensuring that the clinician with overall accountability for a patient's care is identifiable at all times.

Strategies for improvement

Processes for delivering comprehensive care will vary, even within a health service organisation. Take a flexible approach to standardisation so that safety and quality systems can support implementation and innovation at the ward, unit or service level. This may involve developing new models of care in some services or for some patient groups. Work with clinical groups to help them to systematically review their own processes, practices and workflow, to find out how to best implement comprehensive care in their local context.

Design processes to develop, document and communicate comprehensive care plans

Comprehensive care plans are different from traditional nursing care plans or medical treatment plans because they require the expertise of each clinician group to be brought together to coordinate and progress a patient's care and reach agreed goals.

This means that clinical and consumer groups should be involved in agreements about:

- The minimum expectations for the content of comprehensive care plans
- Further expectations for comprehensive care planning in specific settings or services, or for specific patient populations (for example, children, older adults, elective and emergency admissions, Aboriginal and Torres Strait Islander people)
- Triggers for review of comprehensive care plans
- Roles and responsibilities for developing comprehensive care plans
- Processes for supporting shared decision making with patients, carers and families (see Actions 2.6 and 2.7)
- Templates for documenting comprehensive care plans
- Processes for communicating the content of the plan (see Actions 6.4, and 6.7–6.10).

Comprehensive care plans should be developed in partnership with patients, carers and families, and with input from all the clinicians involved in a patient's care (for example, doctors, nurses, pharmacists, allied health clinicians). Organisational requirements for developing comprehensive care plans should reflect the complexity of the service's patients, and may differ between settings and services. For example, a comprehensive care plan for a patient receiving outpatient dialysis might be detailed and complex, but will be used to guide many episodes of care. In contrast, a comprehensive care plan for a patient having elective surgery might be simple and narrowly focused, but will be used for a single, brief episode of care.

Standardised templates can assist clinicians in the goal-setting and comprehensive care planning process, particularly when patients have complex needs.[168,169] Work with clinical groups to agree on the content and use of documents and electronic systems for comprehensive care planning. An overall structure for comprehensive care plans may meet patient needs across the organisation, or specific comprehensive care planning documents may be developed for different services and patient groups.

One example of a standardised template for comprehensive care planning is a clinical pathway for the management of a specific intervention.

Clinical pathways can be simple or complex, depending on the nature of the intervention. Care pathways can improve outcomes for patients, and improve collaboration and teamwork between different professional groups.[170] However, clinical pathways alone may not meet the needs of patients with complex or multiple health problems.

Clinical pathways should include the capacity to document patients' preferences and goals, and individualise aspects of care as required. Develop and implement alternative comprehensive care planning strategies and tools for patients who are having an intervention that is normally managed using a care pathway, but whose care needs cannot be fully addressed with usual care (for example, patients with complex or undetermined conditions, or patients who are receiving concurrent care from multiple medical teams). Some state and territory health departments have developed and endorsed clinical pathways for particular patients, which health service organisations may wish to refer to.

Develop processes to ensure that patients receive care in the setting that best meets their needs

Hospital patient flow is a complex, organisation-wide issue that affects the workforce at all levels. When patient flow processes are suboptimal, the timeliness, safety and quality of patient care can be compromised. Outlying patients can experience higher rates of medical emergency calls, increased in-hospital mortality, increased length of stay and poorer outcomes.[171-174] Multiple bed moves within an admission can increase the risk of complications such as delirium, and can contribute to poor patient experiences.[175-177] Although patient flow affects clinical care, clinical care also affects patient flow. Poorly coordinated, disconnected and reactive care planning can compromise patient flow through the hospital and timely hospital discharge.[178,179]

Develop a patient flow process that is person centred and focused on placing patients in the right bed the first time. This may involve analysing and redesigning multiple processes across the organisation (for example, admission and discharge processes, bed-cleaning processes, comprehensive care planning and delivery processes, and elective and emergency surgery activity). Use data to evaluate the performance of existing processes and to inform collaborative improvement work with professional specialties and consumer representatives.

As a minimum, develop:

- Clear and transparent patient flow processes that enable everyone to understand their responsibilities in relation to patient flow
- Detailed descriptions of the roles and responsibilities for nurse managers and rostered in-charge nurses, departmental heads, after-hours managers and other key participants in the patient flow process
- Processes for flagging patients with clinical priorities or preferences that need urgent or special consideration
- A clear structure for escalation of, and response to, patient flow issues
- Proactive discharge planning processes (for example, criteria-led discharge) that include capacity for early recognition of potentially complex patient discharges, and allow timely planning and coordination activities
- A clear structure for accountabilities in relation to patient flow.

The New South Wales (NSW) Ministry of Health has developed *An Evidence-Based Review and Training Resource on Smooth Patient Flow*[179], a resource for making improvements in patient flow.

Also consider alternative models for acute care that may suit the needs of people with complex care needs, such as:

- Hospital in the Home, which may enable people with complex care needs to leave hospital earlier and return to familiar surroundings with therapeutic support[180]
- Specialist geriatric outreach services to aged care homes, which provide rapid access to acute medical and nursing care for older people experiencing rapid decline, and can reduce avoidable hospital presentations and support the person's choice for treatment.[181]

Establish referral processes

Referring clinicians, and specialist clinicians and services need to work collaboratively to set clear referral criteria. Provide accessible guidance about referral processes to different services that outlines the:

- Clinical or other criteria for referral (for example, persistent cognitive impairment caused by unresolved delirium or undiagnosed dementia)
- Process for making the referral (for example, referring to the service or to a particular clinician, by phone or email)
- Processes for expediting urgent referrals
- Availability of different services (for example, after hours)
- Expected response time
- Follow-up and escalation process for delayed response to a referral.

Standardise aspects of the referral process (such as required documentation) as much as possible, and develop processes for routine referrals for certain patient groups (for example, physiotherapy for postoperative patients).

Work with external services to identify referral processes to support ongoing comprehensive care.

These might include processes for:

- Safe return to rural or remote health services
- Transfer to subacute facilities
- Referral for ongoing care in the community
- Referral for follow-up of specific clinical or other issues
- Referral to services provided by credentialed clinicians in the private sector (for example, physiotherapists, occupational therapists, dietitians, counsellors).

Set up processes for identifying the clinician with overall accountability

Although all clinicians are accountable for the care they provide to patients, the clinician carrying overall accountability for an individual patient's care should have the seniority to make time-sensitive or complex clinical decisions. The clinician who has overall accountability should also be accessible and available so that they can lead and coordinate comprehensive care planning and delivery. Confusion about which clinician has overall accountability for a patient's care can lead to communication issues and delays in clinical decision-making.[182,183]

It is a requirement in the Medical Board of Australia's Code of Conduct that doctors ensure 'that it is clear to the patient, the family and colleagues who has ultimate responsibility for coordinating the care of the patient'.[14] This can be challenging in the hospital context, and identifying

which clinician has overall accountability for a patient's care at any given time can be complex.

Overall accountability for a patient's care may be handed over between several clinicians (including doctors, nurse practitioners, midwives and allied health clinicians) during a 24-hour period, and during the course of a patient's admission. On-call or locum clinicians may carry overall accountability for a patient's care at different times. Further complexity can be added when care is shared between teams (for example, in orthogeriatrics) or when multiple teams are involved in a patient's care (for example, patients with multiple chronic organ diseases, maternity patients with pre-existing medical conditions, children with complex medical conditions).

Work with clinical teams to develop consistent and up-to-date processes for identifying the clinician with accountability for individual patients' care at any time of the day or night. A systematic and predictable process is required so that permanent, temporary, locum and agency clinicians can identify the correct clinician, and so that inconsistencies are not driven by variation in the time of day, the day of the week or the personalities involved.

Develop guidance about:

- The roles and responsibilities of on-call and locum clinicians
- Processes for managing circumstances when the clinician with accountability for a patient's care is not available
- Orientation of new, agency or locum clinicians to the process for identifying who has overall accountability for a patient's care
- How unexpected absences or last-minute changes to rosters will be communicated and managed when these affect the identification of the clinician with overall accountability for a patient's care.

Collaboration and teamwork

Action 5.5

The health service organisation has processes to:

a. Support multidisciplinary collaboration and teamwork

b. Define the roles and responsibilities of each clinician working in a team

Intent

Clinicians are supported to work in collaborative multidisciplinary teams, and they understand their own roles and responsibilities, and those of other team members.

Key task

- Develop structured processes to support multidisciplinary teamwork and collaboration.

Strategies for improvement

To deliver comprehensive care that is safe and continuous, effective communication and teamwork are critical. Implement this action with consideration of the requirements of the Communicating for Safety Standard.

A substantial proportion of potentially preventable adverse events are underpinned by failures in communication and teamwork.[184-188] Given the complexity of health care, teams and clinicians may change regularly or over time, depending on the needs of the patient.[189,190] Improvements in multidisciplinary collaboration and teamwork have been associated with outcomes such as reduced length of stay[191], reduced risk of complications of medical care[192] and reduced risk of surgical complications or death.[193]

Some Australian programs targeting improvements in multidisciplinary teamwork include:

- In Safe Hands (NSW Clinical Excellence Commission)
- TeamSTEPPS® – Team Strategies and Tools to Enhance Performance and Patient Safety (SA Health).

Although interventions to improve multidisciplinary teamwork and collaboration vary, there are consistent indications that structured tools and processes are necessary to achieve effective and lasting change.[170,194,195] Examples of tools and processes that can help to structure and encourage effective teamwork can be found in the Resources section at the end of this standard.

Work with local clinical teams to review current work processes, design or adapt relevant tools, and build the use of structured processes and tools into the workflow.

Consider providing formal teamwork and communication training.[196,197] Skills in communication, collaboration and team behaviours can be developed through simulation, workshops or lectures. Strategies to improve clinical communication are discussed in more detail in the Communicating for Safety Standard.

Action 5.6

Clinicians work collaboratively to plan and deliver comprehensive care

Intent

Clinicians work together to plan and deliver comprehensive care in partnership with patients, carers and families.

Key tasks

- Ensure that clinicians use organisational processes and collaborate with each other, and with patients, carers and families, to plan and deliver comprehensive care.

Strategies for improvement

Use the Partnering with Consumers Standard to guide the development of processes for comprehensive care.

Collaborate with patients, carers and families

Collaborating with patients, carers and family members can ensure that essential baseline information about a patient's condition is established so that deterioration, improvement and strategies for ongoing care can be identified. For example, the carer of a person with advanced dementia is likely to be the most accurate source of information about that patient's usual capabilities, behaviours, preferences and medical history.[198]

As well as being experts in care needs, information providers and part of shared decision making, carers and other family members may also choose to be actively involved in a person's care.[199] Health service organisations can support carers in this role through policies and programs that enable practical strategies such as providing beds or chairs for overnight stays, refreshments, discounted parking and flexible visiting hours. An example is the 40 unique carer zones [video] that were commissioned in single rooms across the new clinical services building at Blacktown Hospital, Sydney. Formal, agreed procedures governing the program were created in partnership with consumers.

Implement shared decision making

Shared decision making is a critical strategy for effectively collaborating with patients, carers and families. Shared decision making is a process of incorporating the best available clinical evidence into a discussion about a patient's values and preferences to make decisions about care.[200] Shared decision making offers a framework for working jointly with patients (and carers and families, if the patient chooses to have them involved) to make decisions about the comprehensive care plan that

are based on a shared understanding of the patient's goals of care, and the risks and benefits of clinically appropriate options for diagnostic tests, treatments, interventions and care.[201]

One model for shared decision making describes five questions that clinicians can use to guide the process[201,202]:

1. What will happen if the patient waits and watches?
2. What are the test or treatment options?
3. What are the benefits and harms of each option?
4. How do the benefits and harms weigh up for the patient?
5. Does the patient have enough information to make a choice?

Another model, framed from the patient perspective, is Ask Share Know, which encourages patients to ask three questions about their care.

The Commission has also developed a Question Builder tool to help patients, carers and families consider questions to ask their doctor and prepare for a clinical consultation.

Use decision support tools

Decision aids are a type of decision support tool that clinicians, patients, carers and families can work through together. Specific decision aids have been developed for some health topics, and an online inventory of existing tools is available.

A generic decision aid tool has also been developed to help clinicians, patients, carers and families work together to make decisions if no specific decision aid is available.

Strengthen teamwork processes

No single clinician can deliver all aspects of the care that a patient needs.[203] Different clinician groups bring specific expertise and need to work together to provide the complete health care that a patient requires. Effective teamwork and collaboration rely on establishing and communicating clear and shared goals. These goals should have meaning for each team member who contributes to the effort to achieve them.[204]

Use processes for clinical handover, communicating critical information and documenting information (described in the Communicating for Safety Standard) to ensure that clinicians collaborate effectively to plan and deliver comprehensive care.

Interventions to improve teamwork vary, but broadly include[205]:

- Training to increase individual competence of team members and offer the opportunity to practise skills (for example, in simulation or role play)
- Structured communication protocols to increase reliability of communication
- Clear articulation of the roles, responsibilities and accountabilities of different team members
- Work and process redesign to provide structured opportunities for effective team communication.

The professional cultures associated with different disciplines and specialty groups can strongly influence the way that clinicians approach goal-setting and decision-making.[204] These cultures contribute to differing degrees of engagement in working collaboratively with other disciplines and professions.[204,206] Set up processes to support clinicians to understand their own accountabilities in relation to planning and delivering comprehensive care, and those of other members of the team.[207] Strategies may include:

- Using structured handover and communication tools[208]
- Using checklists to prompt discussion of patient, family and clinical concerns during bedside rounds[209]
- Using tools to prompt participation from different professional groups at critical moments – for example
  - the surgical safety checklist
  - the central line insertion checklist
- Identifying roles and responsibilities relating to comprehensive care in position descriptions and scope of clinical practice documentation
- Identifying accountabilities relating to collaboration, teamwork, shared decision making and other key skills, attitudes and behaviours required for comprehensive care in performance review processes
- Identifying clinical and executive leaders to lead collaborative practice and act as role models
- Developing processes to manage issues and feedback relating to multidisciplinary collaboration.

Work with clinical leaders to directly and specifically deal with the expectations for clinicians' participation in teamwork for comprehensive care. Suboptimal collaboration and communication can be especially apparent in the relationships between clinicians, and between clinicians and other professional groups.[195,210-212] Such problems have been attributed to issues arising from traditional professional hierarchies and cultures, and the relative seniority of the clinicians involved.[204] Improving the organisation of care delivery routines (such as structured multidisciplinary bedside rounds) within the workflow can help provide opportunities for more effective communication and collaboration between clinicians and other professional groups.[213-215]

Monitor, analyse and report on system effectiveness

Develop systems consistent with the requirements of the Clinical Governance Standard for reporting and analysing adverse events relating to failures of teamwork and communication, and for ensuring that clinicians are professionally accountable for working collaboratively with patients, carers, families and each other in the planning and delivery of comprehensive care.

CRITERION: Developing the comprehensive care plan

> *Integrated screening and assessment processes are used in collaboration with patients, carers and families to develop a goal-directed comprehensive care plan.*

Every patient receiving health care in Australian health service organisations deserves comprehensive care, but some patient groups are particularly vulnerable; for them, comprehensive care has a substantial role in helping to prevent harm. Consider the groups of vulnerable patients that use the organisation's services and ensure that systems for comprehensive care meet the needs of these groups.

For example, 40% of patients in hospitals are aged 65 years or over.[216] Hospitalised older patients often suffer from multiple chronic conditions that may require input from many different clinicians, and are known to be at higher risk of potentially preventable adverse events such as falls, delirium, pressure injury and malnutrition.[217]

The population served by the health service organisation and the nature of the services provided will determine the approach to screening and assessment.

Planning for comprehensive care

Action 5.7

The health service organisation has processes relevant to the patients using the service and the services provided:

a. For integrated and timely screening and assessment

b. That identify the risks of harm in the 'Minimising patient harm' criterion

Intent

Processes are in place for integrated and timely screening, assessment and risk identification.

Key tasks

- Assess the risks and clinical requirements of the patients who use the health service organisation, and agree on relevant screening and assessment processes
- Ensure that the risks of harm identified in the 'Minimising patient harm' criterion of this standard are addressed in these processes.

Strategies for improvement

Develop screening processes

Screening is used to identify existing conditions or issues that may predispose a patient to further harm, and to identify the level of risk for potential new harms to occur. The conditions, issues and risks identified through screening need to be properly assessed to determine what actions should be taken to manage them. Screening should shape the care delivered to a patient.

Many different conditions, issues and risks can potentially be identified through screening.

To develop appropriate screening processes for the health service organisation, consider:

- The cognitive, behavioural, mental and physical conditions and risks encountered by the patient population(s) served by the organisation
- The risks of harm identified in the 'Minimising patient harm' criterion of this standard

- Feedback from quality improvement processes
- The capacity and type of services that the organisation provides.

Use this information to work with clinicians and consumers to develop screening and assessment processes that are appropriate to the needs of patients and the clinical service being provided, and are integrated into clinical workflow.

If one or more of the risks of harm identified in the 'Minimising patient harm' criterion of this standard are not applicable to the organisation's patient population, document the rationale for not including these risks in the organisation's risk assessment processes.

Identify expectations about the timing of initial screening and assessment processes, and indications for repeated screening and assessment, in relevant policies, procedures and protocols.

Processes may vary for different groups of patients who attend the health service organisation and in different services. In some cases, different emphasis will be placed on screening versus comprehensive assessment. For example, in the anaesthetic assessment service, a detailed preoperative screening process may be needed to identify anaesthetic and surgical risks. In the geriatric section, screening processes may be minimal because patients routinely receive a thorough clinical assessment of the common conditions, issues and risks associated with older hospitalised patients.

Integrate screening and assessment

Integrate processes for screening and assessment, wherever possible. This means developing strategies to integrate:

- The multiple tools used to screen for common conditions and risks
- Screening activities with clinical assessment activities
- The input of multiple clinicians.

A recent audit of Victorian health services found more than 150 different screening and assessment forms in use across 11 health services.[218] Validated, integrated screening tools are not always available; however, significant Australian research is being undertaken in this area. Some health service organisations have developed their own integrated screening tools to reduce duplication of effort when patients are admitted.

Link screening activities to clinical decision-making and action when clinical risks are identified. This might mean ensuring that screening tools direct clinicians to the relevant assessments and interventions for managing an identified risk. For example, if a patient is identified as having cognitive impairment, specific assessments and clinical management strategies are recommended.[218]

Integrate the screening and clinical assessment findings of multiple clinicians. This will reduce the need for patients, carers and families to repeat the same information multiple times to different clinicians. It will also help to ensure that the information gained through different professional assessments is addressed in clinical decision-making and incorporated into the comprehensive care plan. Strategies to foster integrated multidisciplinary screening and assessment activities include the use of:

- Shared electronic or paper-based screening and assessment tools and systems
- Shared ward rounds and clinics, multidisciplinary rapid rounding and multidisciplinary case conferencing
- Formalised communication strategies such as checklists, timeouts, multidisciplinary handover meetings and electronic patient journey boards.

Action 5.8

The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems

Intent

People who identify as being of Aboriginal and/or Torres Strait Islander origin are provided with tailored and culturally appropriate comprehensive care.

Key tasks

- Develop policies, protocols and processes for confirming Aboriginal and Torres Strait Islander identification status
- Train the workforce to build competence in working with diverse population groups and specifically for collecting identification information
- Include Aboriginal and Torres Strait Islander identifiers in administrative and clinical datasets
- Monitor and report on the implementation of Aboriginal and Torres Strait Islander identification strategies.

Strategies for improvement

Confirming the identity of a person as being of Aboriginal or Torres Strait Islander origin at the beginning of their care will help health service organisations provide comprehensive tailored and culturally appropriate care, including better assessment of the risks that an individual may face.

If Aboriginal or Torres Strait Islander identity is established through an administrative process, ensure that there are mechanisms for this information to be transferred to the clinical information systems and, critically, the patient's healthcare record.

Monitor trends in reporting, healthcare delivery and health outcomes for Aboriginal and Torres Strait Islander people, and use this to assess the effectiveness of improvement strategies for Aboriginal and Torres Strait Islander consumers.

The correct and consistent identification and recording of Aboriginal and Torres Strait Islander consumers are also important practices in upholding the rights of healthcare consumers. Encourage the workforce to collect information in a professional and respectful manner, without making assumptions about a consumer's identity or about how they are likely to respond to any given question. Be aware that some Aboriginal and Torres Strait Islander consumers may not wish to declare their Aboriginal or Torres Strait Islander heritage.

To improve the willingness of Aboriginal and Torres Strait Islander people to identify themselves, health service organisations can:

- Partner with Aboriginal and Torres Strait Islander consumers and local communities to improve the health service organisation's understanding of reasons for declaring or not declaring their Aboriginal or Torres Strait Islander identity, and to improve processes for Aboriginal and Torres Strait Islander identification
- Develop resources in formats that are easily accessible for Aboriginal and Torres Strait Islander consumers, to explain why the question of Aboriginal and Torres Strait Islander identity is being asked
- Establish mechanisms to improve cultural competency and reflective practice of the workforce.

Further strategies are available in *NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health*.

Action 5.9

Patients are supported to document clear advance care plans

Intent

Patients are supported to document clear advance care plans.

Key task

- Develop processes to support patients to document clear advance care plans.

Strategies for improvement

Advance care planning is a process of preparing for likely future healthcare scenarios. Documented advance care plans or directives come into effect when a patient no longer has the capacity to make decisions for themselves.

The laws that govern advance care plans and directives differ across Australian states and territories. Consider relevant legislation and guidelines when developing advance care planning processes for the health service organisation. The Advance Care Planning Australia website includes links to information and resources, specific to each state and territory, for different populations (including children) in different settings (for example, mental health or intensive care).

Ensure that the advance care planning process includes discussion of a patient's values, preferences, and personal and family circumstances, and occurs in the context of their medical history and condition.

When undertaking advance care planning, patients need to consider many issues, including:

- How their previous experiences of health care influence their preferences for future care
- The quality of life that would be acceptable to them
- Who they would want to speak for them if they lack the capacity to take part in decision-making
- How they will maintain the relevance and currency of their advance care plan.

Outcomes of advance care planning may include nomination of a substitute decision-maker, or documentation of an advance care plan or directive. Patients may want to consider a number of different scenarios through advance care planning, such as their wishes and preferences for future care when:

- An episode of acute deterioration in mental state occurs
- Progressive cognitive decline associated with dementia occurs
- Decisions about end-of-life care are needed.

Advance care planning is an iterative process, and multiple discussions may be needed. Documented advance care plans need to be updated over time.

Include the following in the system for supporting patients to document advance care plans:

- Promotion of advance care planning as an important tool in providing care that aligns with patient preferences
- Consistency with legislative, common law and state or territory requirements
- A senior clinical lead to oversee implementation, evaluation and improvement of advance care planning processes
- Policies and procedures that describe the roles and responsibilities of patients, carers, witnesses, substitute decision-makers and clinicians in advance care planning, and the process for documenting and updating advance care plans
- Information resources, forms and other tools for patients and carers to consider, and document advance care plans in accordance with their wishes.

Screening of risk

Action 5.10

Clinicians use relevant screening processes:

a. On presentation, during clinical examination and history taking, and when required during care

b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm

c. To identify social and other circumstances that may compound these risks

Intent

Patients receive initial and, if necessary, repeated screening for cognitive, behavioural, mental and physical conditions, issues or risks of harm.

Key tasks

- Work with clinicians to integrate screening processes into their workflow
- Develop information about screening processes to include in orientation, education and training programs
- Develop strategies and processes for clinicians to provide feedback about the usability and effectiveness of screening processes.

Strategies for improvement

Work with clinicians in different clinical settings and services to integrate the use of screening processes into their workflow. This may include requiring that credentialed medical and other practitioners use screening tools during clinic appointments before a planned episode of care. Ensure that processes identify:

- When routine screening will occur in an episode of patient care
- The role and responsibilities of those who are responsible for screening individual patients
- The process for ensuring that action is taken when conditions or risks are identified through the screening process
- Indications for repeating the screening process.

Provide orientation, education and training for clinicians to understand their individual roles, responsibilities and accountabilities in using relevant screening processes. Clinicians require training about organisational processes, as well as more specific training about the use of these processes at the ward, unit or service level.

Topics to cover in education for clinicians include:

- When and how to use relevant screening processes and tools
- How to partner with patients, carers and families to optimise the identification of relevant information
- What assessments and actions to take when cognitive, behavioural, mental and physical conditions or issues, or risks of harm are identified
- When to repeat screening processes to identify evolving conditions, issues or risks of harm
- How to provide feedback about any issues with screening tools and processes.

Involve clinicians and consumers in reviewing the effectiveness and usefulness of screening processes. Develop processes for ensuring that updates and changes to screening tools and processes are effectively communicated to clinicians. This may involve developing specific, targeted implementation strategies to ensure that clinicians understand how to use and apply newly developed processes in their work, and have opportunities to provide feedback about usefulness and effectiveness of these processes.

Action 5.11

Clinicians comprehensively assess the conditions and risks identified through the screening process

Intent

Patients receive comprehensive assessment to determine their healthcare needs and appropriate treatment options.

Key tasks

- Ensure that clinicians talk to patients, carers and families about conditions and risks identified through screening processes, and work in partnership to comprehensively assess these conditions and risks
- Involve clinicians in evaluating and improving processes for comprehensive assessment.

Strategies for improvement

Comprehensive assessment relies on clinicians working with patients, carers and families to understand a patient's current health status, and its effect on their life and wellbeing. Integrate usual clinical assessment processes (for example, investigation of the presenting condition) with assessments of specific conditions, issues and risks (for example, a pre-existing chronic condition, a behavioural issue relating to cognitive impairment, a social issue such as homelessness).

Clinicians from different professions and in different services may need to work together to develop a full picture of the patient's needs. Use the processes for communicating critical information that are described in the Communicating for Safety Standard to ensure that assessment findings are effectively communicated.

Clinicians require training about organisational processes, as well as more specific training about the use of these processes at the ward, unit or service level. Provide orientation, education and training for clinicians on topics such as:

- Professional roles, responsibilities and accountabilities in comprehensive assessment processes
- When and how to use relevant assessment processes and tools
- How to partner with patients, carers and families to optimise the identification of relevant information
- How to communicate and document comprehensive assessment findings
- When to repeat assessment processes in response to evolving conditions, issues or risks of harm
- How to provide feedback about any issues with comprehensive assessment tools and processes.

Involve clinicians and consumers in reviewing the effectiveness and usefulness of assessment processes. Develop processes for ensuring that updates and changes to assessment tools and processes are effectively communicated to clinicians. This may involve developing specific, targeted implementation strategies to ensure that clinicians understand how to use and apply newly developed processes in their work, and have opportunities to provide feedback about usefulness and effectiveness of these processes.

Action 5.12

Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record

Intent

Findings of screening and assessment processes are documented accurately and contemporaneously.

Key tasks

- Support clinicians to use organisational and local processes to document the findings of the screening and assessment processes
- Involve clinicians in evaluating and improving documentation processes.

Strategies for improvement

This action should align with the requirements of the Communicating for Safety Standard. Work with clinicians to develop processes for documenting the findings of screening and assessment processes. This may include formalising existing processes, and developing or adapting specific paper or electronic tools.

Clinicians require training about organisational processes, as well as more specific training about the use of these processes at the ward, unit or service level. Provide orientation, education and training for clinicians on topics such as:

- Professional roles, responsibilities and accountabilities in documenting the findings of screening and assessment processes
- How to use paper or electronic tools to document screening and assessment findings
- How to document alerts in the healthcare record
- How to provide feedback about any issues with documentation tools and processes.

Involve clinicians and consumers in reviewing the effectiveness and usefulness of comprehensive care documentation processes. Develop strategies to ensure that updates and changes to relevant tools and processes are effectively communicated to clinicians. This may involve developing specific, targeted implementation strategies to ensure that clinicians understand how to use and apply newly developed processes in their work, and have opportunities to provide feedback about usefulness and effectiveness of these processes.

Action 5.13

Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that:

a. Addresses the significance and complexity of the patient's health issues and risks of harm

b. Identifies agreed goals and actions for the patient's treatment and care

c. Identifies the support people a patient wants involved in communications and decision-making about their care

d. Commences discharge planning at the beginning of the episode of care

e. Includes a plan for referral to follow-up services, if appropriate and available

f. Is consistent with best practice and evidence

Intent

Clinicians use shared decision-making processes to develop person-centred and goal-directed comprehensive care plans that meet identified patient needs.

Key tasks

- Support clinicians to use shared decision-making processes in the context of planning and delivering comprehensive care
- Provide guidance about the requirements for comprehensive care plans in the health service organisation.

Strategies for improvement

This action requires clinicians to use the processes described in the Partnering with Consumers Standard to work with patients or substitute decision-makers to reach shared decisions about the comprehensive care plan. It also requires clinicians to use the processes described in the Communicating for Safety Standard to document the comprehensive care plan and communicate its content to relevant members of the workforce.

The level of detail in a comprehensive care plan should reflect the significance and complexity of a patient's clinical situation. For example, the comprehensive care plan for an older frail person with multiple comorbidities, an existing pressure injury and no family, who is admitted through the emergency department for severe pneumonia, will require a much greater level of detail than that required for an otherwise well young person admitted for an elective procedure. The Victorian Department of Health and Human Services website has more information about comprehensive care for older people.

Ensure that comprehensive care plans include:

- Agreed goals of care and actions required to achieve them
- Actions required to manage identified risks of harm
- Actions required to ensure safe discharge from the health service organisation
- Indications for review of the comprehensive care plan.

The comprehensive care plan may also identify the individuals who are accountable for the actions required to achieve the goals of care, manage clinical risks and ensure safe discharge from the health service organisation.

Identify goals of care

Ensure that goals of care reflect the input of doctors, nurses, allied health clinicians, consumer liaison officers (for example, Aboriginal liaison officers), the patient, carers and family. Goals of care may include:

- Condition- or disease-specific goals such as 'give maximum three days of antibiotics and fluids; seek specialist palliative care advice regarding symptom control; likely palliation if significant deterioration occurs or if there is no improvement within 72 hours'
- Functional goals such as 'maintain ability to independently perform activities of daily living'
- Personal goals such as 'attend daughter's wedding in four weeks'.

Ensure that goals of care also identify the overall intent of an episode of care, including whether there are any agreed limitations on medical treatment. For example, the Tasmanian Department of Health and Human Services' Medical Goals of Care Plan indicates whether the overall goal of medical care is intended to be:

- Curative or restorative without limitations on treatment
- Curative or restorative with limitations on treatment
- Palliative symptom management
- Terminal care.

Clinicians who deliver care to people who experience mental illness can work collaboratively to ensure that clinical goals are balanced with the person's own values. The *National Framework for Recovery-Oriented Mental Health Services: Guide for practitioners and providers* describes how this can be implemented.

Identify support people

A person-centred healthcare system is one that supports patients to make informed decisions, and successfully manage their own health and care. This includes giving patients choice about when to let support people, such as family or carers, be involved in their decision-making or make decisions on their behalf.[219] Family or carers know the patient best, and their presence can help to reassure patients in times of uncertainty, anxiety or vulnerability.

To identify support people a patient wants involved in their care, develop effective processes that include:

- Asking the patient during initial conversations or admission processes to identify any support people they wish to be involved in communications and decision-making about their care
- Allowing the patient to nominate or change their nominated support people at any time throughout their care
- Documenting the contact details for a patient's support people in their healthcare record and treatment notes
- Communicating about a patient's support people, including any changes in support people, to all members of the patient's healthcare team.

In some cases, a patient may need the organisation to put them in contact with someone who can provide support for communication and decision-making. Provide:

- Contact details for local, state or territory consumer health advocates or organisations that can provide support for healthcare decision-making
- Access to interpreters or interpreting services that can be involved in discussions about health and healthcare options
- Access to cultural support service or cultural liaison officers, such as Aboriginal health workers.

Support people cannot be part of a patient's healthcare decision-making if they are not present. Review the organisation's visiting policies to identify opportunities to allow a patient's support people to be present throughout care. One strategy to support this is patient-directed visiting, which removes restrictions on visiting times, allowing carers and family to decide on the visiting times that best suit them.

Where a support person is not nominated by a patient and a substitute decision-maker is required to make a decision on the patient's behalf, ensure that processes are in place to identify appropriate substitute decision-makers.

Plan for discharge

Part of the comprehensive care planning process is planning for discharge from the health service organisation. This includes identifying any services, equipment and follow-up that may be needed to safely discharge the patient. Develop processes to ensure that follow-up arrangements are made before the patient leaves the health service, and that any required referrals are dealt with promptly. The person, and their family and carers, should be engaged in discharge planning from the beginning of the healthcare episode.

Review the comprehensive care plan

The comprehensive care plan may include general indicators that are applicable to all patients, as well as specific indicators relating to individual patients. Some examples of general indicators are:

- Regularly scheduled review based on length of stay (for example, routine weekly review, or routine review when expected length of stay for a particular intervention or procedure is exceeded)
- Review after critical events such as medical emergency calls
- Review after handover to a new specialty or service (for example, after discharge from intensive care to the ward)
- Review if the patient, substitute decision-maker or family requests it or expresses concerns.

Some examples of individual indicators are:

- Failure to reach a planned goal within a predetermined time (for example, failure to clinically improve after a period of treatment)
- Whether potential complications of a condition or treatment occur
- Review after particular procedures or interventions have been performed, or when the results of diagnostic tests are available
- A patient at the end of life is readmitted.

See the Resources section at the end of this standard for resources and programs to support the delivery of comprehensive care.

CRITERION: Delivering comprehensive care

> *Safe care is delivered based on the comprehensive care plan, and in partnership with patients, carers and families. Comprehensive care is delivered to patients at the end of life.*

This criterion outlines strategies for the delivery of comprehensive care for all patients. It includes specific actions about providing care to those at the end of life.

Comprehensive care at the end of life is consistent with the principles of person-centred, goal-directed and compassionate care that are articulated in the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*.[220]

Using the comprehensive care plan

Action 5.14

The workforce, patients, carers and families work in partnership to:

a. Use the comprehensive care plan to deliver care

b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care

c. Review and update the comprehensive care plan if it is not effective

d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur

Intent

The comprehensive care plan is used to direct the delivery of safe and effective care that aligns with the patient's needs and preferences.

Key tasks

- Develop processes to ensure that clinicians and other members of the workforce are aware of their obligation to provide care in accordance with the comprehensive care plan, and in collaboration with patients, carers and family members
- Develop processes to ensure that the effectiveness and currency of the comprehensive care plan are routinely reviewed
- Develop guidance about indications to reassess the patient's care needs, preferences and goals, and revise the comprehensive care plan.

Strategies for improvement

Provide education and training

Provide orientation, education and training for clinicians and other members of the workforce so that they understand their individual roles, responsibilities and accountabilities in delivering care in accordance with the comprehensive care plan. In addition to providing training to doctors, nurses, midwives and allied health clinicians, training is also needed for auxiliary members of the workforce involved in delivering patient care. For example, members of the food service workforce may need training about their role in managing risks associated with malnutrition and dehydration, and ward clerks may need training to ensure that substitute decision-makers are identified and carers can see patients outside usual visiting hours. Ensure that training covers organisational processes and more specific processes at the ward, unit or service level.

Topics to cover in workforce education include:

- When and how to use the comprehensive care plan
- Roles, responsibilities and accountabilities of different team members in delivering comprehensive care
- Assessment, documentation and communication of patient progress against the goals of care
- Indications to repeat screening, assessment and comprehensive care planning processes
- How to partner with patients, carers and families to optimise the delivery of comprehensive care
- How to support the specific role of carers in delivering comprehensive care
- How to gain access to other expertise (for example, specialist input) and equipment (for example, pressure-relieving mattresses) required for delivering comprehensive care in alignment with a patient's needs
- How to provide feedback about issues with processes that support the delivery of comprehensive care.

Involve patients and carers

The Partnering with Consumers Standard includes strategies to ensure that clinicians work in partnership with patients when delivering care. Extra strategies may be needed to ensure that collaboration with carers and families is effective, and in line with the preferences and consent of individual patients, carers and families.

Collaboration with carers and family is becoming increasingly important in the delivery of safe and high-quality care. Carers and family members often have intimate knowledge of what is 'normal' for a patient, and can detect small changes that may indicate substantial deterioration or improvement in a patient's condition.[183,218] Involving carers and families in the delivery of care may also help to reassure patients, and ensure that their needs are being met.[42] For example, carer involvement in the delivery of care to patients with cognitive impairment can help to reduce patient distress and assist in planning for transitions of care.[218]

Carers may have an official role that goes beyond that of other family members. Accurately identify carers to ensure that they have access to support and services that help them to fulfil their role, and to ensure that any legal matters in relation to consent and decision-making are established.[221,222] For example, carers for children and young people may have identification cards that establish their role as legal guardians, which need to be sighted. For Aboriginal and Torres Strait Islander people, there may be a collective approach to carer responsibilities. Confirming who is responsible for different aspects of care is important for ensuring that carer engagement is effective. More information is available in *Comprehensive Care for Aboriginal and Torres Strait Islander Consumers*.

Useful documents that may help to inform and support collaboration with specific groups of carers are available from Carers Australia, including:

- A resource for young carers
- A literature review providing practical strategies to help overcome isolation among Aboriginal and Torres Strait Islander carers
- A background paper about culturally and linguistically diverse carers in Australia, which includes information and links to resources.

Review processes

Involve the workforce and consumers in reviewing the effectiveness and usefulness of comprehensive care delivery processes. Develop processes for ensuring that updates and changes to comprehensive care planning tools and processes are effectively communicated to clinicians. This may involve developing specific, targeted implementation strategies to ensure that members of the workforce understand how to use and apply newly developed processes in their work.

The Recognising and Responding to Acute Deterioration Standard contains more information about how to reassess the patient's needs when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported (Action 8.5).

Comprehensive care at the end of life

Action 5.15

The health service organisation has processes to identify patients who are at the end of life that are consistent with the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*[220]

Intent

Patients with end-of-life care needs are identified as soon as possible to maximise opportunities for appropriate decision-making and care.

Key task

- Use the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care* to develop a systematic process for identifying patients with end-of-life care needs.

Strategies for improvement

The *National Consensus Statement: Essential elements for safe and high-quality end-of-life care* sets out suggested practice for health service organisations delivering end-of-life care in settings that provide acute health care. It describes 10 essential elements of care.

The fourth essential element in the consensus statement provides detail about the need to use triggers to recognise when patients are approaching the end of life. Considering the likelihood of a patient dying offers opportunities to identify their needs and preferences, review their goals and comprehensive care plan, and consider how best to align care with the individual's expressed values and wishes. Routine use of simple trigger tools and questions can prompt clinicians to use their clinical judgement to make a holistic assessment of whether a patient has end-of-life care needs.

Develop processes aimed at identifying patients at two critical points:

- When death is likely in the medium term (that is, within the next 12 months), but episodes of acute clinical deterioration may be reversible
- When death is likely in the short term (that is, within days to weeks, or during the current admission), and clinical deterioration is likely to be irreversible.

Work with clinicians to set up processes for identifying patients with end-of-life care needs in the health service organisation. A combination of clinical judgement and research-based algorithms is better at identifying end of life than either strategy alone. The consensus statement includes actions to support the development of processes.

A series of online education modules based on the consensus statement and targeted at clinicians working in hospitals is available from the End-of-Life Essentials website.

Action 5.16

The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice

Intent

Clinicians can access advice from specialist palliative care clinicians when planning and delivering end-of-life care.

Key tasks

- Develop agreements with local palliative care providers to enable access to specialist palliative care advice
- Develop processes for clinicians to access specialist palliative care advice.

Strategies for improvement

Although many clinicians may regularly be involved in providing care to patients approaching the end of their life, this is the core business of specialist palliative care clinicians. If a patient has unmet physical, psychosocial or spiritual care needs at the end of life, specialist palliative care involvement can improve quality of life. Gain access to specialist palliative care advice by:

- Referring a patient to specialist palliative care
- Seeking a consultation from a palliative care specialist
- Seeking informal advice to help manage the patient.

If the health service organisation has an on-site specialist palliative care service, work with that service to develop processes to enable clinicians to seek advice. This may include a process for accessing informal advice from a specialist palliative care doctor or nurse, or developing formal referral guidelines.

If the health service organisation does not have a specialist palliative care service, develop agreements to seek advice from, and make referrals to, specialist palliative care providers in nearby health services or in the community.

In some cases, specialist palliative care advice may be limited to telephone support or videoconferencing. Such advice can be a source of primary information or a valuable sounding board to help make decisions about a patient's management. Develop clear guidelines indicating when and how to seek such advice.

Action 5.17

The health service organisation has processes to ensure that current advance care plans:

a. Can be received from patients

b. Are documented in the patient's healthcare record

Intent

Patients with an advance care plan receive care in line with their plan if they lack the capacity to participate in decision-making.

Key task

- Develop processes to receive, document and provide access to advance care plans.

Strategies for improvement

In this action, advance care planning refers to the process of preparing for likely clinical scenarios near the end of life. Advance care planning can help to ensure that patients' preferences are known if they are no longer able to speak for themselves, and can reduce the likelihood of unwanted or inappropriate treatment.

The outcome of advance care planning processes may be the documentation of an advance care plan, which may include a formal advance care directive and nomination of a substitute decision-maker. Legislation and policy governing the documentation of advance care directives and nomination of substitute decision-makers vary in each state and territory. The Advance Care Planning Australia website includes information for consumers and clinicians, and links to state and territory resources to guide advance care planning and the documentation of advance care directives.

Develop standardised processes for:

- Determining whether a patient has a pre-existing and up-to-date advance care plan and, if so, ensuring that a copy is available in the healthcare record
- Ensuring that advance care plans are readily accessible to clinicians involved in providing care to patients
- Providing access to documented advance care plans in all areas where care is provided, and in emergency situations.

Advance care plans can be documented on paper or stored electronically in the patient's digital healthcare record.

Evaluate processes for receiving and acting on advance care plans by using the reportable event system to investigate failures to provide care in accordance with a patient's advance care plan. Consider adding items relating to advance care planning to the statewide or organisation-wide incident management and investigation systems. For example, in South Australia, items relating to advance care planning have been added to statewide incident reporting systems, including:

- Delay or failure in obtaining the advance care plan
- Missing, inadequate or illegible documentation of the advance care plan
- Communication inadequate or failed between clinicians
- Communication inadequate or failed between substitute decision-maker/family/carers and clinicians
- Patient incorrectly identified or advance care plan does not match patient
- Substitute decision-maker contact delayed or not attempted
- Dispute between clinicians
- Dispute between substitute decision-maker/family/carers and clinicians
- Advance care plan ignored, not followed or not used
- Planned treatment option unavailable.

Action 5.18

The health service organisation provides access to supervision and support for the workforce providing end-of-life care

Intent

The workforce has access to support and supervision to alleviate workplace stress associated with delivering end-of-life care.

Key task

- Develop processes to ensure that all members of the workforce providing end-of-life care know how to access supervision and support.

Strategies for improvement

Dealing with death and dying can be challenging for clinicians, and for other members of the workforce such as ward clerks, porters and cleaners. It can add considerably to workplace stress. Chronic unmanaged stress can erode empathy, and could contribute to poorer experiences for patients, carers and families.

Put processes in place to aid access to peer support, mentoring and appropriate clinical supervision.

Develop a policy framework outlining how clinical supervision and support are provided in the health service organisation. Ensure that this includes access to external services for formal clinical supervision, counselling or debriefing after particularly distressing or problematic episodes of care. Provide information to the workforce about access to supervision and support at orientation at the start of employment and during regular refresher training.

Develop resources and training materials to support clinicians to develop skills in self-care, reflective practice and providing peer support to colleagues. Detailed information about stress and burnout relating to the care of the dying, and strategies for prevention, is available from the CareSearch website.

Action 5.19

The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care

Intent

Patients receive safe and high-quality end-of-life care.

Key tasks

- Implement processes for evaluating the safety and quality of end-of-life care.

Strategies for improvement

Ensure that evaluation of end-of-life care addresses the safety and quality of the care provided, not just the potential preventability of death. This includes reviewing whether end-of-life care is delivered in line with the planned goals of care.

Capture feedback about the safety and quality of end-of-life care from different perspectives, including nurses, doctors, allied health clinicians, patients, substitute decision-makers, carers and families. Work with clinicians to decide on meaningful measures of the safety and quality of

end-of-life care in the health service organisation, such as:

- The number of expected and unexpected deaths
- Rates of documented patient goals and preferences for end-of-life care
- The length of time between recognising that a patient was likely to die and the time of death
- Adequacy of assessment and management of terminal symptoms
- Rates of clinical intervention (for example, chemotherapy, dialysis, diagnostic testing, antibiotic use) in the last days of life
- The number of advance care plans received and developed
- Carer and family perceptions and experiences of end-of-life care
- Workforce perceptions and experiences of providing end-of-life care.

Develop strategies for routine data collection about safety and quality relating to both expected and unexpected deaths, and the delivery of comprehensive care at the end of life. This may include using sources such as consumer experience data and health service administration data, and processes such as mortality and morbidity meetings.

Palliative Care Australia's National Standards Assessment Program (NSAP) has patient and family evaluation tools for health service organisations to use:

- NSAP Audit Tool 2: Patient interview
- NSAP Audit Tool 3: Family evaluation of palliative care.

Health services that submit their results to Palliative Care Australia receive a report that can be used as evidence to support this action.

The Commission is developing survey and audit tools to help assess the overall safety and quality of end-of-life care in the organisation. More information is available on the Commission website.

Action 5.20

Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*[220]

Intent

Clinicians support consumers, carers and families to make shared decisions about end-of-life care.

Key task

- Provide guidance for clinicians about using processes for shared decision making in the context of end-of-life care.

Strategies for improvement

The consensus statement sets out suggested practice for health service organisations delivering end-of-life care in settings that provide acute health care. It describes 10 essential elements of care.

Use the actions described in the first essential element of the consensus statement and in the Partnering with Consumers Standard to guide the development of processes to support clinicians to work collaboratively with patients, carers and families, and make shared decisions about end-of-life care.

The patient and the clinical team are essential participants in discussions and decision-making about care at the end of life. Include substitute decision-makers, carers and families according to the patient's wishes and state or territory legislative frameworks. More information about advance care planning in each state and territory is available from the Advance Care Planning Australia website.

Having conversations about death, dying and the end of life requires compassion, knowledge,

experience, sensitivity and skill on the part of the clinicians involved. Provide orientation, education and training for clinicians to understand their individual roles, responsibilities and accountabilities in working with patients, carers and families to make shared decisions about end-of-life care. This may include developing peer support and mentoring programs to help clinicians practise and improve their skills over time. Training, education and mentoring programs should be consistent with the actions described in the consensus statement, and may need to cover several processes and skills, such as:

- Using organisational shared decision-making processes
- Supporting shared decision making in patients with fluctuating capacity
- Strengthening communication skills and preparing for discussions about end-of-life care
- Developing cultural competence
- Providing information about organ and tissue donation
- Documenting the outcome of shared decision-making processes.

Many states and territories have strategies and resources in place to support efforts to improve end-of-life care. Refer to these when planning improvements within the health service organisation. Links are provided in the Resources section at the end of this standard.

CRITERION: Minimising patient harm

> *Patients at risk of specific harm are identified, and clinicians deliver targeted strategies to prevent and manage harm.*

The screening actions in this standard aim to identify the patients who are at the greatest risk of harm while receiving health care. The specific risks identified in this criterion are areas in which at-risk patients are commonly harmed. Implementing targeted, best-practice strategies can prevent or minimise the risk of these specific harms.

Preventing and managing pressure injuries

Action 5.21

The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines

Intent

Evidence-based guidelines are used for prevention and care for patients at risk of, or with, a pressure injury.

Key tasks

- Use information from screening and assessment processes to prevent and manage pressure injuries
- Develop or adapt a wound management system that is based on best-practice guidelines
- Identify individuals or groups with responsibility for overseeing this system.

Strategies for improvement

Use the screening processes in Action 5.10 to identify patients at risk of pressure injuries and plan for comprehensive care. Use Action 5.12 to ensure that the risk factors and a decision about the need for comprehensive and ongoing skin inspections are documented. Ensure that processes for preventing pressure injuries are based on best-practice guidelines and that details of prevention strategies are communicated to the team caring for at-risk patients.

Prevention and Treatment of Pressure Ulcers: Clinical practice guideline[151] is the relevant best-practice guidelines. These guidelines outline the components of, and techniques for, comprehensive skin and tissue inspections.

Implement a comprehensive wound management system that describes the protocols and processes for patient care when a patient's pressure injury has been identified. Include the assessment, treatment, monitoring and documentation of pressure injuries.

Ensure that assessment of pressure injuries incorporates:

- The use of a validated risk assessment tool
- The use of a pressure injury classification system
- Assessment of pain using validated self-reporting tools such as verbal descriptor, visual analogue or numerical scales
- Ongoing assessment that evaluates the effectiveness of the wound management plan.

Ensure that treatment addresses:

- Pain management
- Wound management
- Adjunctive treatment options such as heel elevation, prophylactic dressings or electrotherapy

- Referral to allied health services when indicated, including dietetics or occupational therapy.

Conduct ongoing assessments of pressure injury risks and pressure injury healing, and documentation of all management plans, treatments and interventions provided.

Action 5.22

Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency

Intent

The risk of harm from pressure injuries is minimised by routinely conducting skin inspections.

Key task

- Develop or adapt a process to prompt clinicians to perform and document comprehensive skin inspections as part of routine patient care.

Strategies for improvement

Incorporate comprehensive skin inspections for patients who are screened as being at high risk of pressure injury into routine admission processes, as outlined in Action 5.11. For at-risk patients, conduct skin inspections on admission and on an ongoing basis, depending on the patient's clinical needs. Best-practice guidelines provide recommendations on how often skin should be inspected.

Document the results of skin inspections in the healthcare record, as outlined in Action 5.12. When pressure injuries are identified, ensure that measurements and images are included in the documented wound assessment.

For patients at risk of developing a pressure injury or who have an existing pressure injury, integrate skin inspections into patients' daily care plans, in line with Action 5.13.

Prevention and Treatment of Pressure Ulcers: Clinical practice guideline[151] is the relevant best-practice guidelines. These guidelines outline the components of, and techniques for, comprehensive skin and tissue inspections.

Action 5.23

The health service organisation providing services to patients at risk of pressure injuries ensures that:

a. Patients, carers and families are provided with information about preventing pressure injuries

b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries

Intent

Patients with, or at risk of, pressure injuries are provided with information and are involved in their pressure injury care, and devices and equipment that minimise the risk of harm are used.

Key tasks

- Provide information for patients and carers about the prevention and management of pressure injuries

- Facilitate access to equipment and devices for the prevention and management of pressure injuries.

Strategies for improvement

Provide patient information

Patients, carers and families can help clinicians to prevent and manage pressure injuries. Provide patients, carers and families with information that will assist them to understand and take part in the development of effective and appropriate strategies, including information on:

- Risk factors, preventing pressure injuries and self-care
- How to gain access to credible electronic knowledge sites
- How to change the environment to reduce risk
- How to gain access to ongoing care.

Strategies to distribute information may include:

- Providing brochures, fact sheets, posters, and other printed and online material
- Providing opportunities for patients to discuss pressure injuries with clinicians on presentation for care and during care
- Broadcasting prevention and management messages about pressure injuries on patient television and audio services.

Arrange access to products, equipment and devices

Access to products, equipment and devices can prevent pressure injuries or reduce harm when injuries have already been sustained.

To enable access to products, equipment and devices, consider:

- Evaluating products, equipment and device requirements, usage and effectiveness
- Determining the type and number of support devices the organisation may require and options for access to the equipment
- Scheduling routine maintenance and coordinating repairs to maximise the availability of equipment
- Developing guidelines on how to gain access to required equipment (for example, rental options).

Preventing falls and harm from falls

Action 5.24

The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for:

a. Falls prevention

b. Minimising harm from falls

c. Post-fall management

Intent

Clinical practice for preventing and managing falls is evidence based, and patient risks and harm are minimised.

Key task

- Identify all areas in the organisation that present falls risks and develop a risk management approach to implementing evidence-based improvement strategies.

Strategies for improvement

Falls remain a major safety and quality risk in health service organisations. Falls prevention and harm minimisation plans based on best practice and evidence can improve patient outcomes.

Best-practice guidelines and guides for preventing falls and harm from falls in older people are available on the Commission's website.[152-154]

These resources were developed for hospital, community and aged care home settings. The resources comprise detailed guidelines, shorter guidebooks and fact sheets, and include strategies for falls prevention, managing falls risks and responding to falls.

Many organisations and expert bodies have developed falls prevention resources that can be used by health service organisations.

Delirium should be considered a risk factor for falls.[164] Refer to Action 5.29 and the Delirium Clinical Care Standard for strategies to manage risks of harm related to delirium.

Action 5.25

The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls

Intent

Patients are provided with equipment and devices to promote safe mobility and reduce harm from falls.

Key tasks

- Identify, and facilitate access to, the equipment and devices required for the organisation's patient population
- Develop a log to register equipment and devices used in falls prevention and management, and record their maintenance.

Strategies for improvement

Adjust the environment in line with a patient's risk profile and make equipment available for the patient to mitigate the risk of falling. This may include:

- Adjusting chair and bed heights
- Using lighting that is even and activated by sensors, particularly over stairs and at night
- Providing slip-resistant surfaces
- Providing well-maintained walking aids and wheelchairs
- Reducing clutter and trip hazards around the patient
- Cleaning up spills and urine promptly
- Providing stable furniture for handholds
- Ensuring effective brakes on beds, wheelchairs and commodes
- Reducing the use of physical restraints
- Placing call bells within reach.

Special equipment can include commodes, body protective equipment and appropriate footwear.

Recording and monitoring equipment and devices may include:

- Evaluating previous equipment and device requirements and effectiveness
- Determining the type and number of support devices the organisation may require, and options for access to the equipment
- Scheduling routine maintenance and coordinating repairs to maximise the availability of equipment
- Reviewing falls incident reports to evaluate the role that access to equipment played in the incident.

Action 5.26

Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies

Intent

Patients, carers and families are provided with information about falls risks and preventing falls.

Key tasks

- Provide information to, and have discussions with, patients, carers and families about falls risks
- Seek feedback on information provided to patients and carers, and amend it to improve the information
- Ensure that the discharge planning protocol prompts the workforce to consider referral to appropriate services.

Strategies for improvement

Provide patient information

Involving patients, carers and families in the development of falls prevention and harm minimisation strategies may reduce the frequency and severity of falls. Providing information to, and discussing information with, patients, carers and families will help them understand and take part in the prevention and management strategies.

Fact sheets for patients are available that describe different aspects relating to falls.

Seek feedback from patients, carers, families and the workforce about the information provided to patients to inform quality improvement.

Ensure access to referral services

Create a log of services available that accept referred patients after discharge.

Set the criteria for referral, and include these in policies, procedures and protocols.

Detail prevention strategies, falls risks and patient history in discharge information to enable continuity of care between health services.

Nutrition and hydration

Action 5.27

The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice

Intent

Patients' nutrition and hydration needs are identified and documented in their comprehensive care plan.

Key tasks

- Put in place processes for addressing patients' nutrition and hydration needs.

Strategies for improvement

Food is part of the care that is provided to patients who are admitted to hospital, and should not be considered solely as part of hotel services. Malnutrition adversely affects patient outcomes, and nutrition needs to be considered as an integral part of the comprehensive care plan.

In line with the requirements in Action 5.1, ensure that the health service organisation has evidence-based nutrition policies, procedures and protocols for managing nutritional wellbeing and recovery, and malnutrition that comply with relevant legislation and state or territory requirements.

Patients should be screened for risk of malnutrition and other specific nutritional requirements.

The multidisciplinary team is responsible for implementing a food and nutrition system. To be effective, all members of the workforce involved need to understand their roles and responsibilities, as well as the role of nutrition in clinical care. Identify the clinical and non-clinical members of the workforce who need training for the best operation of the system.

In line with the requirements in Action 5.2, ensure that quality improvement processes are in place to improve the effectiveness and appropriateness of the nutritional systems. This may involve collecting and analysing data on:

- Age, life stage, and cultural and religious background of patients
- Organisational casemix and profile of length of stay
- Nutrition assessments
- Complaints and incidents.

Ensure that processes for planning, preparing and distributing food, fluids and nutritional supplements are timely, safe and appropriate to the setting of care. Ensure that ordering and delivery processes support the right foods and fluids being delivered to the right patient at the right time.

Processes for menu and meal planning should:

- Reflect the nutritional requirements appropriate to the age and life stage of patients receiving care[223]
- Reflect the special dietary needs appropriate to the organisation's casemix[224,225]
- Consider psychosocial, cultural and religious needs
- Offer food and fluid choices that are appealing and that patients enjoy
- Consider flexible meal timing and service arrangements
- Be relevant to patients' length of stay, and to patients who are admitted frequently.

Patients who are not admitted overnight may receive treatment across extended periods, such as in a day surgery unit, day obstetrics unit, renal dialysis unit, radiotherapy or chemotherapy unit, rapid assessment and planning unit, medical assessment and planning unit, short-stay ward, or emergency department. Treatment in such units may be frequent for many weeks or on a continuing basis. Consider referring these patients for nutrition assessment and including nutritional care in the patient's comprehensive care plan.

Action 5.28

The workforce uses the systems for preparation and distribution of food and fluids to:

a. Meet patients' nutritional needs and requirements

b. Monitor the nutritional care of patients at risk

c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone

d. Support patients who require assistance with eating and drinking

Intent

The workforce ensures that the nutrition and hydration needs of patients are met.

Key tasks

- Monitor the nutritional care of patients
- Provide assistance to patients to ensure that their nutrition needs are met.

Strategies for improvement

A nutrition risk assessment is part of the organisation's screening and assessment processes, and involves:

- Conducting screening on admission and weekly during an episode of care if care changes or if the patient's condition changes, or at routine review
- Considering nutrition risk such as malnutrition and dehydration, dysphagia, special dietary needs, food intolerance or allergy
- Documenting the results of nutrition risk screening and assessment.

Where a nutrition assessment is required, consider:

- Weight and intake history
- Physical assessment
- Condition of the mouth, teeth or dentures
- Ability to swallow safely
- Ability to open packages
- Ability to self-feed
- Nutritional impact of symptoms of disease or treatment.

Monitor the nutritional care of patients at risk

Ensure that the nutrition care for each patient is planned and documented. For patients with, or at risk of, malnutrition or dehydration, increase the level of food and fluid intake, and nutritional status monitoring. Act when poor oral intake, weight loss or other change in nutritional status is detected.

Consider the role of nutrition and hydration in planning and providing end-of-life care. This includes following advance care plans for nutritional support, and recognising a drop in food and fluid intake as part of the dying process.

Monitor patients to ensure that periods of fasting before and after surgery and tests are minimised.

Identify, and provide access to, nutritional support for patients who cannot meet nutritional requirements with food alone

Consider the need for nutritional support such as oral nutrition supplements, enteral nutrition or parenteral nutrition when oral intake is inadequate or contraindicated.

Support patients who require assistance with eating and drinking

Monitor patients' food intake and their capacity to independently eat and drink, and help when required.

Action 5.29

The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to:

a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard[226], where relevant

b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation

Intent

A system for caring for cognitive impairment is implemented that minimises the risk of harm for people with cognitive impairment or at risk of developing delirium

The use of antipsychotics and other psychoactive medicines is in line with best practice and legislation.

Key tasks

- Review, revise or develop a system for providing high-quality care for patients with cognitive impairment
- Allocate roles, responsibilities and accountabilities for establishing or maintaining the system
- Implement a system for caring for cognitive impairment
- Regularly monitor the use of best-practice evidence-based strategies in the care plan, provide feedback and implement improvement strategies.

Strategies for improvement

Implement a system

A well-designed system for caring for patients with for cognitive impairment will support clinicians to:

- Routinely screen for cognitive impairment[226] in patients aged 65 years or over using a validated tool (Action 5.10)
- Screen patients of any age at risk of delirium and when the patient, carer, family or other key informants raise concerns about cognitive impairment.

An initial screen provides a useful baseline for further monitoring. Note that a positive score on a screening tool is not a diagnosis but a prompt for further assessment, early intervention and early family involvement. Document the results and communicate them to patients and family, and the relevant members of the workforce who interact with patients, including primary care clinicians.

For all patients with cognitive impairment:

- Assess for delirium and reassess with any changes in behaviour or thinking[226] using validated delirium assessment tools applicable to the setting (see Action 8.5)
- If delirium is detected, investigate and treat the causes of delirium; comprehensive history taking and physical examination can enable targeted investigations
- Investigate (or refer for investigation) other causes of cognitive impairment – for example, a person may have developed cognitive impairment as a result of a recent acquired brain injury or an undiagnosed dementia, requiring further assessment, treatment and follow-up
- Partner with patients, carers and family members who have a central role in the prevention, early recognition, assessment and management of cognitive impairment; develop systems for their early consultation and involvement
- Comprehensively assess and develop an individualised plan (see Action 5.12 and 5.13)

- Provide relevant information to patients, carers and families in an easy-to-understand format, including information on delirium risk, delirium, and the roles of patients, carers and families; delirium may be a frightening experience for patients and families, and can be associated with feelings of remorse and shame[227]
- Respond to other care needs, including assistance with nutrition[228] and hydration (see Action 5.27), reorientation, safe mobilising, maintaining or restoring functioning, and providing meaningful activities[229,230]; these strategies also assist in prevention of delirium and other geriatric syndromes[231], and a well-structured and well-supported volunteer program can assist in implementation[180,232]
- Set goals of care based on the needs and preferences of the person with cognitive impairment; use processes for informed consent, shared and substitute decision-making, and advance care planning to set goals of care
- Manage medication issues, including
  - treating pain and reducing sedation[233]
  - undertaking medication reconciliation, and reviewing to identify, reduce or stop medicines that can cause or exacerbate cognitive impairment (see Action 4.10)
  - providing accurate medicines lists (see Action 5.12)
  - consulting, informing and educating patients, carers and substitute decision-makers (as well as the patient's general practitioner and care facility) about these processes
- Communicate effectively[234] and seek information to provide individualised care
- Respond appropriately to behavioural symptoms (see 'Manage the use of antipsychotic medicines', below)
- Provide a supportive environment– for example, implement evidence-based design principles in scheduled major capital works or refurbishments, as well as through simple, small-scale changes at the ward and room level (see Actions 1.29 and 1.30), and support carers and family members when they choose to be actively involved in a person's care
- Manage transitions effectively, including
  - information exchange and transfer of responsibilities among all relevant health service organisations and care providers, including seeking early primary care input (see Actions 6.7 and 6.8)
  - access to hospital substitution, outreach, fast-track or transition programs
  - referral for appropriate follow-up for undiagnosed cognitive impairment and after a delirium episode – for example, many patients who are identified with cognitive impairment or experience delirium may have undiagnosed dementia[235]
- If a comprehensive diagnostic process is not appropriate during admission, arrangements must be put in place for post-discharge assessment[236]; ensure that referral pathways are in place for post-discharge assessment, and involve and inform patients and carers about ongoing care decisions.[226]

Note that these steps are not linear. For example, keeping a person safe through responding to other care needs should happen at the same time as investigating the possible cause of delirium, if detected.

For patients at risk of delirium, implement multi-component delirium prevention strategies[226,237]

Patients aged 65 years and over, and patients with a known cognitive impairment (such as dementia), severe medical illness or hip fracture are considered to be at greatest risk.[226]

Note that delirium prevention strategies are also useful delirium management strategies – for example, early treatment of dehydration, sepsis, metabolic imbalance, immobilisation, sensory impairment and sleep disturbance.[233]

Introduce protocols to prevent and treat pain, reduce sedation, enable safe early mobilisation and reduce sleep disturbance.[233]

Set up procedures to avoid or remove catheters in a timely manner.

For all patients, be alert to, and assess for, delirium when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported (see Action 8.5)

To implement a system for caring for patients with cognitive impairment, use the screening, assessment and comprehensive care planning processes described in the Comprehensive Care Standard for guidance, including items that cover advance care plans.

Other relevant NSQHS Standards include the:

- Clinical Governance Standard, including developing a risk management framework, assessing and responding to training needs, and providing safe environments
- Partnering with Consumers Standard, including actively involving patients in their own care (as well as carers and families), obtaining informed consent, meeting the patient's information needs and sharing decision making
- Medication Safety Standard, particularly for medication reconciliation and review, and medicines lists
- Communicating for Safety Standard, particularly actions for clinical handover, communicating critical information and documentation
- Recognising and Responding to Acute Deterioration Standard, including systems to recognise and escalate care with acute deterioration in mental state, including delirium.

A Better Way to Care: Safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital[238] and the Delirium Clinical Care Standard[226] set out suggested strategies for health service organisations in early recognition, prevention, treatment and management of cognitive impairment. *A Better Way to Care* also provides links to further resources that are useful in implementing this action.

Links to other tools and resources to support the implementation of this action are available in the Resources section at the end of this standard.

Manage the use of antipsychotic medicines

Incorporate best practice[236] and legislation for the use of antipsychotics and other psychoactive medicines for people with cognitive impairment into policies and procedures. This includes:

- Conducting a comprehensive, formal assessment of any behavioural symptoms or changes, including assessment of potential unmet needs
- Communicating effectively and understanding the person
- Involving carers and family members
- Creating a supportive environment
- Managing training and education of the workforce (see Action 5.30)
- Avoiding physical restraint, if possible, and following guidance in Action 5.35 to minimise restraint
- Trying non-pharmacological approaches in the first instance
- Seeking behavioural management advice when required
- Starting pharmacological treatment only if a patient is severely distressed, or is at immediate risk of harm to themselves or others, and non-pharmacological interventions have been ineffective[226]
- If pharmacological interventions are prescribed
  - following 'start low, go slow, time limit and review'
  - selecting the agent based on evidence according to diagnosis, severity and patient factors such as comorbidities
  - avoiding multiple agents
  - considering evidence and pharmacokinetics when selecting dose, frequency and timing
  - documenting indications for use and providing instructions for community prescribers[239,240]
- Monitoring and collecting feedback on the use of antipsychotics and other psychoactive medicines.

Ensure that policies for preventing and responding to aggression include specific guidance on responding to acute behavioural disturbance in relation to cognitive impairment. Use non-pharmacological approaches in the first instance, involve carers and families, minimise sedation, and ensure that any medicine use is evidence based, including age-specific evidence. Over-sedation can have serious consequences, such as dehydration, falls, respiratory depression, pneumonia and death.[241]

Action 5.30

Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to:

a. Recognise, prevent, treat and manage cognitive impairment

b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care

Intent

Risks are minimised by undertaking strategies to recognise, prevent, treat and manage cognitive impairment

Clinicians, patients, carers and families work together to minimise anxiety or distress experienced by the person with cognitive impairment.

Key tasks

- Review and, if necessary, revise the organisation's education and training program to support implementation
- Provide access to education and training about the system that supports caring for patients with cognitive impairment, and agreed tools and responsibilities
- Work with clinicians and consumers to design and implement systems for working together, and for implementing strategies to minimise anxiety and distress experienced by a person with cognitive impairment
- Use regular feedback from patients, carers and families to improve collaboration.

Strategies for improvement

The whole workforce has a role in providing care and creating a person-centred culture. This means that all levels of the workforce need access to continual, targeted education, information and training.

Provide orientation, education and training for the workforce to understand their individual roles, responsibilities and accountabilities in working with patients, carers and families to prevent and reduce the risk of harm for people with cognitive impairment or at risk of developing delirium.

Include information about forms of cognitive impairment other than dementia and delirium, because people with other forms of cognitive impairment also have poor experiences.[242]

Ensure that training and education programs cover the elements of the system for caring for cognitive impairment described in Action 5.29.

Multifaceted education programs that include enabling and reinforcing techniques can result in positive outcomes for patients.[243] Online training and education resources are included in the Resources section at the end of this standard.

Consider liaising with Dementia Training Australia, Dementia Support Australia and Dementia Australia.

Consider developing initiatives such as recruiting cognitive champions who can reinforce education, offer peer support to help clinicians improve their skills and confidence, and organise relevant resources for their wards.[244]

Consider implementing evidence-based programs, such as TOP 5[245], that assist clinicians and carers to work together to reduce a person's distress. Well-structured and well-supported volunteer programs and modification of the environment (see Action 1.29) can also help to reduce a person's distress.

Action 5.31

The health service organisation has systems to support collaboration with patients, carers and families to:

a. Identify when a patient is at risk of self-harm

b. Identify when a patient is at risk of suicide

c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed

Intent

The workforce has the skills and knowledge to engage collaboratively to identify and respond to patients at risk of self-harm or suicide.

Key tasks

- Implement screening for thoughts of self-harm or suicide for people who present with self-harm, mental illness or acute emotional distress
- Set up a tiered system for response according to the level of risk
- Ensure that the environment is safe
- Maintain a recovery-oriented approach throughout engagement.

Strategies for improvement

Identify risk of self-harm

When a person presents with self-harm or thoughts of self-harm, their physical safety is often the clinical priority. Triage can be supported by use of a validated tool such as the Mental Health Triage Tool.[246]

Maintain an empathic, non-judgemental approach while implementing clinical actions. Engage therapeutically with the person to understand what the act or thought of self-harm means for the person. Self-harm can be related to suicidal thoughts, or can be independent of these. The person may or may not be clear about their intent. Some self-harm may be enacted without suicidal ideation, but still present a risk to the person's life. Always consider self-harm seriously.

Processes of respectful and effective therapeutic engagement create safety for people who have thoughts of self-harm or suicide. Avoid making presumptions about the person's intent, including whether the person's self-harm does or does not indicate suicidal thoughts or is 'attention-seeking'. Communicate with the person, their carers and family, and other clinicians in non-judgemental language.

The Royal Australian and New Zealand College of Psychiatrists endorses the national guidelines developed in the United Kingdom by the National Institute for Health and Care Excellence on the clinical management of self-harm.[247]

Some people have recurrent episodes of self-harm, including people who have been diagnosed with borderline personality disorder. Members of the workforce may experience conflicting feelings about treating people for recurrent self-harm. Clinical guidelines have been developed to support health service organisations.[248]

Identify risk of suicide

When a person presents with suicidal thoughts, or has attempted suicide, their immediate physical safety is a priority. Use the environment, formal observation, and engagement with the person and any accompanying support people to ensure that the person remains safe until comprehensive assessment is conducted and a collaborative care plan is initiated. Steps taken to implement this action align with the Clinical Governance Standard, the Partnering with Consumers Standard, and the Recognising and Responding to Acute Deterioration Standard.

Ensure that the organisation has a system in place for frontline members of the workforce to gain access to specialist mental health expertise to assess and manage a person with suicidal thoughts. This process should be developed locally, and reflect available resources and partnership agreements. Ensure that members of the workforce are aware of the local process and how to escalate care. Review the effectiveness of the local process regularly, and in response to critical incidents.

Ensure implementation of national, state or territory, or local policies, such as the NSW Health policy Clinical Care of People Who May Be Suicidal.[249]

Many people who attempt suicide have contacted a member of the workforce before the attempt. Train all members of the workforce to recognise signs of potential risk for suicide and engage therapeutically to develop trust so that people can discuss these thoughts. People who have been treated after a suicide attempt report that the attitudes of members of the healthcare workforce were an important factor determining whether they would disclose suicidal thoughts in the future.[165]

For some people, treatment after a suicide attempt may be the first time that the clinical or social stressors leading to the attempt have come to light.

Comprehensive psychosocial assessment may reveal mental illness or substance use conditions that can respond to clinical treatment, or social factors such as domestic violence that increase the risk of suicide. Ensure that the organisation has the capacity to deal with the issues, or has established links with partner organisations.

Adopt a recovery-oriented approach, focused on restoring hope, throughout clinical engagement with a person after a suicide attempt. The specific treatment immediately after a suicide attempt is likely to be a brief episode in the person's experience. They and their families will be dealing with the long-term effects, and interventions need to:

- Align with the patient's and family's existing skills, values and preferences
- Identify the supports that may be needed to achieve these
- Link to these services.

Currently, less than half of the people who have attempted suicide report being involved in treatment decisions.[165]

Carers and family members often need extra support to cope with a person's suicide attempt. Provide these services, or arrange for a partner organisation to do so. These supports are also needed for family members if a person has completed suicide. A range of organisations can provide this support, including:

- Lifeline
- Support After Suicide
- beyondblue.

Use tools and resources

Population screening is recommended for certain groups when higher risk has been identified for members of the group who have no previous history of mental illness or self-harm. For instance, women accessing prenatal services are screened using the Edinburgh Postnatal Depression Scale.

The national framework for suicide prevention sets out the roles of health service and other organisations. Called Living is for Everyone, the framework is supported by a regularly updated website. The website also contains a series of fact sheets, which include guidance about suicide prevention strategies and how to implement them.

Reflecting the specific issues facing Aboriginal and Torres Strait Islander Australians, there is also a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.[250] Ensure that members of the workforce are familiar with this strategy, and review processes to ensure that they cover the issues for the local Aboriginal and Torres Strait Islander communities. Support this approach with workforce training in culturally competent care, and the employment of, or partnerships with, experts in Aboriginal and Torres Strait Islander mental health, and social and emotional wellbeing.

Action 5.32

The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts

Intent

Adequate follow-up support is arranged and agreed by the nominated participants for when people who have self-harmed or reported suicidal thoughts leave the health service organisation.

Key tasks

- Develop a collaborative post-discharge treatment plan involving the person, their carers and family, and key service providers before the person leaves the health service organisation
- Communicate this plan verbally and in writing to all people who have a role in implementing the plan
- Ensure that the plan is implemented.

Strategies for improvement

People who have recently attempted suicide are at increased risk of a subsequent attempt in the days and weeks following discharge from healthcare settings.[165] People who have recently started antidepressant medicines are at increased risk of suicide. However, there is considerable variation in follow-up arrangements when people leave a health service organisation after a suicide attempt, with up to 30% of people leaving without any formal arrangements in place.

It is therefore essential that health service organisations ensure adequate follow-up for people who have harmed themselves or reported suicidal ideation. The Living is for Everyone framework underlines that 'it is critical that the chain not be broken, as levels of risk can change rapidly'.[251]

Develop the post-discharge treatment plan

Ensure that development of the plan is collaborative and recovery oriented, using the principles of shared decision making outlined in the Partnering with Consumers Standard. Engage the person, their carers and family, and any other person involved in implementing the plan, and give them the opportunity to advise whether actions within the plan are feasible.

Post-discharge care may require cooperation across a number of different health and other service organisations in the community. Ensure that the roles and contact details are available to all key participants. If there is a person coordinating services, or if care is shared between different clinicians and services, include this information in the plan.

Communicate the post-discharge treatment plan

Ensure that communication of the plan is multimodal, using verbal, written and electronic means (where available). Confirm receipt of communication about the plan from key participants before discharge. Conduct all communications in respectful, non-judgemental language.

Implement the post-discharge treatment plan

Confirming implementation of the plan can present a challenge. For specialist mental health services, the rate of post-discharge community care within seven days is a nationally agreed performance indicator[252], and follow-up can be confirmed internally within the organisation.

In situations in which clinical accountability is being transferred between services, support this process by establishing partnerships. For instance, when a person is being discharged from a private hospital, and they have an appointment with a private psychiatrist who has seen them in hospital and is sharing care with a general practitioner, processes can be implemented that specify when each clinician is reviewing the person, and how communication is being shared. Negotiate these arrangements such that they do not breach privacy legislation, but also such that privacy cannot be invoked and leave key participants uninformed of critical information.

The National Institute for Health and Care Excellence in the United Kingdom has developed guidelines for the longer-term clinical management of self-harm[253] that align with the guidelines for short-term clinical response. These guidelines have been endorsed for use in Australia by the Royal Australian and New Zealand College of Psychiatrists.

Ensure that health service organisations working with recovery-oriented practice balance risk management with people's stated preferences for care, particularly when a person has recently been identified as at high risk of self-harm or suicide.

Predicting, preventing and managing aggression and violence

Action 5.33

The health service organisation has processes to identify and mitigate situations that may precipitate aggression

Intent

The risk of aggression and violence is minimised by reducing environmental or procedural triggers for aggression.

Key tasks

- Identify factors in the environment that could trigger aggression or complicate management of aggression when it occurs
- Identify elements of the organisation's procedures that could contribute to stress, which may lead to aggression
- Implement strategies to lessen stresses caused by environmental or procedural factors.

Strategies for improvement

Aggression and violence are predictable in healthcare settings, and health service organisations need to implement strategies to reduce the risk of aggression occurring, and reduce the risk of harm when it does occur. This action relates to steps that an organisation can take to modify environmental or procedural factors that can contribute to the risk of aggression.

It links to Action 1.29, which addresses designing healthcare environments to maximise safety. It also links to Action 5.34, which addresses strategies to reduce the risk of aggression in individual patients.

Healthcare environments can be stressful places. People are dealing with uncomfortable experiences, including pain and uncertainty, in environments that are both unfamiliar and high stimulus. People also experience frustration with processes that may be routine for members of the healthcare workforce, but are new and not always comprehensible from the perspective of the patient or carer. For some people, these contextual factors can lead to feelings of aggression.

Although the design of healthcare environments can contribute to reducing aggression, it is not always possible to change the 'bricks and mortar' in the short term.

Use the given environment in ways that reduce the risk of aggression, such as:

- Allowing people to move around, preferably with access to outside areas
- Reducing stimulus such as bright lights or loud noises
- Providing privacy using curtains or side lounges.

Sensory modulation spaces and resources help people to manage their own distressing feelings and regain control without restrictive interventions or aggressive outcomes.

The Safewards intervention is a specialist concept, designed for use in mental health inpatient units. The model acknowledges the settings and processes through which mental health inpatient services are inherently stressful. It guides members of the workforce to recognise potential sources of conflict or 'flashpoints', and implement a range of strategies to contain risks.

Action 5.34

The health service organisation has processes to support collaboration with patients, carers and families to:

a. Identify patients at risk of becoming aggressive or violent

b. Implement de-escalation strategies

c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce

Intent

Collaborative processes are used to minimise the risk of aggression and violence, and incidents are managed safely when they occur.

Key tasks

- Train the workforce to effectively screen for specific risks
- Implement processes that support members of the workforce to use strategies to reduce the risk of violence
- Implement processes to respond to aggression and violence when they occur, to minimise the risk of harm to people.

Strategies for improvement

Screening for risk of aggression and violence is an important and complex undertaking for members of the healthcare workforce. Because it is predictable that violence will occur in healthcare settings, ensure that the health service organisation has effective risk assessment and risk management processes in place. The National Institute for Clinical Excellence guidelines recommend the use of standardised tools to augment clinical judgement.[254]

Predictive factors for risk of aggression include:

- Previous history of aggression or violence
- Intoxication or withdrawal from licit or illicit substances
- Acute brain injury
- Cognitive impairment.

Ensure that the use of screening tools and risk management processes does not lead to stigmatising practices, which have been associated with suboptimal healthcare delivery. In particular, ensure that people with mental illness are not automatically assessed as presenting high risk for aggression, and, conversely, that people without mental illness are categorised as low risk. Risk assessment needs to be a dynamic process, based on evidence, rather than assigning a person to a category and proceeding.

There will be times when a person who has not been screened as presenting a risk of violence becomes aggressive. Be alert to changes in a person's behaviour, cognitive function, perception, physical function or emotional state that may indicate deterioration in their mental state and lead to aggression. This action aligns with the Recognising and Responding to Acute Deterioration Standard. The *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state*[255] outlines the processes to effectively manage these situations.

Train the workforce in the use of de-escalation strategies, which are demonstrated to reduce the likelihood of verbal aggression progressing to physical violence.[256] De-escalation strategies are appropriate for patients with severe behavioural disturbance relating to delirium or dementia, when sedation should be avoided unless they are at risk of

harm to themselves or others. Ensure that policies relating to preventing and responding to aggression include specific guidance on sedation that is age appropriate.

Principles for Safe Management of Disturbed and/or Aggressive Behaviour and the Use of Restraint[257] contains valuable information about aggressive patient behaviour.

Minimising restrictive practices: restraint

Action 5.35

Where restraint is clinically necessary to prevent harm, the health service organisation has systems that:

a. Minimise and, where possible, eliminate the use of restraint

b. Govern the use of restraint in accordance with legislation

c. Report use of restraint to the governing body

Intent

Harm relating to the use of restraint is minimised.

Key tasks

- Understand where and when restraint is used in the health service organisation
- Benchmark the use of restraint
- Demonstrate implementation of strategies to reduce the use of restraint
- Ensure that members of the workforce who implement restraint are trained to do so safely
- Monitor and document appropriate observations during and subsequent to restraint
- When restraint has occurred, offer debriefing for the people involved, including patients, carers and members of the workforce.

Strategies for improvement

Know the types of restraint

Restraint is the restriction of an individual's freedom of movement.[258] It includes mechanical restraint, physical restraint, and chemical or pharmacological restraint.

Mechanical restraint is the application of devices (including belts, harnesses, manacles, sheets and straps) to a person's body to restrict their movement. This is to prevent the person from harming themselves or endangering others, or to ensure that essential medical treatment can be provided. It does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's capacity to get off the furniture, except when the devices are only used to restrain a person's freedom of movement. The use of a medical or surgical appliance for the proper treatment of physical disorder or injury is not considered mechanical restraint.

Physical restraint is the application by members of the healthcare workforce of hands-on immobilisation or the physical restriction of a person to prevent them from harming themselves or endangering others, or to ensure that essential medical treatment can be provided.[259]

Chemical/pharmacological restraint is defined in some state and territory mental health Acts, but there are no nationally comparable data supply activities for this category.[259] There is a lack of consensus on the definition of chemical/pharmacological restraint[260], because of difficulties in determining whether a clinician's intent is primarily to treat a person's symptoms or to control their behaviour. For this reason, the Commission does not currently require health service organisations to report on the use of chemical restraint (except when this is directed

under state or territory legislation). Nonetheless, organisations should seek to understand if there is inappropriate use of medicines, and note if rates of rapid tranquilisation increase.

Use strategies, tools, resources and training to minimise restraint

Restraint is practised in mental health services and other health service organisations. Minimising and, if possible, eliminating the use of restraint and seclusion were identified as a national safety priority for mental health services in Australia in 2005.[166]

The key to minimising use of restrictive practices is to be alert to changes in a person's behaviour or demeanour that may suggest a deterioration in their mental state. Be receptive to information from the person themselves, and from their carers and families. People who have experienced mental health issues, or cared for someone who does, often have detailed knowledge about what can lead to a deterioration in their mental state, and what strategies are most effective for restoring their capacity to manage their mental state without the use of restrictive practices. These principles are outlined in the *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state*.[255]

The National Seclusion and Restraint Project identified six main strategies for health service organisations to minimise restraint:

- Leadership towards organisational change
- Use of data to inform practice
- Workforce development
- Use of restraint and seclusion reduction tools
- Improving the consumer's role
- Debriefing techniques.

These are described in detail in the Mental Health Professional Online Development training module Reducing and Eliminating Seclusion and Restraint.[261] This training module also includes information on strategies to reduce the use of restraint.

The Royal Australian and New Zealand College of Psychiatrists *Position Statement 61: Minimising the use of seclusion and restraint in people with mental illness*[260] supports the principles outlined above, and makes recommendations, including a review of the concept of chemical restraint, and cautions against using prone restraint.

Within mental health services, the use of restraint is governed through state or territory legislation, or mandatory policy. It is critical that health service organisations ensure that, when restraint is practised, members of the workforce are aware of, and practise within, the legislation of their state or territory. Legislative requirements differ between states and territories. The 2014 *Seclusion and Restraint Project Report* by the Melbourne Social Equity Institute maps these differences.[262] Links to current state and territory legislation are provided in the Resources section at the end of this standard.

Outside mental health services, restraint is used, but often with less reporting and oversight. Older people with cognitive impairment are more likely than the general population to be restrained in acute care services, and also more likely to experience adverse outcomes relating to the use of restraint.[263,264] In 2009, the Commission released *Preventing Falls and Harm From Falls in Older People: Best practice guidelines for Australian hospitals*.[154] These guidelines explain that, although falls prevention is often cited as a reason for using restraints, research has shown that restraint can increase the chance of falls. These guidelines include strategies to reduce the use of restraint and to prevent falls.

In 2015, SA Health released a suite of documents relating to the use of restrictive practices in health care, including a policy framework, guidelines, implementation tools and fact sheets for clinicians.

Action 5.36

Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that:

a. Minimise and, where possible, eliminate the use of seclusion

b. Govern the use of seclusion in accordance with legislation

c. Report use of seclusion to the governing body

Intent

Harm relating to the use of seclusion is minimised.

Key tasks

- Implement strategies to minimise the use of seclusion
- Ensure that seclusion is only implemented by members of the workforce who have been trained to implement it safely
- Monitor and document appropriate observations during and subsequent to seclusion
- Review the use of seclusion within the health service organisation.

Strategies for improvement

Seclusion is the confinement of a patient, at any time of the day or night, alone in a room or area from which free exit is prevented.[258]

The strategies to minimise the use of restraint (see Action 5.35) also apply to seclusion, as both are restrictive practices. Ensure that the workforce is trained in de-escalation skills, implement routine observations of the person in seclusion, and provide for the person's physical needs and dignity.

The use of seclusion in mental health services is governed by state and territory legislation and mandatory policy. This typically includes designated processes for reporting and review of the use of seclusion, at local unit, hospital, local health network, state or territory, and national levels. Links to current state and territory legislation are provided in the Resources section at the end of this standard.

The use of seclusion outside designated mental health services is unlawful, and health service organisations should ensure that it does not occur.

Resources

Developing the comprehensive care plan

Care of Confused Hospitalised Older Persons (CHOPs) program

Dementia Care in Hospitals Program

Older people in hospital

Royal Children's Hospital Complex Care Hub

Triple CCC Project – Care, Communicate, Coordinate.

Multidisciplinary teamwork

Australian Commission on Safety and Quality in Healthcare – *Standard Operating Protocols for Implementing Whiteboards to Assist with Multidisciplinary Communication on Medical Units*

Cancer Australia – Planning a multidisciplinary care meeting

In Safe Hands program – Structured interdisciplinary bedside rounds

Institute for Healthcare Improvement – How-to guide: multidisciplinary rounds

Advance care planning

Advance Care Planning Australia

End-of-life care

Australian Commission on Safety and Quality in Healthcare – End-of-life care

Flinders University – End-of-life essentials

New South Wales Agency for Clinical Innovation and Clinical Excellence Commission – Palliative and end of life care: A blueprint for improvement

Queensland Health – *Statewide Strategy for End-of-Life Care 2015*

SA Health – End of life care for health professionals

Tasmanian Department of Health and Human Services – Advance care planning for healthy dying

Victorian Department of Health and Human Services – End of life and palliative care

Western Australian Department of Health – End of life

Tools and processes to help identify patients with end-of-life care needs include:

- The SPICT™ (The Supportive and Palliative Care Indicators Tool)
- Gold Standards Framework
- AMBER Care Bundle

Nutrition and hydration

Nutrition standards

Dietitians Association of Australia – *Nutrition Manual*, 9th edition, 2014

NSW Agency for Clinical Innovation – *Nutrition Standards for Adult Inpatients in NSW Hospitals*

NSW Agency for Clinical Innovation – *Nutrition Standards for Consumers of Inpatient Mental Health Services in NSW*

Queensland Health – *Nutrition Standards for Meals and Menus*

The Nutrient Reference Values for Australia and New Zealand, the *Australian Dietary Guidelines* and the *Australian Guide to Healthy Eating* are intended for use with healthy populations but may be relevant to some groups receiving care in hospitals and day procedure services

Victorian Department of Human Services – *Nutrition Standards for Menu Items in Victorian Hospitals and Residential Aged Care Facilities*

Western Australian Department of Health – *Nutrition Standards for Adult Inpatients in WA Hospitals*

Nutrition risk screening and assessment tools

Lady Cilento Children's Hospital – Paediatric Nutrition Screening Tool

Malnutrition Screening Tool

Malnutrition Universal Screening Tool

Mini Nutritional Assessment

Subjective Global Assessment

Other tools

- Discharge report
- Food and fluid consumption chart
- Food diary

Preventing delirium and managing cognitive impairment

Australian Commission on Safety and Quality in Health Care resources

A Better Way to Care: Safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital

Delirium Clinical Care Standard

Implementing systems for cognitive impairment

Care of Confused Hospitalised Older Persons (CHOPS)

Dementia Care in Hospitals Program

Acute care e-learning course for dementia

The View from Here

Delirium

Australasian Delirium Association

Delirium awareness video

Health Research & Educational Trust (United States) – Preventing and Managing Iatrogenic Delirium Change Package

Hospital Elder Life Program (HELP) for Prevention of Delirium

Queensland University of Technology – Learn about delirium

Responding to distress

Dementia Support Australia – Resources library

NPS MedicineWise and Alzheimer's Australia resource on medicines and dementia (includes a fact sheet on *Strategies to Address Distress*)

NSW Agency for Clinical Innovation – Volunteer Dementia and Delirium Care program

Royal Australian and New Zealand College of Psychiatrists – *Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD): A handbook for NSW health clinicians*

University of Sydney – *Clinical Practice Guidelines and Principles of Care for People with Dementia in Australia*

Communication

Alzheimer's Australia – *Dementia Language Guidelines*

Alzheimer's Australia – *Talk to Me: Good communication tips for talking to people with dementia*

Alzheimer's Society – *This is Me*

Centre for Developmental Disability Health – *Working with People with Intellectual Disabilities in Healthcare Settings*

Focus on the Person

NSW Agency for Clinical Innovation – Sunflower Tool

Queensland Health – Communication changes after ABI

Stroke Foundation – Communication after stroke

Environment

Dementia Enabling Environments

Dementia Training Australia

Partnering with patients, carers and family

NSW Clinical Excellence Commission – Top 5 Initiative

Predicting, preventing and managing self-harm and suicide

National Health and Medical Research Council – *Care After a Suicide Attempt*

Predicting, preventing and managing aggression and violence

CPI – *Nonviolent Crisis Intervention*® training program

MTU Training Concepts – *Predict, Assess and Respond to Challenging Behaviour (PART)*

NSW Health – *Violence Prevention and Management Training Framework for NSW Health Organisations*

Minimising restrictive practices

Legislation

ACT Mental Health Act 2015, Chapter 5 – Mental Health Orders, Part 5.4 – Psychiatric treatment orders, s. 65 – Powers in relation to psychiatric treatment order

Northern Territory Mental Health and Related Services Act 2004, Part 9 – Regulation of certain treatments and measures, s. 61 – Mechanical restraint

Queensland Mental Health Act 2016, Chapter 8 – Use of mechanical restraint, seclusion, physical restraint and other practices

South Australian Mental Health Act 2009, Division 4 – Level 3 inpatient treatment orders, s. 34A – Confinement and other powers relating to involuntary inpatients

Tasmanian Mental Health Act 2013, Division 5 – Seclusion and restraint, s. 57 – Restraint, s. 58 – Records

Victorian Mental Health Act 2014, Part 6 – Restrictive interventions, Division 1 – General, Division 3 – Bodily restraint

Western Australian Mental Health Act 2014, Part 14 – Regulation of certain kinds of treatment and other interventions, Division 6 – Bodily restraint

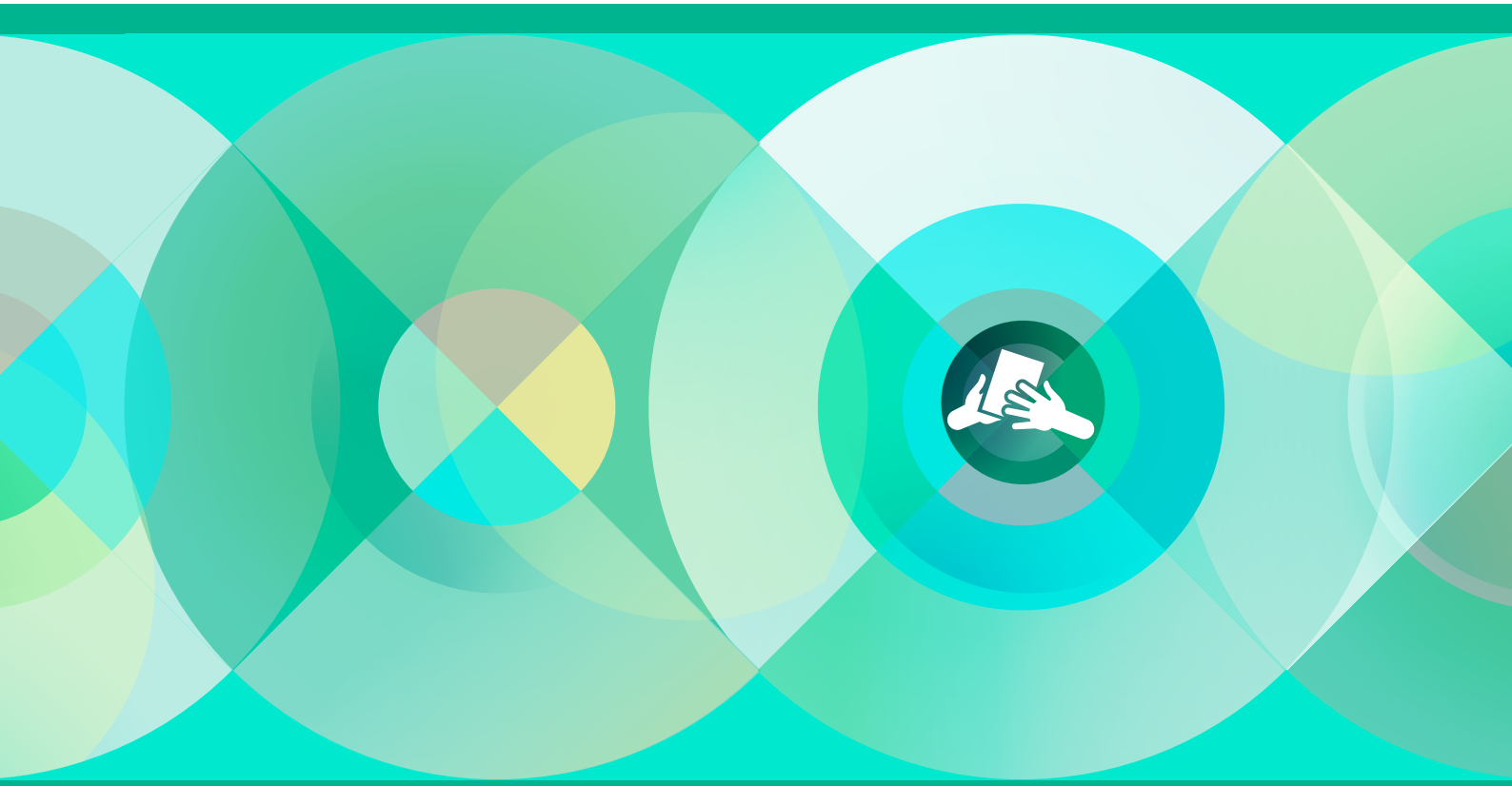
Policies and guidelines

NSW Health – *Policy Directive: Aggression, seclusion and restraint in mental health facilities in NSW*

SA Health – *Policy Guideline: Restraint and seclusion in mental health services*

6

Communicating for Safety Standard



Communicating for Safety Standard

Leaders of a health service organisation set up and maintain systems and processes to support effective communication with patients, carers and families; between multidisciplinary teams and clinicians; and across health service organisations. The workforce uses these systems to effectively communicate to ensure safety.

Intention of this standard

To ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for patients.

Criteria

Clinical governance and quality improvement to support effective communication

Correct identification and procedure matching

Communication at clinical handover

Communication of critical information

Documentation of information

Introduction

Communication is a key safety and quality issue, and is critical to the delivery of safe patient care. Communication failures, and inadequate or poor documentation of clinical information can result in errors, misdiagnosis, inappropriate treatment and poor care outcomes.[185,190,209,265-268] Communication errors are also a major contributing factor in sentinel events in health service organisations[269], and communication issues are identified as one of the most common underlying factors in complaints about the Australian healthcare system.[270-272]

This standard recognises the importance of effective communication in health care and the essential role that communication plays in ensuring safe, coordinated and continuous care (Figure 2). Actions in this standard focus on three high-risk areas where communication is critical to patient safety:

- When patient identification and procedure matching should occur
- When all or part of a patient's care is transferred within an organisation, between multidisciplinary teams and clinicians, across organisations and on discharge (that is, at transitions of care)
- When critical information or risks emerge or change throughout the course of care.

Contemporaneous documentation and recording of information that supports the provision of health care are also essential.

Communication is inherent to patient care, and informal communications will occur throughout care delivery. This standard is not intended to apply to all communications within the organisation. Rather, it aims to ensure that systems and processes are in place at key times when effective clinical communication and documentation are critical to patient safety.

About this standard

This standard specifically outlines the high-risk situations when effective communication is critical to ensure safe, continuous patient care. The standard requires health service organisations to implement systems and processes to support effective clinical communication and documentation.

This standard is informed by research and work undertaken in Australia and internationally, which recognises the importance of effective clinical communication and documentation to the delivery of safe and high-quality health care.[209,267,268] This includes work by the Australian Commission on Safety and Quality in Health Care (the Commission) on the Ensuring Correct Patient, Correct Site, Correct Procedure Protocol[273]; the National Clinical Handover Initiative Pilot Program[268]; the *OSSIE Guide to Clinical Handover Improvement*[209], and the Implementation Toolkit for Clinical Handover Improvement.[274] The Commission has also supported research on improving transitions of care[275], patient–clinician communication[276] and documentation.

Figure 2: Actions that support effective clinical communication and safe patient care across the NSQHS Standards

Clinical governance and partnering with consumers

Overarching actions that support integrated clinical governance, quality improvement and organisational systems to support effective clinical communications

- **Clinical Governance Standard:** ● 1.16, 1.17, 1.18 – Healthcare records; and ● 1.12 – Open disclosure
- **Partnering with Consumers Standard:** ● 2.3, 2.4, 2.5 – Healthcare rights and informed consent; ● 2.6, 2.7 – Sharing decisions and planning care; and ● 2.8, 2.9, 2.10 – Communication that supports effective partnerships
- **Communicating for Safety Standard:** ● 6.1, 6.2, 6.3, 6.4 – Clinical governance and quality improvement to support effective communication

Consider documentation requirements at all stages

Relevant, accurate, complete and timely information is documented in the healthcare record to support patient care (●3.7, ●4.5, 4.6, 4.8, 4.10(c), 4.12, ● 5.4(a), 5.9, 5.12, 5.13, 5.17(b), ●6.6, 6.11, 7.5, ●8.4(a), 8.5(e))

Effective communication is critical at all stages of care

Clinicians should have the skills and knowledge to effectively communicate with patients, carers, families and other members of the care team

Patient's journey

A patient enters a health service organisation

FLOW OF INFORMATION – All relevant information should follow the patient

A patient exits a health service organisation

A patient is in their home/community/ other service

Communicating at registration and admission

Actions to gather administrative information; information about a patient's goals and preferences; and information to inform the plan of care

- Correct identification and procedure matching (●6.5, 6.6)
- Sharing decisions and planning care (●2.6, 2.7)
- Communication to support effective partnerships (●2.8, 2.9, 2.10)
- Informed consent and decision-making capacity (●2.4, 2.5)
- Medication history (including adverse drug reactions) and reconciliation (●4.5, 4.6, 4.7, 4.8)
- Routinely asking patients if they identify as Aboriginal or Torres Strait Islander (●5.8)
- Planning for comprehensive care, screening of risk and clinical assessment (●5.7, 5.9, 5.10, 5.11)
- Preventing delirium and managing cognitive impairment (●5.29, 5.30)

Communicating to plan care and when care, therapy or medication is provided

Actions to support effective communication to support decision-making about care, including between clinicians and multidisciplinary teams; and between clinicians and patients, families and carers

- Correct identification and procedure matching (●6.5, 6.6)
- Sharing decisions and planning care (●2.6, 2.7)
- Communication to support effective partnerships (●2.8, 2.9, 2.10)
- Providing information to patients on their medicine needs and risk (●4.11)
- Systems to deliver comprehensive care, developing and using comprehensive care plan (●5.4(a), 5.13, 5.14)
- Identifying at all times the clinician with overall accountability for patient care (●5.4(d))
- Collaboration and teamwork (●5.5, 5.6)
- Comprehensive care planning, including end-of-life care where appropriate (●5.9, 5.13, 5.15, 5.20)
- Preventing delirium and managing cognitive impairment (●5.29, 5.30)

Communicating acute deterioration and escalating care

Actions where acute deterioration occurs and care needs to be escalated

- Clinicians recognise acute deterioration (in physiological and mental state) and escalate care (●8.5(e), 8.6, 8.8, 8.9)
- Escalation by patients, carers or families (●8.7)

Communicating at transitions of care

Actions when all or part of a patient's care is transferred on a temporary or permanent basis

- Correct identification and procedure matching (●6.5, 6.6)
- Structured clinical handover (●6.7, 6.8)
- Sharing decisions and planning care (●2.6, 2.7)
- Communication to support effective partnerships (●2.8, 2.9, 2.10)
- Ensuring timely and appropriate referral (●5.4(c))
- Communicating infectious state (●3.7)
- Reviewing current medicine order, reconciling any discrepancies at transitions of care (●4.6)
- Providing medicines list to receiving clinicians at transitions of care (●4.12(b))

Communicating at discharge

Actions relevant on discharge, noting that discharge is one type of transition of care

- Correct identification and procedure matching (●6.5, 6.6)
- Structured clinical handover (●6.7, 6.8)
- Sharing decisions and planning care (●2.6, 2.7)
- Communication to support effective partnerships (●2.8, 2.9, 2.10)
- Aligns with comprehensive care plan (●5.13)
- Provision of medicines list to receiving clinicians at transitions of care (●4.12(b))

Follow-up communication

Actions that support closed-loop communication

- Communicating critical information to clinicians and patients (●6.9)
- Transfering responsibility and accountability for care (●6.8(f))
- Predicting, preventing and managing self-harm and suicide (●5.31, 5.32)

Communicating when critical information emerges or changes

Critical information may arise throughout the course of care, and may require changes to the plan of care

- Communicate critical information and risks to clinicians and patients (●6.9)
- Patients, carers and families able to communicate critical information (●6.10)
- Review and adapt plan, reassess patients needs (●5.14(c)-(d))
- Communicate adverse drug reactions during an episode of care or ineffective management of medication (●4.8)

Links with other standards

Communication is important across all aspects of care. Implementation of this standard will depend on the organisation-wide systems required under the Clinical Governance Standard and the Partnering with Consumers Standard. These two standards set the overarching requirements for effective implementation of actions within this Communicating for Safety Standard. There are also strong links with actions in the Medication Safety Standard, the Comprehensive Care Standard, and the Recognising and Responding to Acute Deterioration Standard. If appropriate, these standards should be applied in conjunction with this standard.

For example, the Clinical Governance Standard requires organisations to integrate multiple information systems, where they are used (Action 1.16e), and have in place a healthcare record system that makes the healthcare record available to clinicians at the point of care (Action 1.16a). By ensuring that clinicians have access to all the relevant information, these actions support clinicians to effectively communicate. In turn, this standard requires organisations to have systems to contemporaneously document relevant information in the healthcare record, ensuring that the most up-to-date information is available to clinicians.

Communication is integral to all aspects of patient care, and should be considered in the broader context of service delivery. Figure 2 provides a visual representation of how communication with patients, carers and families, and between clinicians and multidisciplinary teams is important during the whole patient journey. It maps where actions across the NSQHS Standards should be considered when implementing strategies and processes to improve communication. It also highlights the importance of considering how the NSQHS Standards work together.

Case study 1: Royal Brisbane and Women's Hospital

Service profile: Royal Brisbane and Women's Hospital (RBWH), Queensland, is a 937-bed quaternary and tertiary referral teaching hospital close to the Brisbane central business district, with approximately 7,500 workforce members.

What changes did the service make and why?

The service introduced an extensive new program for safe clinical handover, underpinned by a need to create awareness that clinical handover was not just shift to shift, but involved the whole transition of care. The RBWH took a phased approach to the rollout, which was led by its Safety and Quality Unit:

- 2012 – Literature review and organisational mapping
- 2013 – Pilot program
- 2014 – Hospital-wide implementation
- 2015 – Evaluation of program, targeting gaps, support of quality improvement projects
- 2016 – Monitoring and continued improvements.

The OSSIE guide gave an overview and set the direction for implementation.[209] After reviewing the literature and handover programs elsewhere, the Clinical Handover Steering Committee chose to follow the framework and templates developed by NSW Health.[277]

The aim was to introduce a single framework for communication across the hospital that allowed different areas of the hospital to customise it to their needs.

The RBWH piloted the single framework for handover in 10 areas of the hospital to see if they could use this standard, but flexible, approach in a quaternary hospital.

This was so members of the workforce could target their own gaps and quality improvement needs, and address the silos through a generic framework across the patient journey.

Training and awareness have been a key aspect of the program, with in-service training and awareness initiatives conducted in 360 areas of the hospital to date.

What were the outcomes?

The program has resulted in changes in practice, from small to large. For example, pharmacy and oncology departments have changed their forms for handover reports so the most important details for safe handover are clearly shown. The hospital believes that the standardisation of communication in all its various forms and professional groups has improved, and will continue to do so. In addition, the hospital has recognised that major changes are required to embed safe handover in after-hours settings. As a result, multiple changes have been made, including:

- The introduction of new or improved handover tools, including telephone handover
- Formalisation of medical handover at night across the hospital
- Use of the Patient Flow Manager IT system to provide the medical workforce with a medical handover checklist, and escalation plans that are mainly used by residents
- New processes for identifying high-risk patients in the after-hours setting – for example, senior nurses are using a handover tool and standardising their processes to ensure that high-risk patients are identified earlier.

CRITERION: Clinical governance and quality improvement to support effective communication

> *Systems are in place for effective and coordinated communication that supports the delivery of continuous and safe care for patients.*

For systems and processes to work effectively and consistently across a health service organisation, they need to be embedded in the overall governance of the organisation.

This criterion requires organisation-wide governance, leadership and commitment to support effective clinical communication with patients, carers and families; between clinicians and multidisciplinary teams; and across organisations. To meet this criterion, health service organisations are required to:

- Integrate clinical governance and apply quality improvement systems
- Apply principles of partnering with consumers, health literacy and shared decision making when developing and implementing organisational clinical communication processes
- Implement safety and quality systems and processes to support effective clinical communication during high-risk situations.

Organisations will need to understand their priorities; identify their risks in relation to clinical communications; and consider how to best deal with these within their given resources, and workforce and organisational structures.

This criterion aligns closely with the Clinical Governance Standard and the Partnering with Consumers Standard.

Integrating clinical governance

Action 6.1

Clinicians use the safety and quality systems from the Clinical Governance Standard when:

a. Implementing policies and procedures to support effective clinical communication

b. Managing risks associated with clinical communication

c. Identifying training requirements for effective and coordinated clinical communication

Intent

Safety and quality systems support effective clinical communication.

Key tasks

- Establish and implement governance structures for clinical communication
- Develop and implement policies and procedures for clinical communication
- Use organisation-wide risk management systems to identify, monitor, manage and review risks associated with clinical communication
- Deliver or provide access to training on clinical communication based on the specific needs of the clinical workforce.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' safety and quality systems.

- Action 1.7 – policies and procedures
- Action 1.10 – risk management systems
- Actions 1.19, 1.20 and 1.21 – education and training

Health service organisations should:

- Use these and other established safety and quality systems to support the policies and procedures, risk management and training for clinical communications

Ensure that current versions of all relevant policies and procedures are readily available and accessible to clinicians.

Policies may be developed or adapted at different levels within the organisation. However, all policy documents should be incorporated into a single, coherent set to maximise the effectiveness of the policy development process.

Implement policies and procedures

Policies and procedures should outline how organisation-wide systems support effective clinical communication.

Organisations vary significantly, depending on the size of the service, settings and circumstances. This highlights the need for a flexible approach to implementation.[209] Implementation of policies and procedures to improve clinical communications therefore requires consideration of the existing organisational structure and governance framework, and how the policies and procedures fit within the organisation's context. Development of separate policies or procedures is not necessarily required – it may be more efficient and effective to have an overarching policy framework, supported by a flexible standardisation approach that is fit for purpose and accommodates specific localised environments (for example, communication in a general ward compared with an emergency department).

Policies and processes could include:

- An organisation-wide strategy that outlines clinical communication processes, and the flow of information to patients, carers, families and clinicians responsible for providing care
- Situations when identification, procedure matching, structured clinical handover, communication of critical information and documentation are required (linked to Actions 6.4 and 6.11)
- Agreed processes for communicating in these situations, including the structure and method of communication, and relevant information to be communicated – for example
  - points of care at which communication is required
  - appropriate communication methods
  - roles and responsibilities of the workforce
- Guidance on how to engage with, and support, patients (and carers) to communicate about their care.

Ensure that policies and procedures describe patients as key participants in clinical communication, and how patients, carers and families can be involved in clinical communication strategies and associated processes.

Document the policies, processes, resources and tools for clinical communication. Make these available to the workforce to ensure that a consistent approach is taken across the organisation and members of the workforce understand what is required of them when using the organisation's clinical communication processes. This can be done through the organisation's website, at meetings, through newsletters or noticeboards, or by displaying communication techniques and processes in the ward or on patient charts.

Set up governance and reporting structures to support effective clinical communication across the organisation, and effective collaboration with patients and clinicians. This could involve setting up committees with governance oversight for improving or monitoring clinical communication.

Ensure that membership of committees reflects the different disciplines that work in the organisation and are involved in delivering patient care. In particular, ensure that consumer advisors on committees or the composition of a consumer/community advisory committee reflect the organisation's day-to-day patient community (see Action 2.11). A network of consumer advisors (groups and individuals) who can provide advice about the development of effective clinical communication processes and collaboration initiatives may be helpful.

Manage risks

Use established risk management systems (see Action 1.10) to identify, monitor, manage and review risks associated with communicating for safety. Develop processes to manage clinical risks for different populations served within the organisation, clinical and workplace risks for the workforce, and organisational risks.

Use information from measurement and quality improvement systems, and adverse events, clinical outcomes and patient experience data to inform and update risk assessments and the risk management system.

Consider the types of risks that may be associated with clinical communications, such as[278]:

- Contextual risks (for example, noise, interruptions, inadequate space and time, absent participants)
- Informational risks (for example, information that is unstructured, incomplete, irrelevant, inaccessible, inaccurate or not up to date)
- Interactional risks (for example, failure to design communication processes that are accessible, legible and intelligible to recipients and to which recipients can actively contribute).

Ensure that the organisation-wide risk management system can identify, assess, manage and document organisational risks associated with poor clinical communication or communication errors (see Action 1.10). This could include:

- Failure to correctly identify patients or match procedures
- Failure to communicate critical tests or diagnostic results
- Communication errors that result in misdiagnosis
- Miscommunication of clinical information at clinical handover
- Risks associated with poor documentation.

Consider potential clinical risks associated with electronic health systems (hardware and software) that are intended to aid or facilitate communication processes. For example, electronic health systems and new technology have the potential to enable faster, more effective communication; however, information systems and technology can also present challenges for privacy, and risks to clinical safety and quality if they are poorly implemented or integrated.

Consider the interaction between non-technical dimensions of healthcare (workflow, policies and personnel) and technical dimensions (software, hardware, content and user interface).[279] Patient safety issues can occur when one or more technical dimensions interact unexpectedly with non-technical dimensions. For example, a change in the way that one system presents information to a clinician may lead to incorrect interpretation if the clinician is unaware of that change. Ensure that the organisation considers, monitors and manages these risks.

Carefully consider the planning and implementation of electronic handover solutions, such as electronic discharge summary systems. Use the Electronic Discharge Summary Systems Self-Evaluation Toolkit[280] and *National Guidelines for On-Screen Presentation of Discharge Summaries*.

Identify training requirements

Assess the competency and training needs of the workforce in line with the requirements of Actions 1.19, 1.20 and 1.21. Perform a risk assessment to inform the training schedule and to set priorities for the members of the workforce who need training. Develop, or provide access to, training and education resources to meet the needs of the workforce in relation to clinical communication.

Provide ongoing education and training to new and existing members of the workforce about the organisation's clinical communication policies, processes and tools. This should include information about what is required, roles and responsibilities (including how and when to escalate care, and who to), and the structure or

standardised format to be used for communicating when identification, procedure matching, clinical handover and communication of critical information are required.

Provide information through orientation, training, regular updates at workforce and management meetings, mentorship programs, and feedback or debriefing sessions with members of the project workforce or clinicians.

Ensure that performance management processes established in Action 1.22 give priority to continuous development of the workforce's communication skills. Identify any communication skills that need to be improved or refined, and incorporate these into the organisation's training system.

Given the complexity of care and the number of people that can be involved in clinical communications, consider ongoing support for multidisciplinary education and training initiatives to encourage and sustain the implementation of any strategies.[281] This will enable different members of the workforce to have a shared understanding of the processes and requirements for effective clinical communication.

Applying quality improvement systems

Action 6.2

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:

a. Monitoring the effectiveness of clinical communication and associated processes

b. Implementing strategies to improve clinical communication and associated processes

c. Reporting on the effectiveness and outcomes of clinical communication processes

Intent

Quality improvement systems are used to support the effectiveness of clinical communications.

Key tasks

- Review, measure, and assess the effectiveness and performance of, organisational and clinical strategies for clinical communications
- Implement quality improvement strategies for clinical communications based on the outcomes of monitoring activities
- Provide information on the outcomes of quality improvement activities to the governing body, the workforce, consumers and other organisations.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' quality improvement systems.

- Action 1.8 – quality improvement systems
- Action 1.9 – reporting
- Action 1.11 – incident management and investigation systems

Health service organisations should use these and other established safety and quality systems to support monitoring, reporting and implementation of quality improvement strategies for clinical communications.

Strategies to improve effective communication will take time, leadership, commitment (across the whole organisation) and resources.[209]

Identify a suitable individual, group or committee to take responsibility for monitoring and evaluating organisation-wide clinical communication systems. Consider how monitoring and evaluation in relation to improving clinical communications inform and feed into existing evaluation processes in the organisation.

In large organisations, the local workforce (for example, in units, wards) may find it useful to set up a local project team or appoint a member of the workforce to oversee, plan and coordinate the implementation and evaluation of the clinical communication systems in their own local setting. Tailor this to the individual workforce and setting, but ensure consistency with best-practice guidelines.

Monitor effectiveness and performance

Use the organisation's quality improvement systems to identify and prioritise the organisational and clinical strategies for clinical communications.

Strategies for monitoring effectiveness of clinical communications may include:

- Audits of workforce compliance with policies, procedures and protocols for clinical communication and associated processes
- Audit and evaluation of patient healthcare records to check whether critical information has been recorded and acted on; this could include information contained in discharge summaries, clinical handover checklists or consent forms, actions taken as a result of an alert, and timely communication of critical information.

Stakeholder engagement at all levels of the organisation is an essential part of quality improvement systems and to lead change. This includes feedback from patients, carers and families about their experience with the organisation's communication processes.

Ensure that quality improvement and incident management and investigation systems include monitoring and evaluation of incidents, adverse events and near misses relating to patient identification, procedure matching, clinical handover at transitions of care, failure to communicate critical information, and inadequate or poor documentation. These incidents could include:

- Mismatching events
- Clinical handover incidents
- Communication errors that contribute to misdiagnosis or failure to escalate
- Readmission because of poor discharge planning.

Ongoing monitoring of adverse events allows organisations to keep track of whether there are safety gaps in their clinical communication processes, and to modify these processes to suit the service context. Evaluation allows organisations to measure the progress and impact of clinical communication processes and possible improvement strategies.

Safe Communication, developed by the Quality Improvement Clinic (United Kingdom), is a useful step-by-step guide to measuring the effectiveness of clinical communication processes.[282]

Implement quality improvement strategies

Implementation of quality improvement strategies is essential to ensure that clinical communication systems and processes continue to operate effectively, and any areas for improvement are identified and acted on. It can also help to determine where communication is being done well in the organisation. Ongoing monitoring and regular evaluations are necessary to track changes over time, and to report on adverse events or risks that may relate to clinical handover or other communication failures.

Use the results of monitoring activities to show improvements, or areas in which improvement is required. If appropriate, use quality improvement activities that are consistent and measurable across the corporate group, network or health service.

Use the results of organisational risk assessments to identify gaps, plan, and set priorities for areas for investigation or action.

When adverse events or near misses occur, specifically investigate to identify any issues in the performance or use of the system. Use this information to make improvements.

One model to implement strategies to improve clinical communications is the plan–do–study–act (PDSA) cycle.[274,282] The PDSA cycle is an iterative

feedback process that allows improvements to respond to changing circumstances or consequences, as well as ensuring continual and increasing engagement of clinicians. Engagement of clinicians and other relevant workforce members is essential to any quality improvement process.[209]

Report outcomes

Ensure that processes are in place to facilitate feedback, and provide review findings from monitoring quality improvement processes to relevant committees or meetings about governance and leadership. Members of the relevant committee or the individual(s) responsible for governance arrangements should ensure that actions are taken to improve clinical communication systems.

Data obtained through these processes should be fed back to the highest level of governance and the local workforce. This may help inform clinicians and the local workforce of areas that may need improvement, and provide a strong case for them to change practice and take part in improvement activities. This feedback process also contributes to a culture of transparency and accountability.

Partnering with consumers

Action 6.3

Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Intent

Principles of person-centred care, shared decision making and health literacy inform the way clinicians communicate with patients, carers and families during the key high-risk situations described in the Communicating for Safety Standard.

Key tasks

- Review strategies in the Partnering with Consumers Standard to inform the implementation of actions in the Communicating for Safety Standard
- Provide information to patients about clinical communications tailored to their specific needs and level of health literacy.

Strategies for improvement

The Partnering with Consumers Standard has specific actions (Actions 2.3–2.10) relating to health service organisations' processes for involving patients in their own care, shared decision making, informed consent and effective communication.

Effective clinical communication requires the active participation of patients, carers and families.

Health service organisations should use established processes from the Partnering with Consumers Standard when:

- Conducting patient identification and procedure matching
- Performing clinical handover
- Communicating critical information.

Ensure that communication with, and information provided to, patients, carers and families about procedures, treatments and care (including follow-up care after discharge) reflect health literacy principles, and are delivered in a way that supports effective partnerships (see Actions 2.8–2.10).

Ensure that the organisation has support systems for patients who need assistance to communicate. This could include ensuring that interpreters are available, and putting in place processes to support patients with hearing or vision problems.

Support patients, carers and families to effectively use clinical communication processes and tools to actively take part in communications.

Implement processes to review internally developed patient information relating to clinical communications by conducting regular patient feedback or experience surveys (see Action 2.9).

Case study 2 demonstrates a number of strategies to engage patients, carers and families in communications about their care.

Case study 2

This case study shows the links between the Communicating for Safety Standard and the Partnering with Consumers Standard, and demonstrates how organisations may implement a range of strategies, processes and tools that support effective patient–clinician communication, person-centred care and safe transfer of care.

This case study is an example of a public health service organisation with a number of statewide specialist services that has implemented a person-centred approach across the organisation. The organisation's culture and plan are guided by the Australian Charter of Healthcare Rights, with strong leadership and consumer input (as indicated by positions such as Manager for Patient Experience and Consumer Participation, and a broad range of volunteers with diverse responsibilities).

The organisation promotes six 'good ward management principles':

- Having all patients reviewed within two hours of admission
- Decision-making by senior multidisciplinary team members
- Daily interdisciplinary rounds for all patients
- Allocation of patients to a designated team
- Active management of patients to ensure that they are hospitalised for only as long as clinically necessary
- Appropriate transfer of care on discharge.

The workforce within the organisation manages a multitude of complex patient transitions, from community to hospital, and from emergency department to acute, subacute (with aged care or geriatric streams), internal rehabilitation, residential care, home and community.

An electronic communication system ensures consistency of information and provides the nursing workforce with more time for patient engagement. The type and extent of patient engagement depend on the transitions and the age, status, ability and preferences of the patient.

Case study 2 *continued*

> *The first thing is there's a multitude of complex transitions – from community to hospital, transfer from subacute to acute to transition care to community or residential care. Subacute encompasses a number of streams of care including aged care with geriatric medicine and rehabilitation. It can be quite difficult to engage the patients, in which case you have to work through the family. With a younger cohort of patients it's more straightforward. Inpatient care transitions are about involving the patient from day one, being open and transparent, setting goals, reality checks about where we've got to, and having a key liaison or 'go to' person so there's always someone the patient can interact with in terms of the evolution of their discharge plan. It's the go-to backwards and forwards.* – Gerontologist

The organisation has instituted a range of models of care and tools for service delivery. Bedside handover is used throughout the service, but with wide variability in the processes used in different wards. The Patients Come First strategy encompasses five areas, each with its own specific objectives:

- Australian Charter of Healthcare Rights
- Patient information
- Person-centred care education
- Patient feedback
- Consumer and carer engagement.

A number of other initiatives are aimed at patient engagement. For example, 'Let me know' has members of the workforce wear 'Let me know' buttons to prompt patients and families for feedback on their care or to encourage them to call back with any post-discharge needs. The message is also visible on rental TV messages, screensavers and other materials.

Tools: 'Let me know' buttons worn by the workforce invite patients and families to share their thoughts, ideas and preferences for care.

The service uses tools for consumer feedback, where volunteers are trained to gather electronic and paper-based feedback from patients in multiple languages. A Project Manager for Consumer Participation collects patient stories as a 'powerful teaching tool for change', celebrating positive experiences and identifying service gaps. A Volunteer Manager audits the input from volunteers twice a year as part of patient feedback, working with the Patient Liaison 'Go to' person, who communicates patient and family concerns at weekly team meetings using 'journey board discussions' at the ward level. The service also uses a toolkit for person-centred care developed jointly by the state and Australian governments to focus on person-centred care for older people. This toolkit was designed to 'do things with rather than for people'. There is also a care service for family members to stay overnight, and flexible visiting hours that promote family engagement in care.

Tip: Volunteers can be used to gather authentic patient and family feedback about care, but this feedback requires a subsequent plan to deal with issues that may emerge.

The pre-admission tool is a multidisciplinary assessment that prompts patient inclusion in goal-setting for care, including advance care planning, preferences and values relating to what is to be achieved, 'tempered with what is possible and realistic'. Members of the workforce engage patients in 'goal-directed transitions' where they are included in open and transparent goals, time frames, and realistic achievements for their rehabilitation or discharge.

Case study 2 *continued*

Tip: Engaging patients in plans for their transitions in care requires not only understanding patient preferences, but also providing information on what is realistic to expect.

Patient whiteboards are used to engage patients in two-way communication. A system of scheduled daily multidisciplinary rounds are provided in general medical wards to include patient and family participation, and ensure that information is provided in plain English, demystifying medical jargon. Before the rounds, team members conduct a 'daily journey board huddle' to make sure 'everyone is on the same page'. Discharge planning is variable in different wards, but patients are provided with a 24-hour post-discharge hotline to communicate their concerns back to the hospital. General medical wards also provide videos and USBs with discharge information that patients can take home to check the information provided in hospital and ensure that they understand instructions from doctors, pharmacists or other members of the team.

> *It takes the team, the nursing team, the allied health team, the medical team and the family and patient. Everybody's on board. We're here for the patient.* – Nurse manager

Lessons learned:

- Large public organisations can embed person-centred care with strong leadership and commitment, and by capitalising on multidisciplinary input
- When carefully managed, the volunteer workforce can provide valuable input into quality care processes and ensure continuity of engagement with patients and families
- Goal-directed planning can make discharge plans more efficient
- Person-centred care models that have been found to be effective on some wards need to be carefully evaluated for their applicability to other wards.

Adapted from the Deakin University and Griffith University review *Engaging Patients in Communication at Transitions of Care*.

Action 6.4

The health service organisation has clinical communications processes to support effective communication when:

a. Identification and procedure matching should occur

b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge

c. Critical information about a patient's care, including information on risks, emerges or changes

Intent

Processes to support effective clinical communication are in place for key high-risk situations, where effective communication with patients, carers and families, and between clinicians and multidisciplinary teams is critical to ensure safe patient care.

Key tasks

- Identify the situations within the organisation in which identification, procedure matching, structured clinical handover and communication of critical information are required
- Review the organisation's policies and processes to determine whether they support and enable effective communication at these times
- If there are gaps, or improvements can be made, revise or develop policies and processes to reduce these gaps
- Provide resources and tools to encourage effective communication processes at these times.

Strategies for improvement

Some states and territories may have mandated tools and approaches for patient identification, procedure matching, clinical handover and communication of critical information. Comply with relevant state and territory policies.

Identify situations when safe communication is required

Consider all the situations and times in the organisation when identification, procedure matching and information about a patient's care need to be communicated or transferred to ensure that the patient receives the right care. This includes communication with the patient, carer and family (if appropriate), and between clinicians and multidisciplinary teams. Situations can include:

- When care, treatment or medicine is provided to a patient
- When a patient is undergoing a procedure
- When there is a change of clinician (for example, at shift change); for high-risk patients, this could include when a clinician goes on a break or has to leave the patient unattended (for example, in an intensive care unit)
- When a person is moved between different levels of care in the same location (for example, surgery to ward)
- When part of person's care is transferred for diagnostic purposes
- When there is follow-up of patient referrals and communication of test results (for example, from pathology or radiology)
- When a person is transferred to a different service (for example, hospital to aged care home or other non-government organisation)
- When a person is admitted to a hospital, or leaves a hospital and returns to their carer or primary clinician (for example, general practitioner).

Clinical communication policies should describe what is expected and required of the workforce in key high-risk situations. These should be tailored to the service context.

Review policies and processes

Actions to identify the health service organisation's clinical communication needs may include:

- Reviewing or mapping the organisation's current clinical communication processes
- Analysing patient flow patterns and work processes that require information to be shared (inside and outside the organisation)
- Collecting baseline data about the clinical communication issues or needs of the organisation by interviewing, surveying or observing the workforce and consumers
- Performing a risk assessment to determine clinical communication gaps, areas for improvement or good practice.

Engage management, clinicians (senior and junior) and consumers to ensure that there is a comprehensive understanding of the gaps and issues, whether the workforce is aware of existing communication processes, and whether they are using them.

Where gaps are identified, revise or develop policies and processes to reduce these gaps. Do this in collaboration with clinicians, consumers and other members of the workforce to ensure that they are user centred and meet the needs of the people involved. This may include consultations, small pilots to test a process, collaborative design workshops or small working groups.

Provide resources and tools to aid effective communication processes

Provide information about the policies, processes, resources and tools for communicating at key high-risk situations to all members of the workforce.

Educate, train and support the workforce about the use of these tools and their responsibilities to effectively communicate in key high-risk situations.

Support teamwork and effective communication

Consider how teams work and communicate with each other within and outside the organisation (across disciplines). Patient identification, procedure matching, clinical handover and communication of critical information in acute care services will often involve multiple clinicians or teams. Given the complexity of health care, these clinicians and teams may change regularly or over time, depending on the needs of the patient.[190,191]
To deliver comprehensive care that is safe and continuous, teamwork and effective communication are critical. The links between this standard and the Comprehensive Care Standard are important to ensure that safe, comprehensive care is delivered.

Communicate with transport services

When a patient is transferred into or out of the organisation, consider what processes are in place to communicate with the transport services that are moving the patient (for example, ambulance, the Royal Flying Doctor Service). These services may have their own communication protocols and processes. Collaborate with them to ensure that there is a shared understanding of roles, responsibilities, how communication should occur and the documentation of clinical information.

Consider the role of non-clinicians

Consider the role that non-clinicians play in communicating with patients about their care or transfers. Non-clinicians (such as members of the wards, reception and administration workforces) communicate regularly with patients about appointments, tests, referrals and transfers. They therefore have a role in patient care.

Implement policies, directives or memorandums that outline the expectations and requirements for non-clinicians when they are communicating with patients (including maintaining patient confidentiality). An example could include setting the expectation that members of the workforce who are transferring patients communicate with the patient to let them know where they are going, why they are being moved, if they are going over bumps, and so on. This is to ensure that the patient feels safe, secure and cared for at all times.

CRITERION: Correct identification and procedure matching

> *Systems to maintain the identity of the patient are used to ensure that the patient receives the care intended for them.*

Correctly identifying and implementing processes to match patients to their intended care is critical to ensuring patient safety. Risks to patient safety occur when there is a mismatch between a patient and components of their care. This includes diagnostic, therapeutic and supportive care.

Patient identification is performed often in all care settings, and can be seen as a relatively unimportant or routine task. The development of safety routines for common tasks (such as patient identification) provides a powerful defence against simple mistakes that may cause harm. Routines allow the workforce to focus their attention on activities that require more cognitive processing and judgement, such as providing clinical care.[283] The design and implementation of routines should consider human factors such as human capabilities, limitations and characteristics.[284] It is also important to educate and remind the workforce about the use of routines, including who does what, when and how.

Tools such as the WHO Surgical Safety Checklist[285] and the Commission's Ensuring Correct Patient, Correct Site, Correct Procedure Protocol[286] provide a basis for developing these routines.

Studies using both large and small databases of healthcare records in the United States have demonstrated that the risk of false positive matching decreases from a 2-in-3 chance when using family name only, to a 1-in-3,500 chance when given name, family name, postcode and date of birth are used.[287]

Regardless of the type of care, therapy or service that is provided, all organisations need to ensure that a comprehensive organisation-wide system is in place to reliably identify patients at each treatment episode, and that there are processes for correct procedure matching.

This criterion is particularly focused on clinical situations in which there may be greater risks to the patient, including procedural areas such as surgery, investigations (for example, radiology) and specific treatments (for example, nuclear medicine). The focus for action is on the use of protocols for matching patients to their intended care.

This criterion does not relate to establishing the legally correct identity of people who may choose to use an alias. The criterion is to ensure that a person's declared identity can be matched with any care, therapy, medicine or service that is provided within the organisation.

Action 6.5

The health service organisation:

a. Defines approved identifiers for patients according to best-practice guidelines

b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated

Intent

A comprehensive, organisation-wide system is in place for the reliable and correct identification of patients when care, medicine, therapy and other services are provided or transferred.

Key tasks

- Define the approved patient identifiers for use in the organisation, according to best-practice guidelines
- Develop or confirm an organisation-wide system for patient identification
- Implement policies and processes that require at least three approved identifiers to be used at registration and on admission; when care, medicine, therapy or other services are provided; and whenever clinical handover or transfer occurs, or discharge documentation is generated.

Strategies for improvement

Develop a patient identification system

An organisation-wide patient identification system is the set of written policies, procedures and protocols that ensure the consistent and correct identification of a patient at any time during an admission or course of treatment. This system is central to efforts to ensure correct patient identification and procedure matching. Policies, procedures and protocols for specific activities (such as patient registration, or generating and checking identification bands) should be included within, or linked to, this system.

Approved patient identifiers are items of information (such as name, date of birth or healthcare record number) that can be used to identify a patient when care, medicine, therapy or services are provided.

At least three approved patient identifiers are required each time identification occurs. This provides manual and electronic patient identification systems with the best chance to correctly match a patient with their record, without imposing impracticable demands on information gathering.

Patient identifiers may include:

- Patient name (family and given names)
- Date of birth
- Gender
- Address (including postcode)
- Healthcare record number
- Individual Healthcare Identifier (IHI) (see Action 1.17 for more information).

Specify the data items approved for patient identification in the organisation, and use at least three identifiers:

- On admission or at registration
- When matching a patient's identity to care, medicine, therapy or services
- Whenever clinical handover or patient transfer occurs
- Whenever discharge documentation is generated
- In specific service settings, if they are different from those generally used across the organisation.

Where the My Health Record system is in use, include the national unique IHI as a patient identifier (see Action 1.17). Do not use identifiers such as room or bed number, because these frequently change and are not unique to patients.

Standardise patient identification bands (if used)

If the organisation uses patient identification bands, identify where these need to be used within the organisation, and what arrangements are in place for maintaining and checking the identity of people who are not wearing identification bands.

Ensure that patient identification bands are standardised and comply with the *Specifications For A Standard Patient Identification Band*. These specifications apply to bands that have the primary purpose of identifying the patient within the health service organisation. They do not apply to bands or bracelets that have other purposes (such as triggering an alarm when a patient leaves a certain area). Neither the NSQHS Standards nor the specifications require all people receiving care to wear identification bands.

The Commission recommends using identification bands as described in the specifications, and not to vary the specifications. The specifications were developed to minimise adverse events associated with patient identification and procedure matching, and using identification bands that do not comply with the specifications may increase the risk of such events. If it is considered necessary to use a band that differs from the specifications, assess the potential risks associated with any proposed changes, identify strategies to reduce these risks and document this process.

When disposing of patient identification bands, consider issues relating to maintaining the confidentiality and privacy of patient details.

Assess the use of coloured patient identification bands (if used)

The Commission recommends that no coloured bands are used to alert clinicians to specific clinical information (such as falls risk, allergies or resuscitation status). Using colour-coded bands to indicate clinical risk:

- Is based on tradition rather than evidence of any patient safety benefit[288,289]
- Can cause confusion and error because of inconsistencies in meaning for different colours across different organisations, especially when members of the workforce work across different health service organisations[290-292]
- May not accurately reflect the patient's clinical situation or be synchronised with the healthcare record.[288,290]

If it is considered necessary to have a colour system for identifying a known allergy or other known risk, the patient identification band should be red only (see *Specifications for a Standard Patient Identification Band*).

Take a multi-factorial approach if patient identification bands are used to manage clinical risk for patients with specific characteristics or conditions. For example:

- Check the medication record for allergies before prescribing, dispensing or administering medicines (see the Medication Safety Standard)
- Use a multi-factorial prevention program that involves surveillance, together with interventions such as reviewing medicines (see Action 4.10), making the environment safe (see Action 1.29), screening for infections (see Action 3.6) and minimising the use of restraints (see Action 5.35).

Consider other methods of patient identification

Specialist areas of the organisation may have specific needs regarding patient identification and procedure matching. For example, in mental health units or dialysis units, patient identification bands may be inappropriate, and other methods such as photographic identification may be required. Decide which methods for patient identification and procedure matching will be used in each service or unit, and include these in, or link to, the organisation-wide patient identification system. Consider privacy when adopting a particular method of patient identification (for example, asking for verbal confirmation of a patient's address in an open waiting room may not be appropriate).

Action 6.6

The health service organisation specifies the:

a. Processes to correctly match patients to their care

b. Information that should be documented about the process of correctly matching patients to their intended care

Intent

Explicit processes are in place to correctly match patients with their intended care, to ensure that the right patient receives the right care.

Key tasks

- Develop explicit, documented protocols that outline the process of matching a patient to their intended treatment, tailored to the procedure and organisation
- Check that these processes align with nationally agreed policies, if they exist
- Ensure that policies specify which information should be documented about the process of identification and procedure matching.

Strategies for improvement

Resources and procedures should be organised, integrated, regulated and administered to correctly identify patients at any point during an admission or course of treatment. Document and implement these so that all members of the workforce clearly understand their responsibilities and accountabilities.

Correct identification is particularly important at transitions of care, where there is an increased risk of information being miscommunicated or lost.[275,293] Transitions of care occur frequently in health care and include situations when a patient's care is transferred between members of the clinical workforce, to another health service organisation or to their primary care clinician. At these times, information about a person's identity is critical to ensuring safe patient care. Consider this action alongside other actions within this standard (in particular, Actions 6.7 and 6.8).

The type of patient identification and procedure-matching process will depend on the type of procedure, the design of workflow in a particular area or organisation, and the risks for the patient. Clearly document the process for how patient identification and procedure matching are performed in each specialist area to ensure that no requirements are overlooked. For example, in most procedural areas, 'timeouts' are required with the whole team before a procedure can begin. In other situations (such as radiology, where there may be only a single operator), this could be done as a 'stop to verify' that all requirements are correct.

Align protocols with agreed policies, where they exist. A set of procedure-matching protocols for specific therapeutic and diagnostic areas such as surgery, nuclear medicine and radiation therapy is available on the Commission's website.

The WHO Surgical Safety Checklist has been demonstrated to improve patient safety[294] and is widely used in Australia. This checklist includes elements relating to patient identification and procedure matching, and can be used as the patient identification and procedure-matching protocol. There is also an Australian and New Zealand version of this checklist.

The key steps that underlie these protocols of care are:

- If necessary, mark the site of the procedure
- Verify the identity of the patient
- Verify the details of the procedure being undertaken, including the site of the procedure
- Take a timeout or similar stop with all members of the team to do a final check before starting the procedure
- Confirm all documentation, samples, and other information and materials following completion of the procedure.

To develop protocols for other clinical situations, involve those with local knowledge of the process to adapt the patient identification and procedure-matching protocols for their specific requirements. When deciding which clinical areas should have their own specific patient- or procedure-matching protocol, focus on areas of higher risk for patients and the organisation.

Support communication among clinicians and with patients

Supporting team participation and communication in safety checks is key to achieving a shared understanding of what is required and improving patient safety. Communication strategies used during the checking processes could include 'making sure, double checking', 'verbalising information' and 'deliberate confirmation of checklist items with oral validation'.[195] These strategies promote closed-loop communication and allow an opportunity for participants to ask questions or clarify concerns.[195,295,296]

Incorporate patient identification and procedure matching into structured clinical handover processes, as required under Actions 6.7 and 6.8. Ensure that the documentation required for patient identification at handover, transfer and discharge is determined by these policies, procedures and protocols.

If appropriate, support patients, carers and families to take part in the processes to correctly match patients to their care. This may include asking a patient to confirm details about their identity, or asking the patient, family or carer to confirm details about care. For surgical safety checks, the timeout check could be done while the patient is still awake to enable them to contribute to the conversation, rather than performing it after the anaesthetic is given.[195]

Specify the information that needs to be documented about the processes to correctly match patients to their intended care

Ensure that policies describe what documentation is needed about the processes to correctly match a patient to their intended care. The requirements for documentation will depend on the situation. For example, it is not feasible or necessary to record that three identifiers have been used to check the identity of each patient who has been administered a medicine. However, if the surgical safety checklist is used in operating theatres, documented confirmation that it has been used, or the completed checklist itself, can be kept in the patient's healthcare record.

CRITERION: Communication at clinical handover

> *Processes for structured clinical handover are used to effectively communicate about the health care of patients.*

Structured clinical handover has been shown to reduce communication errors within and between health service organisations, and to improve patient safety and care, because critical information is more likely to be accurately transferred and acted on.[209,274] This is especially important at transitions of care, when communication errors are more likely and there is an increased risk of information being miscommunicated or lost. Ineffective communication at clinical handover is also associated with clinicians spending extensive time attempting to retrieve relevant and correct information.[297] This can result in inappropriate care, and the possibility of misuse or poor use of resources.[298,299]

Structured clinical handover at transitions of care

Implement and support the use of structured clinical handover processes in the organisation's service context. This criterion is linked to Action 6.4b, which requires organisations to have clinical communication processes at transitions of care, across all levels of the organisation. Transitions of care occur when all or part of a patient's care is transferred between healthcare locations, clinicians, or different levels of care within the same location. This includes when:

- There is a change in clinician (for example, shift change)
- A patient is transferred to another health service organisation (for example, from hospital to an aged care home, another hospital, community nursing or a palliative care service)
- A patient is moved within an organisation (for example, to the general ward after surgery)
- A patient's care is discussed during multidisciplinary team rounds
- A patient is transferred for a test or appointment
- A patient is discharged.

Transitions of care are not limited to these times, but consider these situations as a minimum requirement for clinical handover policy and processes, if they occur in the organisation.

Under an effective standardised and structured clinical handover process, all relevant participants know the minimum information that needs to be communicated when handovers take place, the purpose of the handover, the structured format to aid communication, and how responsibility and accountability are transferred.[209]

Communication can be a highly variable process, which poses a high risk for patient safety. Variability can result from:

- The situation, such as during
  - shift changes
  - patient transfer within or between a hospital, unit or service
  - patient admission, referral or discharge
- The method, such as
  - face to face
  - by telephone
  - using written orders
  - aided by electronic handover tools or systems
- The place in which clinical handover takes place, such as
  - at the patient's bedside
  - in a common staff area
  - at a hospital or clinic reception
- Who is involved in the clinical handover process, such as
  - individual clinicians within the same organisation (for example, junior doctors, nurses and consultants)
  - a treating clinician and a patient with their family or carer
  - multidisciplinary teams
  - clinicians across organisations or services (for example, ambulance officers and emergency workforce).

Therefore, although standardisation improves the efficiency and effectiveness of clinical handover, there needs to be some flexibility. Processes should not minimise communication or set guidelines that interfere with what the workforce deems to be the

most critical information. A flexible, standardised approach will provide the structure for handover and allow for flexibility to fit the service context and work practices.

Table 2 illustrates several clinical handover solutions in a matrix of clinical situations and handover delivery options. It considers the format clinical handover might occur in and recommendations for how it should be delivered.[300]

Table 2: Clinical handover matrix*

Why implement standard key principles?	Evidence indicates that standardisation of handover processes contributes to safer patient care[250, 285]
What clinical information should be handed over?	Locally defined minimum information content that meets the key principles, ensuring that the most important clinical information is handed over
Who should attend handover?	Key participants in the handover process should be identified and available to attend the handover of their patients

When should handover occur? / **How/where** should handover be delivered?	Multidisciplinary team handover	Shift handover (continuous coverage)	Shift handover (non-continuous coverage)	Escalation of deteriorating patient	Patient transfers for a test or appointment	Patient transfers to another ward	Patient transfers to another facility	Inpatient to community handover	Inpatient to outpatient handover
Face to face (in the patient/carer presence) and written	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
Face to face (in a common area) and written	✓	✓	✓	✓	✓	✓	✓	✓	✓
Telephone and written	~	✓	✓	✓	✓	✓	✓	✓	✓
Telephone only	~	~	~	✓	✓	✓	~	~	~
Written only	✗	✗	✓	✗	✓	~	✗	~	✓
Voice recording	✗	✗	✗	✗	✗	✗	✗	✗	✗

✓✓ Recommended ✓ Adequate ~ Not recommended ✗ Should never occur

* Adapted from WA Health Clinical Handover Policy

Defining the minimum information content

The minimum information content for a particular handover will depend on the context and reason for handover. Be guided by best practice, and determine the minimum information content in consultation and collaboration with the patients, carers and clinicians who are active participants in the clinical handover process.

When defining the minimum information content, consider actions across the NSQHS Standards that require and support communication of relevant information at transitions of care (Table 3).

Table 3: Actions in the NSQHS Standards that support communication of relevant information at transitions of care

Information to be communicated	Actions in the NSQHS Standards
Patient identification	Action 6.5b
Diagnosis (provisional or principal), clinical assessment (including any relevant alerts) and current clinical condition (e.g. stable, improving, deteriorating)	Actions 5.11–5.13, Action 6.8b, Action 8.5e, Action 8.9
Risks of harm, worry or clinical concerns	Action 5.7b, Action 5.10, Actions 5.21–5.36, Action 8.6e
Medication history and current medicines list (e.g. adverse drug reactions, reasons for any changes to medicines)	Actions 4.5–4.7, Actions 4.10–4.12
Emerging or new critical information (e.g. changes in patient condition, new results, results outstanding or needing follow-up, critical information arising post-discharge)	Actions 6.9 and 6.10
Agreed care plan, priorities for care (e.g. further reviews, treatments or procedures; discharge planning; referrals; follow-up)	Actions 5.13 and 5.14
Infectious state (if relevant)	Action 3.7
Transfusion history, blood management and transfusion details (if relevant)	Action 7.5
Identity and confirmation of clinician or healthcare team responsible and accountable for patient care (transfer of responsibility and accountability)	Action 6.8f

Case study 3: Understanding flexible standardisation[209]

The handover of patients with chronic renal failure will differ between the renal ward and the dialysis centre. In the renal ward, the handover might include the logistics of organising dialysis and management of peridialysis care, such as transferring patients at a certain time to the dialysis centre, and avoiding blood pressure measurement and intravenous cannulation on the arm with the arteriovenous fistula.

However, in the dialysis unit, handover of the same patient will include technical detail of dialysis. This might include time and duration of dialysis, venous access, heparin infusion during dialysis, and electrolyte abnormalities that require intervention.

Although some clinical data, such as reason for admission and treatment so far, will be the same for the two wards, the minimum information to be communicated at handover will be slightly different depending on the local setting.

Key principles of clinical handover

The purpose of clinical handover is to ensure that relevant, accurate and current information about a patient's care is transferred to the right person or people, action is taken (when necessary) and continuity of patient care is maintained. To ensure that these events occur, all clinical handover policies and processes need to reflect the key principles of clinical handover. This is required under Action 6.8 and includes:

a. Preparing and scheduling clinical handover
b. Having the relevant information at clinical handover
c. Organising relevant clinicians and others to participate
d. Being aware of the patient's goals and preferences
e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient
f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care.

Clinical handover is more than the transfer of information, which is 'irrelevant unless it results in action that is appropriate to the patients' needs'[301] – it is about maintaining continuity of care.

Effective communication and teamwork between all the people involved in providing patient care, including the patient and their carer, are vital to ensuring effective clinical handover.[302] Actions under this criterion are closely linked to Actions 5.5 and 5.6 in the Comprehensive Care Standard, which require systems to be in place to support collaboration, teamwork and comprehensive care planning.

Engaging patients and carers in clinical handover processes

Patients, carers and family members are key participants in transition communication processes, and the patient's preferences and choices should be known and respected. Patients can have important insights into their conditions, and the circumstances that may affect their ongoing care and needs. Patient engagement and communication at transitions of care improve patient care outcomes, prevent adverse events during care and reduce readmissions to hospital after discharge.[276,303,304]

If practicable, implement systems to engage patients early, and support patients, carers and families to participate in clinical handover and transition of care processes. Consider the organisation's processes, including when handover is occurring, and identify opportunities to engage with patients, carers and families. Ensure that participation is in accordance with the patient's wishes, and include careful consideration of the patient's level of health literacy, language barriers and culture.[276] Consider how actions link to requirements in the Partnering with Consumers Standard.

Resources to support patient–clinician communication at transitions of care are available on the Commission's website.

Communication at transitions for patients with cognitive impairment

The importance of communication at transitions is highlighted for people with cognitive impairment, particularly if they are unable to communicate required information. Information from a person's general practitioner, family, carer or substitute decision-maker, and healthcare record about the patient's medical history, medicines list, recent cognitive changes, advance care plans and goals of care is crucial for accurate diagnosis, medication reconciliation and appropriate treatment decisions (see Actions 5.29 and 5.30). During a hospital stay, family members may be the first to notice changes in cognition and behaviour that should prompt assessment for delirium (see Actions 8.5 and 8.7).

Any diagnosis of delirium or concern about ongoing cognitive impairment needs to be communicated so that arrangements can be put in place for post-discharge assessment, management and support.

A Better Way to Care[238] sets out suggested strategies for health service organisations in early recognition, prevention, treatment and management of cognitive impairment.

Clinical handover

Action 6.7

The health service organisation, in collaboration with clinicians, defines the:

a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines

b. Risks relevant to the service context and the particular needs of patients, carers and families

c. Clinicians who are involved in the clinical handover

Intent

Accurate and relevant information about a patient's care is communicated and transferred at every clinical handover to ensure safe, high-quality patient care.

Key task

- Collaborate with clinicians to define the minimum information content to be communicated for each type of clinical handover identified within the organisation (see Action 6.4).

Strategies for improvement

Define the minimum information content for all clinical handovers relevant to the service. The minimum information required may differ, depending on the type of clinical handover and the situation in which clinical handover is occurring.

One way to define the minimum information content is by 'dot voting'. This is a simple way to collect opinions from the whole team involved in the transfer of care about what information should be included.[282]

Document the minimum information content for different clinical handovers, and make this easily available to the workforce to ensure that all participants involved in a handover are aware of what the minimum information content is for that particular handover, and their roles and responsibilities for communicating and receiving this information. Provide orientation and training to support the workforce in effectively transferring the correct information (see Action 6.1). Provide guidance on the overarching minimum information required for all handovers, and allow this to be

adapted and refined to the different contexts in which handovers occur in the organisation. At a minimum, consider the information that is required to be communicated across the NSQHS Standards (see Table 3).

Examples of frameworks for defining minimum information content

The Royal Hobart Hospital designed an overarching minimum information content framework as part of the National Clinical Handover Initiative.[305] It includes considering:

- Environmental awareness
- Patient identification (see Action 6.5, which requires three approved patient identifiers)
- History, evaluation and management
- Responsibility, risk management and action plans
- Accountability
  - patient – accountability for the care of the patient is transferred to the incoming responsible individual or team, and a patient's preference of care is clearly communicated
  - profession and colleagues – the incoming team understands the tasks ahead, including the consultant in charge of the overall care of the patient
  - organisation – accountable for ensuring the most efficient patient flow through the organisation, and that all issues relating to discharge planning are transferred from one team to another.

Use of structured handover tools can help to provide a framework for communicating the minimum information content for clinical handovers. The iSoBAR framework is an example (Table 4).[278]

A 'patient safety check' process at the end of a handover can help to focus on the patient's safety as a priority. This may include raising or reiterating any safety concerns, such as socioeconomic factors, alerts, allergies or risks.

Other examples of tools to help structure handover include:

- ISBAR (Identify, Situation, Background, Assessment, Recommendation)
- SBAR (Situation, Background, Assessment, Recommendation)
- SHARED (Situation, History, Assessment, Risk, Expectation, Documentation)
- I PASS the BATON (Introduction, Patient, Assessment, Situation, Safety concerns, Background, Actions, Timing, Ownership, Next).

These tools are designed to be flexible and adapted to suit local workforce environments and culture, and the purpose of the handover. They are available on the Commission's website.

Table 4: iSoBAR framework

i	Identification	Introduce or identify patient, self and team
S	Situation	Provide current working diagnosis, specific clinical problems, concerns and critical laboratory results
o	Observation	Check, update and discuss recent vital signs
B	Background history	Update and discuss relevant medical and support information
A	Agree to a plan (actions)	Outline plan for assessment, treatment and discharge
R	Responsibility and risk management	Confirm shared understanding; clarify tasks (read back critical information to check understanding), timing and responsibility is transferred

Action 6.8

Clinicians use structured clinical handover processes that include:

a. Preparing and scheduling clinical handover

b. Having the relevant information at clinical handover

c. Organising relevant clinicians and others to participate in clinical handover

d. Being aware of the patient's goals and preferences

e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient

f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care

Intent

Clinicians use structured clinical handover processes that are consistent with the key principles of clinical handover, to effectively communicate relevant, accurate and up-to-date information about a patient's care to ensure patient safety.

Key tasks

- Document the structured clinical handover processes required in the organisation, ensuring that they are consistent with the key principles for clinical handover
- Clearly communicate the clinical handover policies and processes to the workforce, including expectations for using clinical handover processes
- Provide access to structured clinical handover tools
- Support the workforce, patients and carers to use structured clinical handover processes and tools.

Strategies for improvement

A helpful clinical communication framework to consider is the NSW Health *Clinical Handover – Standard Key Principles*[306], which has also been adapted by the Quality Improvement Clinic in the United Kingdom.[282]

The framework outlines five key principles for clinical handover:

1. Leadership – nominated leader for each clinical handover or transfer of care
2. Values – clinical handover at transitions of care are valued as essential to the delivery of safe care, and preparation for clinical handover is a priority
3. Right people – the appropriate people are involved
4. Specified time and/or place (if appropriate) – a specified setting or place has been agreed, and there is an agreed time, duration and frequency for clinical handover to occur
5. Standardised process – an agreed process for clinical handover that includes an agreed set of information to be covered in transfers (minimum information content, see Action 6.7), which is communicated in a structured way, is action-focused, assigns responsibility for actions and is supported by clear documentation (see Action 6.11).

Outline the transition-of-care situations when effective clinical handover is critical to safe patient care. Consider the format in which handover might occur and how it should be delivered.

Conduct clinical handover using a structured format. Document clear, structured processes for transferring relevant patient information, accountability and responsibility for care in the organisation's policy, using the steps outlined in this action.[274,306] This is to ensure that everyone knows the process for clinical handover, their roles and responsibilities, and what is expected.

Prepare for and schedule clinical handover

Consider the organisation's environment and decide on the best time for clinical handovers to take

place. This may include assessing the environment that the handover is taking place in (for example, ensuring that participants can hear and see each other without interruptions), and setting an agreed time, duration and frequency for clinical handover.[278]

Nominate all key participants for clinical handovers. Consider the need for multidisciplinary input, including clinical and non-clinical workforce members (such as nursing, allied health or psychosocial clinicians, if appropriate).

Inform participants of the clinical handover processes and expectations for participating in handover.

If possible, involve patients, carers and families as key participants in handover.

Allocate specific roles to members of the workforce during handover to ensure continuity of patient care and reduce disruptions. This includes nominating a leader at each clinical handover.

Set the method and location for clinical handover, preferably face to face and in the patient's presence, where appropriate.

Make structured communication tools, such as iSoBAR, ISBAR, SBAR or SHARED, available to the workforce. These tools are designed to be flexible and adaptable to the local workforce environment. Resources including videos and templates are available on the Commission's website.

Support clinicians and the workforce to have situational awareness. This refers to maintaining an awareness of the 'big picture', and thinking ahead to plan and discuss contingencies. Ensure an open and ongoing dialogue as part of the handover, which keeps members of the team up to date with what is happening and how they will respond if the situation changes. This includes informing the workforce about:

- Patients who require considerable levels of attention or immediate care (for example, patients who could be, or are, deteriorating, or who may present occupational safety issues)
- Potential patient movements
- The condition of the work environment and staffing numbers that may affect safety (for example, high workload, busy environment).[185,267]

Have relevant information at clinical handover

To ensure that the most up-to-date and relevant information is communicated, put systems and processes in place to enable clinicians to obtain the necessary documents and information before handover. This may include the healthcare record, advance care plans, progress notes, prepared handover sheets, test results, and information written on electronic journey boards or patient care whiteboards.

This action links to, and is supported by, Action 1.16 in the Clinical Governance Standard and Action 6.11. This requires organisations to integrate multiple information systems (where they are in use), enable access to the healthcare record at the point of care, and ensure that systems are in place to contemporaneously document relevant information in the healthcare record.

Organise relevant clinicians and others to participate

All relevant participants should be present before handover begins.

The designated leader manages and facilitates the handover. This is usually the role of the most senior clinician present; however, this will depend on the handover, and it may be more appropriate to designate a clinician who is involved in coordinating a patient's care.

If appropriate, implement multidisciplinary team handovers or rounds. These should be structured, and when and how often they take place will depend on the context of the health service organisation. Also consider whether all participants need to be present for the whole transfer, or only part of it.

Be aware of the patient's goals and preferences

Ensure that all participants who are involved in the handover are aware of the patient's goals and preferences (see Action 5.13).

If unsure, check with the patient, or their family or carer if appropriate.

The TOP 5 initiative in New South Wales encourages clinicians to engage with carers to gain valuable non-clinical information to help personalise care for patients with cognitive impairment. This information is made available to every member of the healthcare team to improve

communication between the patient, the carer and the team, and information is documented on a TOP 5 form:

- T – Talk to the carer
- O – Obtain the information
- P – Personalise the care
- 5 – Strategies developed.

Support patient, carer and family involvement

Patients often feel anxious when they are being moved or their care is being transferred, particularly if no information is provided to them about the transfer or what to expect. Engage patients in transition communications to help alleviate this anxiety. Strategies to engage patients in transition communications could include[276]:

- Using bedside handover, which has been shown to improve patient safety and patient satisfaction by increasing the accuracy and timeliness of information transferred[307,308]; however, bedside handover may not be appropriate for all circumstances or services, so consider the particular needs of the patients and the organisation
- Providing specific opportunities to include patients, carers and families in rounds, such as pausing and requesting their input and letting them know the team will follow up on complex questions and any concerns after the round
- Ensuring that structured communication tools are patient focused, such as including an opportunity to engage and communicate with patients as part of the tool
- Placing patient care boards or whiteboards around the patient's bedside that record key information about the comprehensive care plan (such as upcoming tests and patient goals), and allowing patients, carers and families to write comments on the board for the workforce
- Signposting the organisation's processes for transfer, including providing clear information about the steps the patient is likely to go through and the different demands that may be made of them along the way, and allowing patients, family members and carers to ask questions
- Providing patients (and carers and families, if appropriate) with discharge information, including about any follow-up appointments
- Developing a display of care team members and their roles, such as a photo board.[309]

Consider how the privacy of a patient and confidentiality of patient information is maintained during transfers of care. This includes when patients are engaged in clinical handover at the bedside. If sensitive information is to be discussed, consider options for conducting aspects of the handover in a private area. Sensitive information may also be recorded on the handover sheet. Ask the patient if they are comfortable with bedside handovers, and let them know the purpose of bedside handovers and why they can play an important role. Let them know that sensitive information may be discussed and ask if they are comfortable with this.[310] When sensitive information is handed over in a private area, involve patients by asking them if they have questions or comments, or inviting them to confirm or clarify information. Detail the options and requirements to ensure privacy in the organisation's privacy policy, and reflect this in the organisation's handover policy.

Also see Case study 2 in Action 6.3.

Ensure transfer of responsibility and accountability for care

Key objectives of clinical handover are to maintain continuity of care, and to transfer professional responsibility and accountability for some or all aspects of patient care. This requires a clear understanding of who is responsible for tasks that need to be performed at any given time, and who may be held accountable for the decisions made and directions specified for a patient's care.[278]

The importance of ensuring the transfer of responsibility and accountability for patient care is emphasised in structured communication tools such as iSoBAR, ISBAR, SBAR and SHARED (see Action 6.7). These provide an opportunity for clinicians to request, recommend, read back/check back and communicate expectations. For example:

- What do I recommend or request to be done?
- What am I asking them (the recipient) to do?

- Has the person I am communicating to confirmed receipt of information? – ask participants to confirm understanding (check back) and provide an opportunity for participants to ask questions
- Does everyone understand what is going to happen next, who is doing what and by when?[311]

Put processes in place to clearly document the transfer of responsibility and accountability across the patient's journey, who is responsible and accountable for patient care, and what has been agreed on. Examples of documentation that shows effective handover of responsibility for care could include:

- Completed transfer forms
- Referral letters or discharge summaries
- Rounding checklists
- Changes to patient comprehensive care plans and pathways.

When a patient is discharged from the organisation, ensure timely communication of critical information to the patient, their general practitioner and/or their primary carer. This may be in the form of a discharge summary (see Actions 6.4 and 6.7). Consider the significance and complexity of the patient's health issues and risks of harm (see Action 5.13), and ensure that the discharge summary is provided to all the relevant people involved in the patient's ongoing care.[312] This includes ensuring that patients, carers and families understand the discharge plans, and (if relevant) who their ongoing care providers are, especially if English is not their first language (see Action 2.10). Ensure that documentation in the discharge summary has correct and up-to-date contact details of all relevant clinicians, and reflects the most current communications about care.

CRITERION: Communication of critical information

> *Systems to effectively communicate critical information and risks when they emerge or change are used to ensure safe patient care.*

When critical information emerges or there is a risk to patient care, timely communication of this information to the appropriate person(s) is essential to ensuring patient safety and delivery of the right care.

How critical information is defined in an organisation will depend on the type of services provided and the needs of the local population using the service. It may be helpful to consider what clinical and non-clinical information is time critical or significant to patient care, such as:

- New critical diagnostic or test results that require a change to care
- Changes in a patient's physical and psychological condition, including unexpected deterioration or development of complications (linked to the Recognising and Responding to Acute Deterioration Standard)
- Errors in diagnosis
- Missed test results
- Predetermined alerts and triggers
- Follow-up communication following a review of results.

This criterion recognises that critical information can arise at any point during a patient's care. These times can occur outside formal clinical handover, and can be closely linked to the formal processes of recognising and escalating acute deterioration, if escalation is required.

This criterion is closely linked to clinical handover (Action 6.8) and recognising acute deterioration (Actions 8.4–8.13). It addresses a communication gap by ensuring that the 'in-between times' are captured, and that organisations have systems and processes in place to support communication of critical communication, whenever it emerges or changes. This is essential because problems in communication at in-between times can result in failure to rescue, inappropriate treatment, care that does not align with a patient's goals or preferences, and poor coordination of care.[313,314]

New critical information can come from several sources, including patients, carers and families.

For timely action to occur, information must be communicated to the right person – that is, a clinician(s) who can make decisions about care. It is important to decide who this is, and to have processes that enable the workforce, patients, carers and families to know who this person is at any given time. What is 'timely' will depend on how important or time critical the information is to a patient's health, wellbeing or ongoing care. For example, communication may need to occur immediately, within hours or within days.

This standard does not apply to all informal communications. The intention is for organisations to consider and define what critical information means for their particular service, and put in place formal processes to ensure that this critical information is communicated whenever it emerges or changes. Ensure that policies and processes include:

- When communication should occur (for example, flags, triggers, alerts, defined criteria or critical values for diagnostic tests, referral criteria)
- Expectations about the time frame in which communication should occur (emphasising timely communication that is relevant to the criticality of the information)
- Who to communicate with, and how to escalate in the event of no response
- The preferred method of communication.

Documenting critical information in the patient's healthcare record is also essential to ensure patient safety, and to support subsequent communications and decisions about care. It is therefore important to consider the requirements under Action 6.11.

In developing processes, consider ways to support closed-loop communication.[313] This is when the person who is communicating the information knows that the message has been received, and there is a response that lets them know that action will be taken to deal with the communication need.[315] Closed-loop communication is especially important if communication occurs through tools or technologies that do not allow two-way communication, such as pagers, email or letters.

Communicating critical information

Action 6.9

Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to:

a. Clinicians who can make decisions about care

b. Patients, carers and families, in accordance with the wishes of the patient

Intent

Emerging or new critical information, alerts and risks are communicated in a timely manner to clinicians who can make decisions about care, and to the patient, family and carer, to ensure safe patient care.

Key tasks

- Define what 'critical information' and 'risks to patient's care' mean for the service context
- Implement processes to identify the clinicians who are responsible for a patient's care and can make decisions about care at any given time
- Identify when and to whom communication of critical information, alerts or risks should occur, including communication with patients, carers or families
- Develop and implement standardised processes that describe how communication of critical information, alerts or risks should occur.

Strategies for improvement

Identify critical information

The nature of critical information or a risk to patient care for the organisation depends on a number of factors, including clinical discipline and patient condition. In defining what critical information means in the service context, consider the type of services the organisation provides and the needs of the local population.

Types of critical information could include:

- Changes to medicines
- New critical results of diagnostic tests, including pathology tests, radiology exams or ultrasound procedures, and results from any diagnostic test that is conducted at the point of care (for example, at the bedside)
- Missed results
- Wrong diagnosis
- Change in patient goals
- Allergies or adverse drug reactions
- Issues with equipment or medical supplies
- Information that requires follow-up with another clinician or the patient (or family or carer, if appropriate).

Review policies for communicating critical information

Ensure that policies and processes clearly define:

- The types of critical information that need to be communicated
- The method for communicating critical information to the responsible clinician or multidisciplinary team
- The method for communicating critical information to the patient (or family or carer, if appropriate)
- The expected time frames for this communication
- How the information is documented (see Action 6.11).

Policies for communicating critical information to patients, carers and families should also consider whether open disclosure is relevant. Organisations are required to have open disclosure processes as a part of Action 1.12.

Use specific strategies and frameworks

Strategies to enable clinicians to communicate critical information could include:

- Implementing daily or triggered 'safety huddles' or team rounds, which are a mechanism for everyone to discuss potential risks and identify safety issues
- Having in place 'critical language', which is an agreed set of terms or common language that indicates to all members of the team that there is a problem or concern – for example, phrases such as 'I need some clarity' or 'I am worried about'; teams that respond to critical language know that, when this type of phrase is spoken, they need to stop, take a moment, pay attention and ensure that everyone on the team is on the same page
- Establishing agreed communication processes and pathways between clinicians, multidisciplinary teams, and pathology, biochemistry and radiology, to ensure that members of the workforce are clear about who to communicate new critical results to, and who is responsible for the action or follow-up.

The SHARED framework may be a helpful structure to use when communicating a critical situation or change in patient condition (developed by Mater Health Services Brisbane as part of the Commission's National Clinical Handover Initiative).

Action 6.10

The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians

Intent

Patients and carers can communicate critical information and risks about their care to clinicians.

Key tasks

- Develop and implement processes for patients and carers to communicate critical information and risks about their care
- Support patients and carers to understand and use these processes.

Strategies for improvement

Consider actions in the Partnering with Consumers Standard when implementing this action.

Ensure that policies describe the processes for patients, carers and families to communicate critical information that has emerged or changed to the clinicians who are responsible for the patient's care.

This could include:

- Informing patients, carers and families about what could be considered critical information
- Informing patients, carers and families about their role in communicating this information
- Providing access to resources or communication tools to support patients, carers and families to communicate critical information to clinicians.

Examples of mechanisms could include information provided on admission, posters, notices in wards or patient rooms, or messages on waiting-room TVs and the organisation's website. Ensure that information is displayed in a way that can be easily noticed and read by patients, carers and families.

Processes to inform patients, carers and families about who they can communicate critical information to when it emerges or changes, at any time, are also important. This may involve displaying information about how, and to whom, patients, carers and families can communicate

critical information in patient rooms and common areas. The information could include:

- A photo board of care team members with contact details
- A phone number (and available phone) for patients, carers and families to call if they are concerned
- A section on the patient whiteboard that identifies who is responsible for their care at any given time and how they can contact them
- Information about how patients and families may request a meeting with their clinician, or an integrated team meeting.

Where possible, allocate specific times for patients, carers and families to communicate with their care team, rather than leaving patient and family queries to random encounters with the workforce.

An example of a tool for implementing this action is the REACH model (Recognise, Engage, Act, Call, Help is on its way) developed by the NSW Clinical Excellence Commission to enable patient- and family-activated escalation.

CRITERION: Documentation of information

> *Essential information is documented in the healthcare record to ensure patient safety.*

Documentation is an essential component of effective communication. Given the complexity of health care and the fluidity of clinical teams, healthcare records are one of the most important information sources available to clinicians. Undocumented or poorly documented information relies on memory, and is less likely to be communicated and retained. This can lead to a loss of information, which can result in misdiagnosis and harm.[316,317]

The intent of this criterion is to ensure that relevant, accurate, complete and up-to-date information about a patient's care is documented, and clinicians have access to the right information to make safe clinical decisions and to deliver safe, high-quality care.

Documentation can be paper based, electronic or a mix of both. It can also take a number of forms, including the care plan, handover notes, checklists, pathology results, operation reports and discharge summaries. For this criterion, organisations are required to have in place systems to ensure that essential information about a person's care is documented in the healthcare record. For documentation to support the delivery of safe, high-quality care, it should[318]:

- Be clear, legible, concise, contemporaneous, progressive and accurate
- Include information about assessments, action taken, outcomes, reassessment processes (if applicable), risks, complications and changes
- Meet all necessary medico-legal requirements for documentation.

Regardless of who records information in the healthcare record, organisations need to ensure that their systems and processes for documentation meet the requirements of this standard. This involves supporting the workforce to document information correctly, and could include policies or training that clearly describe:

- The workforce's roles, responsibilities and expectations regarding documentation
- When documentation is required
- How to gain access to the healthcare record, and templates, checklists or other tools and resources that support best-practice documentation.

Clinical information systems and technologies play an increasingly important role in documentation in the healthcare system. It is essential to consider the safety and quality issues that may arise when designing, implementing or integrating digital health solutions. Any digital health record system that is implemented should meet the elements of best-practice documentation and support effective clinical communication.

This criterion is supported by actions in the Clinical Governance Standard that require organisations to make the healthcare record available to clinicians at the point of care, support the workforce to maintain accurate and complete healthcare records, and integrate multiple information systems if they are used (Action 1.16).

Documentation of information

Action 6.11

The health service organisation has processes to contemporaneously document information in the healthcare record, including:

a. Critical information, alerts and risks

b. Reassessment processes and outcomes

c. Changes to the care plan

Intent

Relevant, accurate, complete and timely information about a patient's care is documented in the healthcare record to support safe patient care.

Key tasks

- Develop and implement systems to support the contemporaneous documentation of critical information in the healthcare record
- Record the organisation's documentation policies, and make them available to the workforce
- Communicate to the workforce their roles and responsibilities for documentation.

Strategies for improvement

Consider and comply with relevant state and territory policies on documentation requirements in relation to clinical information.

Develop policies and processes that encourage a shared understanding of the organisation's documentation requirements. These could outline:

- When documentation is required
- What needs to be documented (that is, critical information, risks, reassessment processes and outcomes, and changes to the care plan)
- What format of documentation is required
- Expectations regarding information being recorded (that is, contemporaneous, accurate, legible and up to date)
- Where information should be documented, and how to gain access to and use the organisation's information management systems
- Roles and responsibilities relating to documentation.

The following 'CARE' elements[319] provide a useful guide when considering what good written documentation may look like in practice. They apply equally to digital information.

Compliant and complete

- All electronic and written documentation adheres to the standards and procedures of the health services and professional bodies concerned; this includes the use of approved abbreviations, and rules for clinician and patient identification
- Documentation is complete and current (for example, new or emerging information is recorded, daily progress notes or care plans are documented, a discharge summary is completed at the time of discharge)
- Clinicians provide the right documents and use them correctly.

Accessible and accurate

- Paper and electronic documents are available to clinicians who need them, when they need them, and are in language that the intended readership can easily understand
- Relevant, up-to-date information is immediately at hand and easy to locate, or searchable (physical accessibility)
- The documents consider the potential future relationship and the needs and the capabilities of those who will use the information (deferred accessibility); clinicians should not use language that excludes the people who will be using the information (such as the patient, carers, families and other clinicians across disciplines)
- The information recorded correctly reflects the event being documented.

Readable

- Documents are legible and can be understood; electronic and paper forms and checklists should provide enough space so that they can be completed accurately and legibly, and include clear instructions about how they should be completed
- Acronyms and abbreviations are avoided (in both design and completion) if there is any potential for ambiguity
- Documents are as specific as possible.

Enduring

- Documents are materially durable, not loose paper that is likely to slip out or fade
- The meaning of the documents is maintained, and they are completed in such a way that someone who is not present at the time of the recording can interpret the information – written information restricts the immediacy of feedback, so predict the reader's need to know, and try to anticipate their queries by providing enough information and justification to explain recommendations and instructions (actions to be taken and why), rather than just listing them.[278]

Implement standardised and structured templates, checklists or forms that are based on best practice and developed in collaboration with clinicians, to support documentation of clinical information.[319] Ensure that the workforce has easy access to these resources, and training about documentation protocols and how to use any standardised forms.

For electronic discharge summaries, core information components are specified by the Australian Digital Health Agency. The Commission's *National Guidelines for On-Screen Presentation of Discharge Summaries* provides recommendations about the best on-screen view of a discharge summary and other strategies to deal with presentation inconsistencies.

If electronic health systems are implemented to support documentation (for example, digital healthcare records, information-sharing systems, electronic patient journey boards), consider requirements under the Clinical Governance Standard (particularly Actions 1.16–1.18), and actions related to managing risks for clinical communication (Action 6.1), and monitoring and reporting incidents (Action 1.11).

Resources

Quality improvement for clinical communication

Australian Commission on Safety and Quality in Health Care – Implementation Toolkit for Clinical Handover Improvement, evaluation plan and evaluation framework (pages 51–52)

Quality Improvement Clinic – *Handover & Transfers of Care: Step-by-step measurement guide*

Clinical communication and handover

Although many of these resources were developed in the context of clinical handover, the framework and principles are helpful when considering how to improve clinical communications more broadly at transitions of care:

- Agency for Healthcare Research and Quality – CUSP Toolkit, 'Implement teamwork and communication' module
- Australian Commission on Safety and Quality in Health Care – Implementation Toolkit for Clinical Handover Improvement
- Australian Commission on Safety and Quality in Health Care – *OSSIE Guide to Clinical Handover Improvement*
- Institute for Healthcare Improvement – *How-to Guide: Multidisciplinary rounds*
- NHS England – *Safe Communication: Design, implement and measure*
- NSW Clinical Excellence Commission – In safe hands
- NSW Health – *Implementation Toolkit: Standard key principles for clinical handover*
- Primary Health Tasmania – *Sharing Points* videos
- SA Health – TeamSTEPPS
- SA Health and NSW Health clinical handover tool – Know the Plan, Share the Plan, Review the Risk

Communicating with transport services

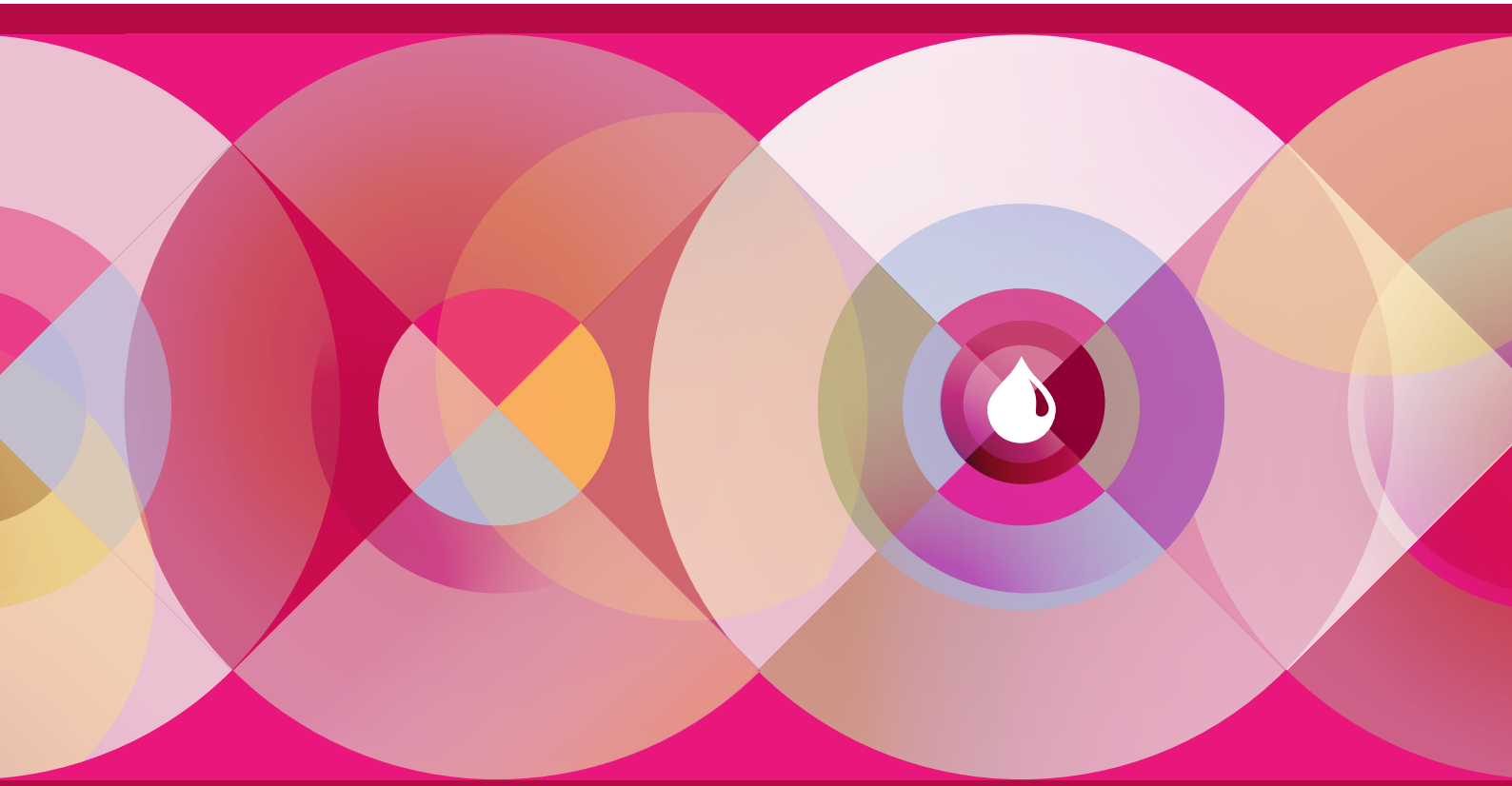
Queensland Ambulance Service – *Clinical Practice Procedures: Other/clinical handover*

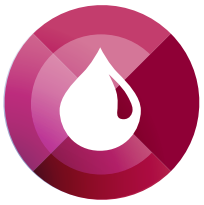
Royal Flying Doctor Service – *Transporting Your Patient: Guidelines for organizing and preparing patients for transfer by air*

Victorian Department of Health – *Protocol for the Clinical Handover of Ambulance Patients into the Emergency Department*

7

Blood Management Standard





Blood Management Standard

Leaders of a health service organisation describe, implement and monitor systems to ensure the safe, appropriate, efficient and effective care of patients' own blood, as well as other blood and blood products. The workforce uses the blood product safety systems.

Intention of this standard

To identify risks, and put in place strategies, to ensure that a patient's own blood is optimised and conserved, and that any blood and blood products the patient receives are appropriate and safe.

Criteria

Clinical governance and quality improvement to support blood management

Prescribing and clinical use of blood and blood products

Managing the availability and safety of blood and blood products

Introduction

Blood and blood products are a vital resource, sourced from the Australian and international donor community, and from commercial manufacture. The use of blood and blood products can be lifesaving, but there are also risks associated with their administration and use. Adverse outcomes can vary in frequency and severity, and include allergic and immunological complications, infections and incorrect blood transfusions.[320,321] Prescribing practices regarding blood vary widely, and a significant proportion of blood transfusions are unnecessary or could be avoided.[322]

The management of patients' own blood, and the use of blood and blood products, are a critical component of health care. The National Blood Authority (NBA) manages the national blood supply to ensure that clinicians have reliable and efficient access to blood and blood products needed for patient care, and to ensure value for money. Blood and blood products are provided to patients free of charge, based on clinical need and appropriate clinical practice.

Transfusion should not be a default decision. It should:

- Be carefully considered
- Take into account all the available evidence-based blood management strategies
- Balance the evidence for efficacy and improved clinical outcome against the potential risks
- Consider patient values and choices.

Scope of this standard

The Blood Management Standard covers all elements in the blood management and clinical transfusion process. This includes the principles of patient blood management (PBM), which involves avoiding unnecessary exposure to blood components through appropriate clinical management of the patient and the use of other, non-blood treatments. Consideration of all treatment options should be covered in the organisation's policies, procedures and protocols (Action 7.1), and in communication with patients about treatment options (Action 7.3).

The Blood Management Standard aims to ensure that patients (and carers) are engaged in decisions about their management and, if they receive blood and blood products, they do so appropriately and safely.

The Blood Management Standard requires clinician leaders and managers of a health service organisation to implement systems to ensure the safe, appropriate, efficient and effective use of blood and blood products. Clinicians and other members of the workforce should use the blood and blood product safety and quality systems.

The term 'transfusion' in this guide covers the administration of all blood and blood products, regardless of their route of administration. The blood and blood products governed under this standard include:

- Fresh blood components, such as
  - red blood cells (RBCs)
  - platelets
  - clinical fresh, frozen plasma
  - cryoprecipitate
  - cryodepleted plasma
- Plasma derivatives and recombinant products, such as
  - albumin
  - immunoglobulins, including immunoglobulin replacement therapy (for example, intravenous immunoglobulin) and hyperimmune globulins
  - coagulation proteins
  - coagulation and complement inhibitors.

Other products that are made or derived from human blood or plasma, such as some types of fibrin sealants (including Tisseel and Artiss), could be considered blood products. However, these products are not included in the scope of this standard, and it is not necessary to apply the actions of this standard to these products. However, ensuring safety and quality is important for all patient treatments. These products should meet safety and quality standards identified in the Medication Safety Standard, as well as any other relevant standards, including those relating to patient consent.

The Blood Management Standard relates to the management of patients' own blood, pre-administration (including assessment of the patient's bleeding risk) and administration, and management and use of blood and blood products.

Patient blood management

The best and safest blood for most patients is their own circulating blood. Patient blood management (PBM) views a patient's own blood as a valuable and unique resource that should be conserved and managed appropriately. Appropriate patient management requires a patient's blood (haemopoietic and circulatory system) to be considered in the same way as all other body systems.

PBM takes an individualised, multidisciplinary approach to the management of a patient's blood, through assessment and the development of a management plan to:

- Optimise a patient's own blood (identify and address the health conditions that, if not managed appropriately, might lead to a blood transfusion, such as anaemia or iron deficiency)
- Minimise blood loss (such as minimal blood draw techniques, point-of-care diagnostic testing, pharmacological strategies, cell salvage, and surgical techniques that reduce blood loss)
- Optimise tolerance of anaemia (with appropriate management, the body can be supported to tolerate anaemia without resorting to blood transfusion).

PBM should be the standard of care applied by all clinicians for patients facing a medical or surgical intervention who are at high risk of significant blood loss.

With better management, patients usually require fewer transfusions of donated blood components, which avoids transfusion-associated complications. PBM is not an intervention or an alternative to allogeneic blood transfusion; it is sound, evidence-based clinical practice.[323]

Action 7.4 includes specific strategies for developing and implementing PBM strategies.

The National Blood Authority website provides more information on PBM and supporting resources.

Stewardship Statement

The *Australian Health Ministers' Conference Statement on National Stewardship Expectations for the Supply of Blood and Blood Products* (the Stewardship Statement)[324] outlines the expectations of clinicians with regard to the responsible, sustainable and appropriate use of blood and blood products. The Blood Management Standard builds on these expectations, and outlines the safety and quality expectations of health service organisations in PBM, and the management of blood and blood products.

The Stewardship Statement lists a number of principles, including the following:

- All blood and blood products are used in a clinically appropriate manner in accordance with relevant professional guidelines and standards
- Informed patient consent procedures are implemented for all patients
- Processes, programs and facilities are in place to minimise the wastage of blood products
- Facilities are accredited with the appropriate bodies to meet all safety and quality obligations
- Transfusion-related adverse event information is collected and managed according to state or territory requirements.

CRITERION: Clinical governance and quality improvement to support blood management

> *Organisation-wide governance and quality improvement systems are used to ensure safe and high-quality care of patients' own blood, and to ensure that blood product requirements are met.*

This criterion requires organisation-wide governance, leadership and commitment to support blood management.

To meet this criterion, health service organisations are required to:

- Apply safety and quality systems to support timely and appropriate blood management
- Use quality improvement systems to monitor, review and improve blood management
- Apply principles of partnering with consumers when designing and implementing blood management systems.

This criterion aligns closely with the Clinical Governance Standard and the Partnering with Consumers Standard.

Safety and quality governance arrangements for blood and blood products may be embedded within, or managed as an adjunct to, broader safety and quality governance arrangements. Regardless of the approach, safety and quality governance arrangements for blood and blood products are required.

Integrating clinical governance

Action 7.1

Clinicians use the safety and quality systems from the Clinical Governance Standard when:

a. Implementing policies and procedures for blood management

b. Managing risks associated with blood management

c. Identifying training requirements for blood management

Intent

Safety and quality systems support clinicians in blood management.

Key tasks

- Ensure that governance structures are in place for blood management
- Develop and implement policies and procedures for blood management
- Use organisation-wide risk management systems to identify, monitor, manage and review risks associated with blood management
- Deliver or provide access to training on blood management based on the specific needs of the clinical workforce.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' safety and quality systems.

- Action 1.7 – policies and procedures
- Action 1.10 – risk management systems
- Actions 1.19, 1.20 and 1.21 – education and training

Health service organisations should:

- Use these and other established safety and quality systems to support the policies and procedures, risk management and training for blood management
- Ensure that current versions of all relevant policies and procedures are readily available and accessible to clinicians.

Policies may be developed or adapted at different levels within the organisation. However, all policy documents should be incorporated into a single, coherent set to maximise the effectiveness of the policy development process.

Implement blood management governance structures

Health service organisations are expected to have a governance group responsible for blood management, with a formalised reporting structure to the organisation's clinical governance and/or managers. The blood management governance group develops and oversees the safety and quality systems for blood management. This may include:

- Ensuring that members of the clinical workforce are trained in documentation requirements relating to transfusion, and receipt, storage, collection and transport of blood and blood products
- Developing strategies to improve and monitor compliance
- Increasing circulation of, or developing new, communiqués for clinicians involved in administering or prescribing blood and blood products to manage the risks identified.

Where any component of blood and blood product management is outsourced, the organisation is responsible for ensuring the safety and quality of those components. Ensure that there is a procedure in place to confirm and monitor the activities of the third party, and receive reports from the third party that would satisfy the requirements under this standard.

Implement policies and procedures

Ensure that there are organisational policies and procedures in place that cover:

- Preoperative anaemia and iron deficiency assessment and management pathways, or evidence through chart audit of a haemoglobin assessment
- Identification of patients at high risk of bleeding
- Use of appropriate diagnostic assays to assess cause of bleeding in a timely manner
- Use of decision support tools to support decision-making about bleeding management
- Cell salvage procedures (an autologous blood conservation technique for minimising blood loss)
- Use of all treatment options
- Management strategies that help minimise the likelihood of transfusion (including any PBM program)
- Support for transfusion alternatives and blood product refusal
- Pre-transfusion practice – strategies to optimise and conserve the patient's own blood, identify patients at risk of bleeding, and pre-transfusion blood sampling and testing
- Pre-, intra- and post-treatment or intervention assessment and documentation of a patient's haemoglobin, ferritin and iron studies
- Prescribing practice and clinical use of blood and blood products, and decisions to use blood and blood products, including any specific requirements (for example, irradiated products)
- Record taking and reporting, including completion of local blood request forms

- Administration of blood and blood products, including venous access; the use of equipment, concurrent fluids and medications; pre-administration identity check of patient and blood product; infusion rates; and observations and monitoring[325]
- Identity checks at the time of pre-transfusion specimen collection, testing, product allocation, and collection of blood products from storage
- Management of blood and blood products – including receipt, storage, collection and transport, wastage, and contingency planning
- Informed patient consent relating to blood and blood products, and partnering with patients in their own care.

Policies, procedures and protocols should accord with national evidence-based guidelines. Where there are no national evidence-based guidelines, develop a local policy, procedure or protocol that communicates the appropriate practices, or rely on clinical judgement.

Manage risks

Use established risk management systems (see Action 1.10) to identify, monitor, manage and review risks associated with blood management. Develop processes to manage clinical risks for different populations served within the organisation, clinical and workplace risks for the workforce, and organisational risks.

Use information from measurement and quality improvement systems, adverse events, clinical outcomes and patient experience data to inform and update risk assessments and the risk management system. Consider the training the workforce may need to effectively use incident management and investigation systems to inform risk management, and to plan and implement quality improvement processes to mitigate these risks.

The administration of blood products involves a number of processes performed by multiple clinicians across different disciplines, which can increase the risk of human or system error. Identify risks associated with transfusion, especially risks relating to procedural errors, and redesign the system to reduce the potential for patient harm.

Risks associated with the administration of blood products may be reduced by avoiding the transfusion altogether, assessing the benefits of PBM strategies that optimise the patient's own blood, and considering all treatment options. Assessing the impact and likelihood of risks relating to blood management and transfusion of blood and blood products will inform decisions about which, if any, blood management and transfusion-related risks to include in the organisation-wide risk management system.

Regularly and comprehensively review systems for effective and appropriate prescribing, sample collection, cross-matching, transport, storage and product administration to minimise the potential for error and patient harm.

Identify system weaknesses by:

- Regularly assessing risks relating to the systems in place for transfusion practice and clinical use of blood and blood products
- Regularly assessing blood-related incident reports, including near misses and root causes, using organisation-wide incident management and investigation systems, and strategies outlined in Action 7.7
- Developing and monitoring transfusion-related key performance indicators to identify and deal with blood-related risks.

Identify training requirements

Assess the competency and training needs of the workforce in line with the requirements of Actions 1.19, 1.20 and 1.21. Perform a risk assessment to inform the training schedule and to set priorities for the members of the workforce who need training. Develop, or provide access to, training and education resources to meet the needs of the workforce regarding blood management.

Action 7.2

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:

a. Monitoring the performance of the blood management system

b. Implementing strategies to improve blood management and associated processes

c. Reporting on the outcomes of blood management

Intent

Quality improvement systems are used to support blood management.

Key tasks

- Review, measure, and assess the effectiveness and performance of, organisational and clinical strategies for blood management
- Implement quality improvement strategies for blood management based on the outcomes of monitoring activities
- Provide information on the outcomes of quality improvement activities to the governing body, the workforce, consumers and other organisations.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' quality improvement systems.

- Action 1.8 – quality improvement systems
- Action 1.9 – reporting
- Action 1.11 – incident management and investigation systems

Health service organisations should use these and other established safety and quality systems to support monitoring, reporting and implementation of quality improvement strategies for blood management.

Monitor effectiveness and performance

The blood management governance group should routinely identify recurring issues, monitor incidents and implement quality improvement strategies.

Use the organisation's quality improvement systems to identify and prioritise the organisational and clinical strategies for blood management.

If clinical decisions result in a deviation from policies and procedures, record the deviation and the justification for the deviation, including any PBM strategies implemented. Ensure that the blood management governance group routinely reviews deviations to identify outliers. This will help identify where changes in clinical behaviour are appropriate, and where refinement of the policy, procedure or protocol is needed to reflect best practice.

If adverse patient outcomes are identified through incident monitoring (see Action 1.11), ensure that the blood management governance group assesses whether these incidents could be reduced by improving policies and procedures.

Investigate, audit or assess practices against national evidence-based guidelines. For example, to assess compliance with clinical practice guidelines, compare the use of products per procedure by unit/clinician or surgeon to identify and analyse outliers.

Implement quality improvement strategies

Use established quality improvement systems to assess and reduce risks across the full range of transfusion practices.

Review these systems to ensure that they include requirements for:

- Monitoring compliance with blood management policies and procedures
- Monitoring compliance with comprehensive documentation of transfusion in the patient's healthcare record
- Improving systems to support more effective PBM
- Reducing risks to individual patients from administration of blood or blood products
- Reducing risks associated with receipt, storage, collection and transport of blood and blood products
- Reducing wastage of blood and blood products
- Monitoring compliance with informed consent policies for blood and blood products (see Actions 2.4 and 7.3).

Mitigate system-related transfusion risks based on the assessment of the likelihood and impact of the risk. Ensure that specific actions to manage identified risks include communicating issues to the workforce, educating clinicians on appropriate practice, and implementing change processes to improve clinical practice.

Report outcomes

Ensure that reporting and feedback mechanisms are in place for blood management that cover each of the following areas:

- Pre-, intra- and post-operative/treatment PBM strategies, including identifying patients at risk of anaemia, iron deficiency, blood loss and bleeding
- Use and management of blood and blood products in accordance with policies and procedures
- Risk mitigation, education, and safety and quality improvement programs for the management and use of blood and blood products
- Risk management processes for adverse events, incidents and near misses relating to transfusion practice
- Policies, procedures and protocols for documenting details of the strategies in place to manage the patient's own blood and transfusion details in the patient's healthcare record
- Availability of blood and blood products
- Informed consent from patients.

Partnering with consumers

Action 7.3

Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Intent

Patients and carers are informed about patient blood management principles, the risks and benefits of using blood and blood products, and all treatment options.

Key tasks

- Review strategies in the Partnering with Consumers Standard to inform the implementation of actions in the Blood Management Standard

- Provide information to patients about patient blood management principles, the risks and benefits of using blood and blood products, and all treatment options, that is tailored to their specific needs and level of health literacy.

Strategies for improvement

The Partnering with Consumers Standard has specific actions (Actions 2.3–2.10) relating to health service organisations' processes for involving patients in their own care, shared decision making, informed consent and effective communication.

Provide information to patients and carers about optimising their own blood, PBM strategies, and the potential need for blood and blood products, including all treatment options, risks and benefits. Provide this in a format that can be understood and is meaningful, and ensure that patients are given the opportunity to ask questions. Ensure that the information is current, and that clinicians have ready access to it.

Information on blood management should suit different health literacy levels, including simpler and more complex information resources, so that clinicians have access to the most appropriate information for an individual patient. Written information and diagrams may be appropriate in certain circumstances; in others, information could be provided online.

Where local information or resources are developed, involve patients and carers in developing these resources (see Action 2.9).

Seek feedback from patients about the information provided using surveys or informal discussions, and make changes to ensure that it is understood and meaningful.

Ensure that organisation-wide informed consent processes (see Action 2.4) include consideration of issues relating to consent for transfusions.

CRITERION: Prescribing and clinical use of blood and blood products

> *The clinical use of blood and blood products is appropriate, and strategies are used to reduce the risks associated with transfusion.*

Although blood and blood products remain a critical element of clinical practice, there is increasing evidence that allogeneic blood transfusions pose risks to patients, and that a significant proportion of transfusions are unnecessary or could be avoided. Allogeneic transfusions can be associated with adverse patient outcomes, potentially leading to increased morbidity, delayed recovery, extended hospital stays or mortality.[323]

Introduction of PBM strategies can minimise these risks. PBM describes a range of medical and surgical strategies that aim to conserve and optimise the patient's own blood, which can reduce or avoid the need for allogeneic transfusion and improve patient outcomes. It is a person-centred approach, as opposed to having a product-centred focus. PBM is not an intervention or an alternative to blood transfusion; it is sound, evidence-based clinical practice that aims to improve clinical outcomes by avoiding unnecessary exposure to blood components. It includes the three pillars of:

- Optimising blood volume and red cell mass (including haemoglobin and iron studies)
- Minimising blood loss
- Optimising the patient's tolerance of anaemia.

Benefits of appropriate management through PBM include:

- Assessment and management of conditions that, without appropriate interventions, might lead to a blood transfusion (so that transfusions are done only when necessary)
- Improved patient outcomes, including fewer complications, faster recoveries and shorter hospital stays
- Reduced patient exposure to the potential risks associated with receiving blood and blood products from another person, including
  - allergic and immunological complications – blood transfusion may be considered as a type of organ transplant and, as with any transplant, the body may react to foreign components
  - infectious risk – blood in Australia is very safe, and donor blood is carefully screened and tested; however, infectious disease transmission remains a very low risk
  - incorrect blood transfused – although strict procedures are used to ensure that patients receive the correct blood product, the potential for a patient to receive the wrong blood (meant for someone else) still exists, which can result in serious medical problems.

The NBA website provides more information on PBM and supporting resources.

Documenting blood management history and decisions

Accurately recording a patient's blood and blood product transfusion history, including any previous reactions and specific indications for use, in the patient's healthcare record is essential to enable easy and accurate review of records. Blood and blood products can be implicated in recalls or lookback processes by the Australian Red Cross Blood Service or other commercial suppliers. The NBA website lists these suppliers.

Health service organisations need to be able to trace all blood and blood products to allow recall if possible, and treatment, testing or counselling of the recipient as required. This can only be achieved through well-maintained records of the fate of all blood and blood products.

Review of transfusion history is also an important component of the pre-transfusion process. It can identify any red cell antibodies, transfusion reactions or special patient requirements[326], and improve transfusion safety by reducing the risk of an adverse transfusion reaction. In addition,

recording detailed information about transfusion is important to allow audit of the patient healthcare record. For example, documenting the indication for transfusion is essential to audit transfusions against guidelines (see Action 7.1).

Reviewing and reporting adverse events

The Stewardship Statement includes the requirement to manage blood and blood products in ways that ensure that transfusion-related adverse event information is collected and managed according to state or territory requirements. Governments have also endorsed the Strategic Framework for the National Haemovigilance Program[327], which redefines the scope of national haemovigilance arrangements to emphasise activities that contribute to national standardisation. The NBA will continue to collect, analyse and report haemovigilance data received from states and territories at the level defined in the Australian haemovigilance minimum dataset.[320]

Although information collected about incidents relating to the administration of blood and blood products varies between states and territories, all states and territories have agreed to align the information they collect about transfusion to allow very specific transfusion-related information to be collected and provided for national reporting. Definitions and types of adverse events that should be reported are in the Australian haemovigilance minimum dataset.[320]

Optimising and conserving patients' own blood

Action 7.4

Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by:

a. Optimising patients' own red cell mass, haemoglobin and iron stores

b. Identifying and managing patients with, or at risk of, bleeding

c. Determining the clinical need for blood and blood products, and related risks

Intent

PBM strategies are in place to ensure that the clinical use of blood and blood products is appropriate and safe, and strategies are used to reduce the risks associated with transfusions.

Key tasks

- Develop effective PBM strategies
- Identify, develop and implement policies, procedures and protocols for PBM to optimise and conserve the patient's own blood, and manage the need for blood and blood products
- Develop and implement education activities for PBM to optimise and conserve the patient's own blood, and manage the need for blood and blood products
- Establish perioperative standard practice for assessment and management of anaemia
- Implement processes to communicate elective surgical time frames to patients' primary carers to enable effective anaemia management in the primary care sector, if possible.

Strategies for improvement

Ensure that all clinicians apply PBM as the standard of care for patients facing a medical or surgical intervention who are at high risk of significant blood loss. Put processes and procedures in place for the various practices that can be initiated before, during and after surgery or other treatments. Provide orientation and training on PBM for all clinicians involved in the clinical pre-, intra- and

post-administration or prescription of blood or blood products.

Develop a PBM implementation plan

Develop a plan for implementing PBM that includes:

- Understanding and raising awareness of PBM practices and concepts
- Using an existing governance structure or implementing a new structure, including identifying and supporting one or more PBM champions
- Selecting the PBM initiatives to implement and set benchmarks to evaluate implementation
- Collecting patient-level data to set pre-, intra- and post-implementation benchmarks for the PBM initiative
- Educating and training the workforce
- Communicating about the PBM Guidelines, including target audiences, strategies and tools for effective implementation, communication channels, and key messages
- Maintaining an effective PBM program through monitoring, ongoing evaluation and reporting against benchmarks for each initiative.
- The National Patient Blood Management Implementation Strategy may help health service organisations develop a plan. Online courses within the BloodSafe eLearning Australia program are useful for training.

Consider PBM initiatives

The NBA has guidance on how to implement a PBM program and initiatives for organisations in the PBM Guidelines, PBM Guidelines companions and National Patient Blood Management Implementation Strategy.

Consider developing local protocols for PBM, including establishing a PBM governance process and group. This could be part of the blood management governance group set up in Action 7.1.

Key initiatives for implementation in all organisations are:

- Optimising patients' own RBC mass, haemoglobin and iron stores
- Identifying and managing patients with, or at risk of, bleeding
- Determining the clinical need for blood and blood products, and related risks.

Optimise patients' own RBC mass, haemoglobin and iron stores

Preoperative anaemia is independently associated with an increased risk of morbidity and mortality[323], and increases the likelihood of RBC transfusion.[322] Managing anaemia before elective surgery can improve a patient's pre-surgery clinical status, and reduce post-surgery morbidity, mortality and length of stay.[323]

Establish a definitive diagnosis of anaemia, including whether it is related to the patient's current condition and if it is correctable. Some forms of anaemia cannot be prevented (if caused by a failure in the cell production process), but others (for example, anaemia caused by blood loss or dietary deficiency) can be prevented and managed.

Before the treatment or surgery:

- Identify, evaluate and manage anaemia as the key strategy for optimising RBC mass, haemoglobin and iron stores in all patient groups
- Communicate with the patient's general practitioner to identify, evaluate and manage anaemia as the key strategy for optimising RBC mass, haemoglobin and iron stores in all patient groups
- Implement preoperative anaemia assessments within the health service organisation
- Develop communication systems between the hospital and the primary care sector to reduce presurgical risks of transfusion
- Ensure that assessment and management of iron stores are considered when managing anaemia and optimising RBC mass
- Use evidence-based therapies for boosting the production of RBCs and optimising RBC mass in specific groups of patients
- Consider using perioperative or day clinics to identify, evaluate and manage anaemia.

To assess impact and success, identify practice changes that increase the number of preoperative patients with optimised haemoglobin and iron stores. Examples of performance indicators include:

- Postoperative infections and adverse reactions from blood products
- Transfusion-related inflammatory events

- Rates at which patients are screened for anaemia and iron deficiency
- Volumes of blood products used
- Rates or proportions of patients transfused
- Hospital length of stay
- Readmissions as a result of infectious complications of transfusion
- Elective surgery cancellations due to non-optimised haemoglobin and iron stores.

Identify and manage patients with, or at risk of, bleeding

Assessment of bleeding risk is a key component of PBM strategies to minimise blood loss. Patients may be at increased risk of bleeding as a result of:

- Advanced age[328]
- Decreased preoperative RBC volume (small body size or preoperative anaemia)[328]
- Medicines affecting haemostasis, including complementary medicines
- Medical conditions causing haemostatic defect, including hereditary bleeding disorders and acquired medical conditions such as chronic kidney or liver disease
- The type of surgery.

Identify patients at high risk of bleeding or excessive blood loss, including history of bleeding diathesis. Use a structured patient interview or questionnaire before surgery or invasive procedures to assess bleeding risk. This should include:

- Personal or family bleeding history
- Previous excessive post-traumatic or post-surgical bleeding
- Detailed information on the patient's medicines, including complementary medicines.

Numerous medicines and complementary therapies affect haemostasis. In the case of anticoagulant or antiplatelet agents, cessation or bridging therapy may be required to minimise blood loss.

To assess bleeding risk before and during treatment, use a multidisciplinary approach to bleeding management and excessive blood loss, including:

- Appropriate diagnostic testing to measure haemostatic capacity for at-risk patients
- For patients at risk of suffering from adverse outcomes from ongoing blood loss over time
  - minimising phlebotomy
  - use of small-volume blood collection tubes
  - use of closed blood sampling systems to minimise loss of blood
- Identifying medicines that affect haemostasis
- Optimising physiological conditions conducive to haemostasis
- Applying appropriate pharmacological support
- Appropriate use of cell salvage
- Appropriate use of factor concentrate.

Determine the clinical need for blood and blood products, and related risks

Allogeneic blood is a valuable adjunct to health care, but it is a limited resource, and transfusion can be a risk for patients. Therefore, diagnosing patient-specific haemostatic dysfunction to support patient-specific treatment will improve patient outcomes, and reduce unnecessary and inappropriate transfusion. The goal of effective management of critical bleeding is rapid and targeted treatment with ongoing assessment of treatment effect.

Evidence-based blood management strategies should be applied for all patients to ensure optimisation of the patient's own blood, but also to reduce the patient's exposure to allogeneic transfusion and many of the associated risks of transfusion.

Human and systems risks associated with transfusions may be preventable, but other risks relate to the nature of blood products and can only be avoided by avoiding transfusions.[322] Risks associated with allogeneic blood transfusion include:

- Wrong blood incidents
- Transmission of bloodborne infections
- Haemolytic transfusion reaction
- Immunosuppression.[329,330]

Review patients' healthcare records and discuss with them their previous and current transfusion risks before transfusion, to identify at-risk patients. This may involve:

- Prescribing and ordering special products to suit the patient's transfusion needs

- Amending administration practices, such as infusion rate
- Increased monitoring of the patient during a transfusion
- Undertaking bedside checks before transfusion
- Matching patient and intended treatment.

Where there is, or may be, a need to treat the patient with blood and blood products:

- Identify the cause of bleeding quickly
- Implement algorithms to manage bleeding (for example, massive transfusion protocol, bleeding management algorithms)
- Develop procedures and work unit guidelines to support appropriate, timely and effective access to providing and transfusing prohaemostatic, anticoagulant, antifibrinolytic and antithrombotic therapies
- Support the use of cell saver to salvage and replace the patient's own blood when appropriate
- Develop and maintain good lines of communication between the clinical environment and blood banks
- Provide ongoing education to support evidence-based bleeding management and sustainability of practice for all patients
- Understand the risks of using and administering blood and blood products
- Ensure that safe transfusion practices are followed when blood products are administered
- Ensure assessment and reporting of adverse reactions or outcomes.

Consider implementing the following initiatives to support these activities:

- Maintain meticulous surgical techniques as the cornerstone of intraoperative blood conservation
- Implement strategies and techniques to minimise iatrogenic anaemia
- Consider cell salvage in the surgical setting
- Consider all treatment options
- Consider using point-of-care testing devices to provide rapid bedside monitoring to help the clinician direct appropriate targeted therapy
- Implement single-unit RBC transfusion practice for haemodynamically stable patients (prescribing only one unit at a time), with clinical reassessment of the patient before prescribing a subsequent unit; although restrictive transfusion thresholds (triggers) are an effective method of reducing and conserving RBC use, RBC transfusion should not be dictated by a haemoglobin 'trigger' alone, but take account of clinical signs and symptoms, and patient tolerance of anaemia.

The NBA has further information on implementing strategies and initiatives.

Documenting

Action 7.5

Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record

Intent

The history of blood product use, and relevant clinical and product information are documented in the patient's healthcare record to minimise risks and optimise clinical outcomes.

Key tasks

- Document comprehensive information, including blood use, transfusion history and transfusion details, before, during and after transfusions

- Develop and implement education activities for the workforce responsible for PBM about documenting transfusion of blood or blood products in the patient's healthcare record, recognising and responding to adverse transfusion reactions, and documenting adverse reactions in the patient's healthcare record.

Strategies for improvement

Transfusion-related adverse events can be associated with high rates of morbidity or mortality.[325] To reduce this risk, assess the patient for a history of RBC antibodies, transfusion reactions or any other special transfusion requirements.[326]

Ensure that the integrated patient healthcare record required under Actions 1.16 and 1.17 includes a record of the administration of blood components. Routinely document the following information in the patient's healthcare record:

- Patient consent, limited consent or refusal, including documentation of information provided to the patient
- Relevant medical conditions
- Indications for transfusion or administration of the blood product
- Any special product or transfusion requirements (for example, irradiated products)
- Known patient transfusion history, including RBC antibodies, transfusion reactions, and any adverse reactions to blood or blood products
- Blood or blood product identification to ensure traceability, such as the blood pack donation numbers (or the product ID and batch number for plasma and recombinant blood products)
- Blood transfusion compatibility label, or the report form, if applicable (this includes a statement of compatibility)
- Type and volume of product transfused or administered
- Date and time of both start and end of transfusion
- Evidence of observations documented on an appropriate form
- Pathology results, including haemoglobin levels and ferritin, as appropriate
- Patient response to administration of blood products, including occurrence and management of any adverse reactions.

Ensure that transfusion details also appear in discharge documentation. If the patient becomes unwell after receiving blood, their transfusion history is important for the treating doctor.[326]

Consider developing local protocols for recording transfusions in the patient's healthcare record. Further guidance about the administration of a blood transfusion, as well as documentation of the transfusion, is in the Australian and New Zealand Society of Blood Transfusion (ANZSBT) guidelines for the administration of blood products.[325]

Provide orientation and training to all clinicians involved in the clinical administration or prescription of blood or blood products. This should include record taking, recognising and responding to suspected transfusion reactions, and reporting to appropriate governance committees.[331]

Audit the contents of patient healthcare records to assess compliance with the requirements of Action 7.5. Include details of this audit in the organisation's audit plan. The audit should reveal the level of compliance of documentation against the requirements of Action 7.5 and/or the protocol for documentation relating to transfusion (if developed to support implementation of Action 7.5).

Set up a process for identifying the proportion of patient healthcare records that do not document transfusion (for example, by auditing the fate of the product as recommended under Action 7.10 against completed patient records).

All members of the workforce involved in transfusion of blood or blood products are expected to receive orientation or training to recognise and respond to adverse transfusion reactions, and document the transfusion and any adverse reactions in the patient's healthcare record.

A checklist for blood product checking is included in the ANZSBT *Guidelines for Transfusion and Immunohaematology Laboratory Practice*.[331] Ensure that organisational blood and blood product management policies, procedures and protocols are consistent with these guidelines.

Action 7.6

The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria

Intent

Systems are in place to ensure that the clinical use of blood and blood products is appropriate, and strategies are used to reduce the risks associated with transfusions.

Key tasks

- Develop and implement policies, procedures and protocols that are evidence based, and in line with national guidelines and criteria for the prescription and administration of blood and blood products
- Ensure that clinicians have the necessary skills to prescribe and administer blood and blood products
- Develop and implement education activities for the prescription and administration of blood and blood products.

Strategies for improvement

Consider developing local protocols for prescribing and administering blood and blood products in accordance with national guidelines and national criteria. Further guidance regarding the administration of a blood transfusion, as well as documentation of the transfusion, is in the ANZSBT guidelines for the administration of blood products.[325]

Provide orientation and training to all clinicians involved in the clinical administration or prescription of blood or blood products, to ensure that they have appropriate skills and expertise.

Ensure that policies, procedures and protocols are in place that accord with national evidence-based guidelines for:

- Prescribing practice and clinical use of blood and blood products – decisions to use blood and blood products including any specific requirements (for example, irradiated products)
- Administration of blood and blood products, including venous access; the use of equipment, concurrent fluids and medicines; pre-administration identity check of patient and blood product; infusion rates; and observations and monitoring.[325]

Where there are no national evidence-based guidelines, develop a local policy, process or procedure that communicates the appropriate practices, or rely on clinical judgement.

Improving the consistency of policies, procedures and protocols with evidence-based guidelines should be part of the blood management quality improvement system (refer to actions for the Clinical Governance Standard and Action 7.2). This includes actions such as developing or reviewing policies, procedures and protocols to ensure alignment with national evidence-based guidelines, and amending such documents as required.

Health service organisations are required to monitor the use of the policies, procedures and protocols. Ensure that these policies, procedures and protocols are readily available to the workforce. Members of the workforce should be trained in the use of such documents and procedures, where appropriate.

Strategies to change clinical practice are more likely to be effective if they use a multifaceted approach that includes a range of the following features:

- Evidence-based content
- Adaptation for local use

- Effective data collection systems to assess and feed back statistics by specialty and clinician
- Clinician involvement in clinical pathway development
- Use of an implementation team (for example, local clinical change team at the local level); in PBM programs, identifying and engaging multiple disciplines (for example, anaesthetists taking a major role in perioperative care) has been particularly successful
- Identification of the evidence–practice gap before implementation
- Identification of potential barriers to change
- Incorporation of reminder systems
- Use of ongoing education and communication
- Use of effective clinical leadership, including local opinion leaders, as part of a structured program.

Provide education, training and tools to the workforce to support the introduction of PBM practices in the clinical setting.

All members of the workforce involved in transfusion of blood and blood products are expected to receive orientation or training for the prescription and administration of blood and blood products.

Reporting adverse events

Action 7.7

The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria

Intent

Transfusion-related adverse events are reported to enable identification of previous adverse reactions or special transfusion requirements, and to drive improvement opportunities.

Key tasks

- Capture blood-related incidents in incident management and investigation systems, and provide reports from these systems to the blood management governance group to inform activities in the blood management quality improvement system (see Action 7.2)
- Provide a summary analysis of blood- and blood product–related incidents to the highest level of governance in the organisation for review and action
- Report transfusion adverse events in accordance with regulator and supplier requirements, as well as local policies and procedures
- Develop and implement education activities for reporting transfusion-related adverse events in accordance with national guidelines and criteria.

Strategies for improvement

An adverse event, adverse reaction or near miss is an incident where the patient experienced actual or potential harm. Adverse reactions, adverse events and near misses relating to blood and blood products often go unrecognised and unreported.[332,333]

Capture transfusion-related incidents, including near misses, in the organisation's incident management and investigation systems under a category for incidents relating to blood and blood products. (Do not include incidents relating to blood spills or blood collection that are unrelated to transfusion.) Routinely report this information to the blood management governance group (refer to Action 7.2) for analysis. This analysis will feed into the assessment of risks (as described at Action 7.1) and implementation of risk mitigation strategies (as described at Action 7.2).

Align local incident reporting with state and national haemovigilance requirements, including classification of incidents.

Provide a high-level summary and analysis of the incidents to the highest level of governance for review.

Report adverse events to the pathology service provider, the Australian Red Cross Blood Service or product manufacturer, and the Therapeutic Goods Administration (TGA; if required). Reporting adverse transfusion events allows identification of other patients at risk because of patient identity error (for example, ABO-incompatible transfusion to a second patient) or because other blood components collected from the implicated donor may also be affected (for example, in cases of bacterially contaminated blood components[325]), and assists in monitoring safety and quality of a product (for example, allergic reactions). The *Blood Component Information* booklet[334] describes adverse reactions, and identifies which reactions must be reported to the Australian Red Cross Blood Service. For commercial products, check with the manufacturer to identify their adverse event reporting requirements. Links to suppliers are on the NBA website.

Report adverse events internally to the appropriate governance level of the organisation. Given the complexity and multifaceted reporting requirements for transfusion-related adverse events, ensure that there is a policy, procedure or protocol in place that identifies the classes of transfusion-related adverse events that must be externally reported, including the time frame for reporting.

All members of the workforce involved in transfusion of blood and blood products are expected to receive orientation or training for reporting transfusion-related adverse events in accordance with national guidelines and criteria.

Action 7.8

The health service organisation participates in haemovigilance activities, in accordance with the national framework

Intent

The health service organisation participates in relevant haemovigilance activities to improve the effective and appropriate management of blood and blood products, and to ensure the safety of people receiving and donating blood.

Key tasks

- Identify and implement processes to take part in haemovigilance programs for health service organisations, local health networks or private hospital groups, state or territory programs or national programs
- Develop and implement education activities for haemovigilance programs.

Strategies for improvement

Identify local and state or territory haemovigilance reporting requirements, and have processes in place to ensure that these are met.

Participate in state or territory and national haemovigilance programs. National data collection contributes to the understanding of transfusion-related errors, and allows identification of safety and quality measures to deliver better transfusion outcomes. In many cases, state or territory governments generate information about blood-related incidents from organisation-wide incident management and investigation systems. In other cases, information may need to be submitted separately.

Provide haemovigilance reporting to the blood management governance group, which is responsible for:

- Independently reviewing adverse events
- Establishing validity classification and assessing imputability
- Reporting adverse events to state and territory systems (see the NBA haemovigilance reporting website).

All members of the workforce involved in haemovigilance programs are expected to receive relevant orientation or training.

CRITERION: Managing the availability and safety of blood and blood products

> *Strategies are used to effectively manage the availability and safety of blood and blood products.*

Health service organisations, the NBA and manufacturers in the blood supply chain play an important role in understanding where blood and blood products are being held. This total picture of the national inventory of blood and blood products is important to ensure that products are held in the most appropriate place so that they can be provided to health services to meet clinical need.

BloodNet is a system that allows health service organisations to enter their inventory levels, and assists in building the picture of the national inventory. The Australian Red Cross Blood Service produces a National Inventory Template relating to fresh blood products held at the Blood Service and health service organisations, which is distributed to health service organisations that receive blood and blood products. In addition, reporting on inventory is available through BloodNet.

Managing blood and blood product inventory involves two key factors, and both processes are required to ensure that blood and blood products are safe:

- Product availability and security – planning of inventory levels held, timing of deliveries and order volume
- Product quality and integrity – physical and process control of product in the organisation to ensure efficient and effective handling to maintain availability and minimise wastage.

The Stewardship Statement states that health service organisations should have processes, programs and systems in place that ensure the safe and efficient receipt, storage and transport of blood and blood products, and that minimise wastage of these products. National blood product planning, management and governance are supported by:

- Health service organisations having an ordering and receipt verification process in place that provides appropriate financial accountability, as required by governments
- Inventory data that are provided on a regular and timely basis to assist in supply and demand planning requirements, especially in times of national shortages.

Many of the risks associated with receipt, storage, collection and transport of blood and blood products can be avoided with adequate systems and processes. Monitor systems for cold chain integrity, sample collection, cross-matching, product collection and inventory management, including storage, handling and transport. Identify and manage weak spots that increase the risk of human error, handling, patient harm or wastage.

As described in Action 7.1, these should align with best-practice standards and guidelines.

Inventory management encompasses all the activities associated with ordering, storing, handling and issuing blood products. Good inventory management ensures appropriate use of this precious resource. Not holding enough product can potentially put patients at risk or disrupt routine services. However, too much inventory can deplete products held by the supplier to insufficient levels, increase the age of blood at transfusion and increase wastage.

The NBA is responsible for ensuring enough supply of blood and blood products to meet clinical needs. The National Blood Supply Contingency Plan is designed to guide the NBA and other relevant stakeholders in facilitating and coordinating a national response in the event of a domestic threat or disaster that affects the provision of a safe and adequate blood supply in Australia. The response by the clinical community is a vital element of the plan. Organisations should have arrangements in place to support the clinical management of blood and blood products in a crisis, and to help clinicians effectively respond to patient requirements.

Action 7.9

The health service organisation has processes:

a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely

b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer

Intent

Blood and blood products are managed appropriately to ensure that they are available and safe for clinical needs.

Key tasks

- Regularly review the risks associated with traceability, receipt, storage, collection and transport of blood and blood products
- Provide training to the workforce on safe blood management
- Review policies, procedures and protocols for addressing risks identified with receipt, collection, storage, handling and transport of blood and blood products, and review reports from inventory management and supply chain systems.

Strategies for improvement

Manufacturers, suppliers, the TGA, distributors, other stakeholders, and states and territories have directions, legislation and relevant requirements relating to storing, distributing and handling blood and blood products safely and securely. Follow these to ensure the safety and quality of the products. Failure to meet the requirements may result in degradation in product quality, and increased risk of patient morbidity or mortality.

Ensure that policies, procedures or protocols are in place relating to the management of blood and blood products, including traceability, receipt, storage, collection and transport of blood and blood products (see Action 7.1). These should cover how products are ordered, receipted, stored, handled and transported in the facility, and include refrigeration protocols, the inventory management process and cold chain integrity.

To identify potential risks in systems:

- Assess compliance with policies, procedures and protocols relating to the management of blood and blood products (as required in Action 7.1)
- Regularly review reports on traceability, receipt, collection, storage and transport of blood and blood products within the organisation
- Monitor incidents relating to traceability, receipt, storage, collection and transport of blood and blood products, and identify recurring issues
- Monitor inventory levels to ensure product availability to meet clinical demand
- Monitor wastage of blood and blood products (as required under Action 7.10)
- Review the risks identified against the reports from the blood and blood product management systems, such as refrigeration temperature registers or reports and temperature loggers.

If possible, use electronic systems (for example, BloodNet) to monitor receipt, transfer and fate (including wastage) of blood and blood products.

Provide orientation and training to all members of the workforce involved in the management of blood and blood products, including ordering, traceability, receipt, storage, collection and transport of blood and blood products.

Where the provision of blood and blood products within an organisation is outsourced, ensure that contracts with providers include requirements to address the strategies identified, and to provide sufficient information to confirm these are implemented. Monitor compliance of the blood management provider with these strategies.

Availability of blood

Action 7.10

The health service organisation has processes to:

a. Manage the availability of blood and blood products to meet clinical need

b. Eliminate avoidable wastage

c. Respond in times of shortage

Intent

Blood and blood products are managed to minimise wastage and ensure that product is available to meet clinical demand in times of shortage.

Key tasks

- Regularly review the risks associated with availability of blood and blood products, including minimising wastage and responding in times of shortage, and develop policies and processes to respond to these risks
- Provide training to the workforce about ensuring blood availability
- Record wastage in a system and monitor wastage reports
- Regularly review inventory requirements, and manage blood and blood products to ensure availability
- Identify, develop and implement contingency arrangements, including planning for times of supply shortage, considering state or territory and national arrangements.

Strategies for improvement

The Stewardship Statement[324] states that health service organisations should have processes, programs and facilities in place to minimise the wastage of blood products, and ensure that inventory data are provided on a regular and timely basis to assist in supply and demand planning requirements, especially in times of national shortages.

Wastage is loss of blood or blood products resulting from carelessness, inefficiencies or even inappropriate use. Product discard is an important component of wastage. Because of the short shelf life of some products (particularly fresh blood products), health service organisations may have policies in place to ensure that enough product is available to meet clinical need, and these policies may mean that wastage cannot be completely eliminated. The goal is to minimise discard while ensuring product availability. Monitor and report all discards through BloodNet and to the local blood management governance group.

Ensure that documented processes and systems are in place to record the fate of products by type. Where possible, use electronic systems (for example, BloodNet) to record discard as part of the fate of the product. Ensure that these processes clearly outline:

- What is to be reported and how
- The format in which it is to be reported
- Who it should be reported to, including the blood management governance group.

Minimise blood wastage

Minimise blood wastage at all times. Implement strategies as part of the blood management quality improvement system to reduce the risks identified in Action 7.9. These strategies may include:

- Identifying a target for wastage, based on targets communicated at a state or national level (the level of wastage will be product-specific, and will also depend on the different services provided by the organisation)
- Identifying appropriate inventory levels that ensure that appropriate blood and blood products are available to meet clinical demand while minimising wastage

- Identifying appropriate inventory management strategies or practices (for example, first-in-first-out)
- Communicating wastage targets to the workforce, and clarifying that meeting the target is not a goal in itself – that is, if product is available but is not clinically indicated, do not encourage use of the product to reduce wastage
- Benchmarking against the current wastage level, and against other similar organisations
- Reviewing ordering practices for non-standard or unusual blood products to ensure that prescribing is based on current knowledge and evidence
- Identifying strategies to ensure that products remain within specifications so that they do not need to be disposed of, including maintaining temperature requirements, reducing unnecessary handling and storing appropriately.

The NBA has developed tools to improve inventory management practice.

States and territories have established targets for discard rates for RBCs, platelets and clinical fresh frozen plasma for the public and private sectors. Monitor and review the organisation's wastage rates against these targets and prepare action plans for how to achieve the targets within the organisation.

The NBA has contingency and risk mitigation measures in place to ensure continuity of the supply of blood and blood-related products and services, including the National Blood Supply Contingency Plan.[335] The response by the clinical community is a vital element of the plan. Ensure that the organisation has arrangements in place to support the clinical management of blood and blood products in a crisis, and to help clinicians effectively respond to patient requirements.

Incorporate state or territory and national arrangements into the organisation's local contingency plans for times of blood and blood product shortage. Test these contingency plans and participate in state, territory or national simulations. If opportunities for improvement are identified, prepare strategies to respond to these, and review them through the blood management quality improvement system (refer to Action 7.2).

Follow instructions from governments during activation of the National Blood Supply Contingency Plan.

Provide orientation and training to all members of the workforce involved in minimising wastage and responding in times of shortage.

If blood management within a health service organisation is outsourced, ensure that contracts with providers include the requirements identified above and provide sufficient information to confirm the routine monitoring of blood and blood product wastage. This requires a system to monitor compliance of blood and blood product providers with these strategies.

Resources

An update of consensus guidelines for warfarin reversal

Australian Standard 3864.1-2012: *Medical Refrigeration Equipment – For the storage of blood and blood products. Part 1: Manufacturing requirements*

Australian Standard 3864.2-2012: *Medical Refrigeration Equipment – For the storage of blood and blood products. Part 2: User-related requirements for care, maintenance, performance verification and calibration*

BloodSafe eLearning Australia – Transfusion practice courses, including 'Collecting blood specimens' and 'Transporting blood'

National Pathology Accreditation Advisory Council – *Requirements for Transfusion Laboratory Practice*

Therapeutic Goods Administration – Blood and blood components

State or territory health departments have numerous high-quality tools and resources related to blood management:

- NSW Clinical Excellence Commission – Blood Watch
- Queensland Health – Blood management
- SA Health – BloodSafe
- Victorian Department of Health and Human Services – Blood Matters Program
- Victorian Department of Health and Human Services – Serious Transfusion Incident Reporting (STIR) guide
- Western Australian Department of Health – Haemovigilance
- Western Australian Department of Health – Patient blood management

Australian and New Zealand Society of Blood Transfusion

Guidelines for the Administration of Blood Products

Guidelines for Transfusion and Immunohaematology Laboratory Practice

Australian Red Cross Blood Service

Blood components and products website

Blood Component Information: An extension of blood component labels

Haemovigilance and patient safety

Patient website

National Blood Authority Australia

Australian Bleeding Disorders Registry

Australian Health Ministers' Conference Statement on National Stewardship Expectations for the Supply of Blood and Blood Products (the Stewardship Statement)

BloodNet

Criteria for the Clinical Use of Intravenous Immunoglobulin in Australia

Guidelines for the Management of Haemophilia in Australia

Guidelines on the Prophylactic Use of RhD Immunoglobulin (anti-D) in Obstetrics

Haemovigilance reporting

Managing blood product inventory

National Blood Supply Contingency Plan

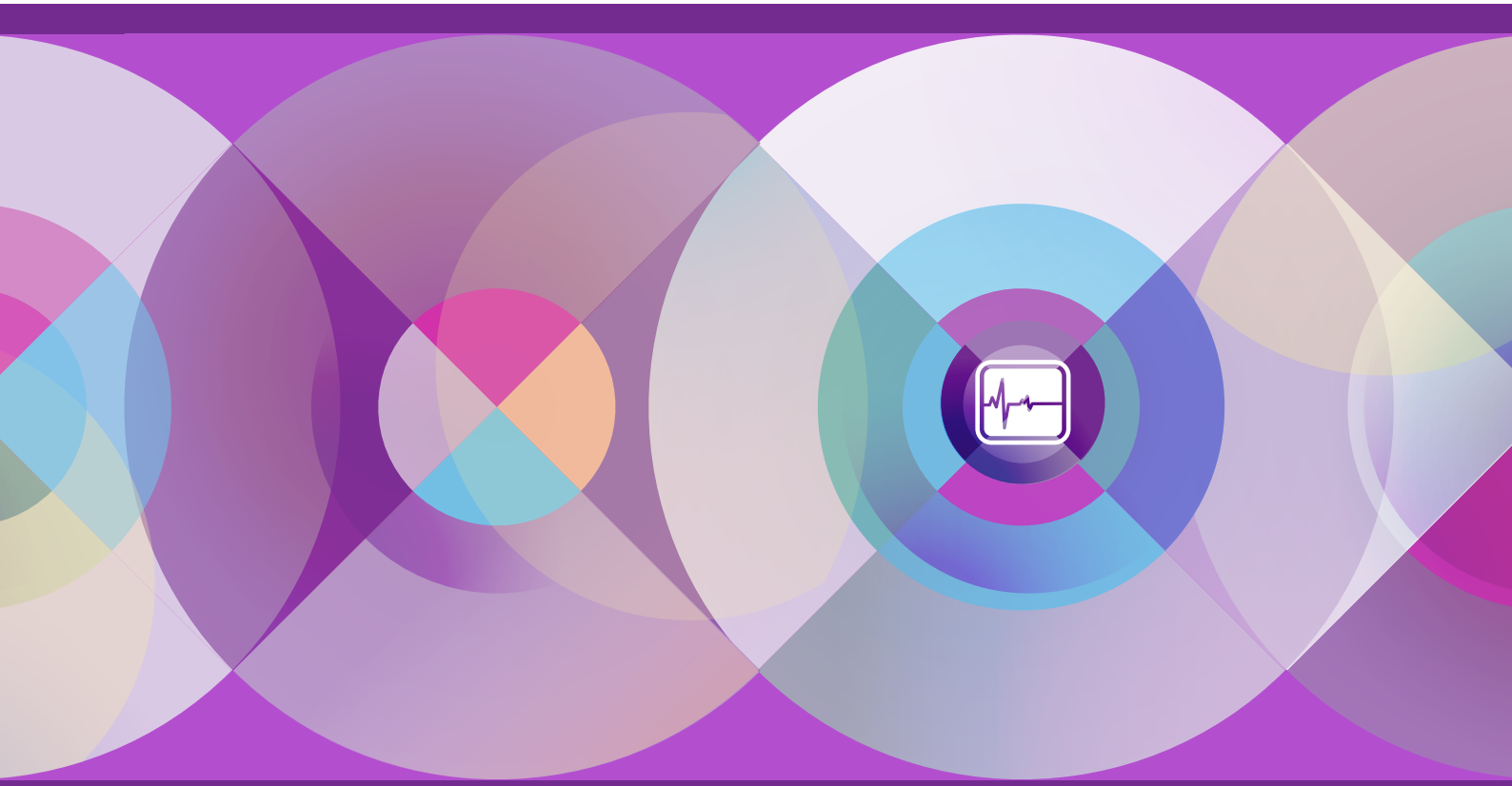
National Patient Blood Management Implementation Strategy

Patient Blood Management Guidelines

What blood products are supplied – National Product List

8

Recognising and Responding to Acute Deterioration Standard



Recognising and Responding to Acute Deterioration Standard

Leaders of a health service organisation set up and maintain systems for recognising and responding to acute deterioration. The workforce uses the recognition and response systems.

Intention of this standard

To ensure that a person's acute deterioration is recognised promptly and appropriate action is taken. Acute deterioration includes physiological changes, as well as acute changes in cognition and mental state.

Criteria

Clinical governance and quality improvement to support recognition and response systems

Detecting and recognising acute deterioration, and escalating care

Responding to acute deterioration

Introduction

Serious adverse events, such as unexpected death and cardiac arrest, are often preceded by observable physiological and clinical abnormalities.[336] Other serious events, such as suicide and aggression, are also often preceded by observed or reported changes in a person's behaviour or mood that can indicate deterioration in their mental state.

Early identification of deterioration may improve outcomes and lessen the intervention required to stabilise patients whose condition deteriorates in a health service organisation.[337]

The warning signs of clinical deterioration are not always identified or acted on appropriately.[338] The organisational and workforce factors that contribute to a failure to recognise and respond to a deteriorating patient are complex and overlapping, and include[339-341]:

- Not monitoring physiological observations consistently, or not understanding changes in physiological observations
- Lack of knowledge of signs and symptoms that could signal deterioration
- Lack of awareness of the potential for a person's mental state to deteriorate
- Lack of awareness of delirium, and the benefits of early recognition and treatment[342]
- Lack of formal systems for responding to deterioration
- Lack of skills to manage patients who are deteriorating
- Failure to communicate clinical concerns, including in handover situations
- Attributing physical or mental symptoms to an existing condition, such as dementia or a mental health condition.[242,343]

Systems to recognise deterioration early and respond to it appropriately need to deal with these factors, and need to apply across the health service organisation. The *National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration*[344] has been endorsed by Australian health ministers as the national approach for recognising and responding to clinical deterioration in acute care facilities in Australia. It provides a consistent national framework to support clinical, organisational and strategic efforts to improve recognition and response systems. This standard builds on the national consensus statement to drive implementation in acute care facilities.

The Australian Commission on Safety and Quality in Health Care (the Commission) has developed the *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state*.[255] This outlines the principles that underpin safe and effective responses to deterioration in a person's mental state, and provides information about the interrelated components that a health service organisation can implement to provide appropriate care.

The Commission's Delirium Clinical Care Standard[226] highlights the importance of being alert to, and assessing, delirium with any reported or observed changes in a person's mental state.

This standard supports the provision of appropriate and timely care to patients whose condition is acutely deteriorating. It requires that systems are in place to detect, recognise and respond to acute deterioration in physiological or mental state. It applies to all patients in the health service organisation: adults, adolescents, children and babies, and medical, surgical, maternity and mental health patients.

CRITERION: Clinical governance and quality improvement to support recognition and response systems

Organisation-wide systems are used to support and promote detection and recognition of acute deterioration, and the response to patients whose condition acutely deteriorates. These systems are consistent with the National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration[344]*, the* National Consensus Statement: Essential elements for safe and high-quality end-of-life care[220]*, the* National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state[255]*, and the Delirium Clinical Care Standard.*[226]

This criterion requires organisation-wide governance, leadership and commitment to support recognition of, and response to, acute deterioration in physiological and/or mental state.

To meet this criterion, health service organisations are required to:

- Apply safety and quality systems to support timely and appropriate recognition of, and response to, acute physiological or mental deterioration
- Use quality improvement systems to monitor, review and improve recognition and response systems
- Apply principles of partnering with consumers when designing and implementing systems to recognise and respond to acute physiological or mental deterioration.

This criterion aligns closely with the Clinical Governance Standard and the Partnering with Consumers Standard.

Integrating clinical governance

Action 8.1

Clinicians use the safety and quality systems from the Clinical Governance Standard when:

a. Implementing policies and procedures for recognising and responding to acute deterioration

b. Managing risks associated with recognising and responding to acute deterioration

c. Identifying training requirements for recognising and responding to acute deterioration

Intent

Safety and quality systems support clinicians in recognising and responding to acute deterioration.

Key tasks

- Establish and implement governance structures for recognising and responding to acute deterioration
- Develop and implement policies and procedures for recognising and responding to acute deterioration
- Use risk management systems to identify, monitor, manage and review risks associated with recognising and responding to acute deterioration
- Develop and provide training to the workforce on recognising and responding to acute deterioration.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' safety and quality systems.

- Action 1.7 – policies and procedures
- Action 1.10 – risk management systems
- Actions 1.19, 1.20 and 1.21 – education and training

Health service organisations should:

- Use these and other established safety and quality systems to support policies and procedures, risk management and training for recognising and responding to acute deterioration
- Ensure that current versions of all relevant policies and procedures are readily available and accessible to clinicians.

Policies may be developed or adapted at different levels within the organisation. However, all policy documents should be incorporated into a single, coherent set to maximise the effectiveness of the policy development process.

Implement policies and procedures

Ensure that policies and procedures provide guidance about aspects of recognising and responding to acute deterioration, such as:

- Screening, assessment and comprehensive care planning processes that are required as part of the Comprehensive Care Standard to identify patients at risk of acute deterioration, and develop appropriate monitoring and escalation plans
- Escalation and emergency assistance processes
- Patient and family escalation processes
- Requirements for communicating and documenting the outcome of rapid response calls
- Roles, responsibilities and accountabilities of multidisciplinary team members in recognising and responding to acute deterioration
- Processes for referral to services required to definitively manage episodes of acute deterioration in physical or mental state.

Manage risks

Use established risk management systems (see Action 1.10) to identify, monitor, manage and review risks associated with recognising and responding to acute deterioration that align with the requirements of the Clinical Governance Standard.

Develop processes to manage clinical risks for different populations served by the organisation, clinical and workplace risks for the workforce, and organisational risks.

Use information from measurement and quality improvement systems, adverse events, clinical outcomes and patient experiences to inform and update risk assessments and the risk management system. Consider the training the workforce may need to effectively use the incident management and investigation system to inform risk management, and to plan and implement quality improvement processes to mitigate the risks.

Assess training and competency needs

Assess the competency and training needs of the workforce in line with the requirements of Actions 1.19, 1.20 and 1.21. Perform a risk assessment to inform the training schedule and to set priorities for the members of the workforce who need training. Develop, or provide access to, training and education resources to meet the needs of the workforce regarding recognising and responding to clinical deterioration.

Action 8.2

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:

a. Monitoring recognition and response systems

b. Implementing strategies to improve recognition and response systems

c. Reporting on effectiveness and outcomes of recognition and response systems

Intent

Quality improvement systems are used to support recognition of, and response to, acute deterioration.

Key tasks

- Review, measure, and assess the effectiveness and performance of, recognition and response systems
- Implement quality improvement strategies for recognition and response systems based on the outcomes of monitoring activities
- Provide information on the outcomes of quality improvement activities to the governing body, the workforce, consumers and other organisations.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' quality improvement systems.

- Action 1.8 – quality improvement systems
- Action 1.9 – reporting
- Action 1.11 – incident management and investigation systems

Health service organisations should use these and other established safety and quality systems to support monitoring, reporting and implementation of quality improvement strategies for recognising and responding to acute deterioration.

Monitor effectiveness and performance

Use the organisation's quality improvement systems to identify and set priorities for the organisational and clinical strategies for recognition and response systems.

Review these systems to ensure that they include processes to monitor the effectiveness of recognition and response systems, such as:

- Intermittent audits of practices such as vital sign documentation
- Data from electronic systems such as missed or delayed escalation
- Ongoing data collection about processes such as rapid response activation, or outcomes such as cardiac arrest rates
- Periodic surveys of workforce attitudes and patient experiences of using the recognition and response systems.

Specifications for quality measures, and other tools for evaluating systems for recognising and responding to acute physiological deterioration are available for download from the Commission's website.

When adverse events occur, investigate them to identify any issues with the performance or use of recognition and response systems. Sentinel events, such as inpatient suicides, should be reviewed to detect if deterioration in a person's mental state was identified, and what steps were taken in response. Other data sources for review include use of restrictive practices, unplanned transfers to mental health units and involuntary treatment rates. Use this information to make improvements.

Implement quality improvement strategies

A Guide to Support Implementation of the National Consensus Statement: Essential elements for recognising and responding to clinical deterioration[183] provides detailed information about how to develop, implement, evaluate and improve systems for recognising and responding to acute physiological deterioration.

Report outcomes

Report evaluation findings to the highest level of governance in the organisation and to the workforce. Use the data to work with consumers, the workforce, clinical leaders and managers to identify and implement improvements to recognition and response systems.

Partnering with consumers

Action 8.3

Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Intent

Clinicians understand the systems for partnering with consumers and use them when recognising and responding to acute deterioration.

Key tasks

- Review strategies in the Partnering with Consumers Standard to inform the implementation of actions in the Recognising and Responding to Acute Deterioration Standard
- Provide information to patients about recognition and response systems tailored to their specific needs and level of health literacy.

Strategies for improvement

The Partnering with Consumers Standard has specific actions (Actions 2.3–2.10) relating to health service organisations' processes for involving patients in their own care, shared decision making, informed consent and effective communication.

Seek consent for non-urgent treatment in line with policies that reflect relevant legislation, as outlined in the guidance for the Partnering with Consumers Standard.

Although clinicians are not legally required to seek consent from substitute decision-makers for urgent treatment, it is recommended that they consult them, if possible, to avoid starting treatment that is contrary to a person's expressed wishes.

If patients have the capacity to take part in the decision-making process when an episode of acute deterioration occurs, ensure that clinicians use the processes for involving patients in their own care, shared decision making, and meeting patients' information needs that are described in the Partnering with Consumers Standard.

If patients do not have the capacity to participate and do not have a documented advance care plan, but a substitute decision-maker is available, ensure that clinicians seek information from the substitute decision-maker about the patient's previously expressed preferences for care. Use this information to decide how to respond.

When patients lack the capacity to take part in decision-making and a substitute decision-maker is not available, clinicians should decide how to respond to acute clinical deterioration using documented information such as current advance care plans, goals of care, treatment-limiting orders, and information from carers and family.

If the treating team is responding to an acute deterioration in a person's mental state, and the person is refusing treatment or is otherwise unable to consent to treatment, decide if the person will be treated as an involuntary patient under mental health legislation. Provide access to legal advice for the workforce to ensure that they practise within this legislation. When a person is an involuntary patient under mental health legislation, members of the workforce should still seek to involve the person in decision-making about their care as much as possible, consistent with maintaining safety.

Provide information to patients about recognition and response systems in a format that is easily understood and meaningful, and ensure that patients are given the opportunity to ask questions. Ensure that the information for patients is current and that clinicians have ready access to it.

CRITERION: Detecting and recognising acute deterioration, and escalating care

> *Acute deterioration is detected and recognised, and action is taken to escalate care.*

Monitoring and tracking changes in vital signs and other observations over time plays a significant role in detecting acute deterioration. Acute deterioration may occur at any time during a patient's admission. If monitoring is intermittent or infrequent, or does not include the right parameters, acute deterioration may not be detected, and recognition and appropriate treatment may be delayed. This can result in serious adverse outcomes for patients.[341,345-347]

Frequency of monitoring often varies[348], perhaps because of differences in individual clinicians' clinical judgement, poor communication among teams, varying views about the importance of monitoring, and a lack of guidelines to inform practice.[349-351] It is therefore necessary to develop systems to ensure that vital signs and other parameters for detecting deterioration in a patient's physical, mental or cognitive condition are being measured. These systems need to ensure that the right parameters are monitored for each patient, and that monitoring occurs at the appropriate frequency (number of times per day) and for the appropriate duration (number of days or weeks). Consistent documentation of measured vital signs and other observed indicators is important for changes to be tracked over time.

Recognising acute deterioration relies on detecting, understanding and interpreting abnormal vital signs and other observations, and escalating care appropriately. This is a complex process that requires knowledge of:

- How to conduct the appropriate observations
- What indicates acute deterioration for individual patients
- Appropriate treatment for the cause of the acute deterioration
- Which clinicians have the skills to provide this treatment
- Who is available to provide this treatment, considering the time of day or day of the week
- How to contact the appropriate clinicians and communicate information about the abnormality
- The appropriate time frame for clinicians to respond
- Alternative or backup options for obtaining a response.

Recognition systems include identifying the requirements for escalating care. These may be documented on vital sign observation charts, in policies and guidelines, and in escalation protocols. Escalation protocols provide details of the criteria, parameters and thresholds that indicate acute deterioration, the action to be taken when deterioration is detected, the process of calling for help and the expected responses.

A graded response to acute deterioration is needed. Patients whose acute deterioration is detected and recognised during the early stages need clinical care and treatments to prevent further deterioration. Patients who deteriorate very suddenly or severely need a rapid response from clinicians with advanced skills.

It is vital to the effectiveness of recognition and response systems that escalation protocols are developed with local knowledge of the individual clinical area or health service organisation. Criteria for escalation that are appropriate for a large tertiary metropolitan hospital will not necessarily be appropriate for a small rural hospital. The availability of resources and clinical expertise also means that response actions vary considerably from one organisation to another. Different protocols may be needed in different locations within a health service organisation, such as in specialist mental health services, the emergency department or standalone outpatient areas. Different protocols may also be needed for escalation of acute physiological deterioration and escalation for deterioration in a person's mental state.

Action 8.4

The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to:

a. Document individualised vital sign monitoring plans

b. Monitor patients as required by their individualised monitoring plan

c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient

Intent

Patients with acute physiological deterioration are identified early.

Key tasks

- Implement a system for documenting vital sign monitoring plans
- Ensure that clinicians have the necessary skills and equipment to monitor patients as required by their individualised monitoring plans
- Implement an observation chart or other mechanism for graphically documenting vital sign observations and tracking changes over time.

Strategies for improvement

Develop monitoring plans

Develop individualised vital sign monitoring plans to manage the clinical risks and needs of each patient. Work with clinicians to design systems for developing and documenting these plans, and to ensure that the systems align with workflow and effectively meet patients' needs. Include capacity to document the frequency (times per day), duration (number of days or weeks) and types of vital signs or other physiological parameters.

Monitoring plans may be included in clinical pathways for specific patient groups who have similar clinical risks and needs, but provide prompts for clinicians to consider whether the monitoring plan meets the needs of each patient, and capacity for them to review and modify the monitoring plan.

Describe the minimum expectations for vital sign monitoring in policy. The *National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration*[344] identifies a core set of six vital signs, and recommends that these should be monitored at least once per eight-hour shift:

- Respiratory rate
- Oxygen saturation
- Heart rate
- Blood pressure
- Level of consciousness
- Temperature.

The frequency of required monitoring may vary between individual patients, and as a patient's clinical situation, clinical risks and goals of care change. Some patients may not need all the core vital sign observations to be monitored at the same frequency (for example, young children may not need blood pressure monitored as often as respiratory rate and oxygen saturation).

Include the core vital signs in monitoring plans for most patients. Specific groups of patients may have extra monitoring requirements (for example, pain and sedation scores, fluid balance, respiratory distress, capillary refill, or pupil size and reactivity). Patients who are at the end of life may not need their core vital signs to be monitored, but will need monitoring of symptoms associated with the dying process, such as pain, agitation, breathlessness and nausea. Paediatric patients may not be able to be monitored for level of consciousness, but accessory muscle use may be a relevant vital sign. Local guidelines may need to be developed for vital sign monitoring in specialist areas such as emergency departments, post-anaesthetic care units,

rehabilitation wards, maternity units and critical care units.

Ensure appropriate skills and equipment

Develop processes to ensure that clinicians are trained to use monitoring equipment correctly, and are competent in measuring and interpreting vital signs accurately. Educate clinicians about the clinical significance of normal and abnormal vital sign observations in the context of acute physiological deterioration. Strategies might include self-directed learning packages, competency-based skills assessment, face-to-face training sessions, simulation and peer review.

Use an audit of vital sign observation charts to evaluate whether vital sign monitoring practices align with policy, and provide feedback to clinicians about their practice. An observation chart audit tool is available on the Commission's website.

Ensure that equipment for measuring and monitoring vital signs and other physiological parameters is readily available and in good working order. Conduct a risk assessment to determine how much equipment is needed. Set up systems for regular checking and maintenance of monitoring equipment. If possible, provide consistent monitoring equipment across the organisation – this reduces the burden of training required and can help to avoid errors introduced by small differences in correct use of equipment. For example, if multiple types of cardiac monitoring equipment are used across an organisation, it can be more difficult for clinicians to use the equipment and troubleshoot, especially in emergency situations.

Document and track vital signs

Regardless of the type of system used to document vital signs, it should include:

- The capacity to display documented vital signs graphically
- The capacity to track changes in vital signs over time
- Thresholds for each vital sign parameter or combination of parameters that indicate abnormality
- Information about the response or action needed when thresholds are reached or physiological deterioration is identified
- The potential to document the normal range for the patient.

Many state and territory health departments, and private hospital groups have developed and implemented track-and-trigger observation charts. Specialist vital sign observation charts have been developed for use in a range of populations, including children of different age groups, obstetric patients and adults. Use these as required by the state, territory or private hospital group.

Electronic systems for tracking vital sign observations may be used, and may improve the detection of deterioration and escalation of care.[352] When implementing these systems, organisations need to:

- Test usability from both the clinical and human factors perspectives
- Develop strategies for mitigating the risk of human errors associated with issues such as workarounds arising from slow data entry processes[353] or alarm fatigue from frequent automatic alerts[354,355]
- Provide training to ensure that electronic systems are used correctly
- Set up processes to evaluate the safety and quality of electronic systems as they are implemented.

Although many electronic systems have automatic triggering of alarms or message prompts when thresholds indicating acute deterioration are reached, human factors testing of paper charts shows that clinicians' ability to detect vital sign trends that indicate deterioration improves when vital signs are presented graphically.[356-358] Set the default display of electronic vital sign monitoring systems so that clinicians can document and review vital sign observations graphically.

If the organisation is planning and implementing electronic systems (for example, electronic vital sign monitoring and escalation systems), ensure that these systems are consistent with the principles underlying paper-based processes and protocols. Also ensure that appropriate clinical and organisational governance experts inform the development of electronic systems for recognising and responding to acute deterioration, and are involved in ongoing monitoring of the safety and quality of these systems.

Action 8.5

The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to:

a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium

b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan

c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported

d. Determine the required level of observation

e. Document and communicate observed or reported changes in mental state

Intent

Adverse outcomes relating to acute deterioration in a person's mental state are prevented through early recognition and effective response.

Key tasks

- Use comprehensive care plans to guide monitoring of people who are at risk of acute deterioration in mental state, incorporating knowledge from the person, and their carers and families about individual early warning signs
- Ensure that members of the workforce are alert to signs of deterioration in a person's mental state, including for people who have not been previously identified as being at high risk
- Ensure that members of the workforce are alert to the signs of delirium
- Ensure that members of the workforce can implement an initial response and keep the person safe until arrangements are made for specialist review.

Strategies for improvement

Be alert for signs of deterioration in a person's mental state

Initial screening should identify people who are at risk of acute deterioration in their mental state, including patients at risk of developing delirium.

If screening identifies risk of deterioration in a person's mental state, conduct a complete mental state examination. Mental health workers complete these routinely. Undertaking a mental state examination also forms part of the curriculum for all members of the clinical workforce.

Comprehensive assessment should differentiate among potential causes for the person's deterioration in mental state.

Delirium can occur at any age and can be prevented. Patients aged 65 years or over, and patients with cognitive impairment (such as dementia), severe medical illness or a hip fracture are considered to be at greatest risk.[226]

People who have not been identified as being at high risk can also experience deterioration in their mental state. Be alert for changes in mental state in all patients.

Use comprehensive care plans to manage patients at risk

If a person has been identified as being at high risk of acute deterioration in their mental state, conduct a comprehensive assessment as outlined in the Comprehensive Care Standard. The comprehensive care plan can incorporate information from a person's advance care plan. When a person is experiencing deterioration in their mental state, they may be able to self-report this to members of the workforce. Similarly, carers or family members may recognise the specific signs that they know indicate the person's mental state is deteriorating. Integrate

this information into the comprehensive care plan, and engage the person – and, with permission, their carers and family – in decision-making.

Ensure that all members of the workforce involved in a person's care are aware of the contents of the comprehensive care plan and are alert to changes that have been identified as individual markers indicating a deterioration in the person's mental state.

For all patients at risk of delirium, this plan should include tailored delirium prevention interventions, regular monitoring and reassessment for delirium with any changes.[226]

Monitor patients at risk

Develop systems to routinely monitor patients at risk of deterioration in mental state, including[233]:

- Prompts for assessment
- Identification of the clinician responsible for assessment, documentation and communication processes
- Actions to be taken, including level of nursing observation
- Regular review and feedback processes.

If delirium is identified as a cause of deterioration in the person's mental state, use indicators from the Delirium Clinical Care Standard for local review and feedback mechanisms.[226,359]

Patients with dementia may experience deteriorating behaviour and mental state (such as agitation, aggression or psychosis) during a stay in a health service organisation. Although these may be viewed as behavioural and psychological symptoms of dementia, a comprehensive assessment is required to rule out possible delirium, pain and other physical problems.[360]

Assess observed or reported changes

With possible delirium, diseases can have atypical presentations in older people, so do not dismiss a family member's non-specific concerns (for example, the person 'is not usually like this') and assess the person for delirium.[347]

Incorporate this information into shared decision making. A tool has been developed to capture and track a person's self-reported mental state daily in inpatient settings.[361] Good outcomes have been reported, and further research will assess the tool's broader applicability.

Engagement with carers and families can help maintain safety for the person experiencing deterioration in their mental state and others, while arrangements for specialist intervention are under way.

Use tools and resources

No tool currently sets out objective criteria for tracking deterioration in a person's mental state equivalent to observation charts for physiological deterioration. Nonetheless, there are parameters that can indicate deterioration in a person's mental state, and these can be used to develop individualised monitoring plans in collaboration with the person, and their carers and families.

These parameters are based on the mental state examination, which is integrated into clinical assessment protocols in most states and territories. Training about mental state examination is available throughout the Mental Health Professional Online Development website.

In addition, a mental health triage tool was developed to augment the Australasian Triage Scale used in emergency departments. It provides a set of structured and defined terms that can be used to assess a person's mental state. The tool also provides the workforce with language to describe and communicate their observations.[246]

The tool uses an ABC mnemonic to align with the airway, breathing, circulation parameters for identifying physiological health status. For mental health, these are described as:

- Appearance
- Behaviour
- Conversation.

Guidelines for using the mental health triage tool are available in the Emergency Triage Education Kit.

The Vanderbilt ICU Delirium and Cognitive Impairment Study Group website[362] includes resources for monitoring and managing delirium in intensive care units as part of a bundle of measures for prevention and safety.

Action 8.6

The health service organisation has protocols that specify criteria for escalating care, including:

a. Agreed vital sign parameters and other indicators of physiological deterioration

b. Agreed indicators of deterioration in mental state

c. Agreed parameters and other indicators for calling emergency assistance

d. Patient pain or distress that is not able to be managed using available treatment

e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration

Intent

The health service organisation has an effective system for escalation of care to minimise risks for patients who are acutely deteriorating.

Key tasks

- Work with clinical groups to agree on parameters that indicate acute deterioration and require escalation of care
- Develop and implement protocols for escalating care when acute deterioration in a patient's condition is detected.

Strategies for improvement

Delays in treatment can occur in the absence of clear criteria for escalating care.[314,363,364] Escalation protocols provide clear, objective criteria that prompt clinicians to call for help, and endorse calling for help when clinicians, patients, family members or carers are subjectively concerned about a patient acutely deteriorating.

Identify parameters for escalation

Use a graded response system within the escalation protocol. This means that the escalation protocol includes at least two levels of response to acute deterioration:

- An emergency response (for example, from a rapid response team) to criteria that indicate severe acute deterioration
- At least one other level of response (for example, from the treating or on-call team) for criteria that indicate less severe deterioration.

The two levels are recommended because early treatment of acute deterioration is better – patients who trigger medical emergency calls have high mortality rates[365,366], and delayed calls to medical emergency teams are associated with poorer outcomes.[337,367]

Work with clinical groups to agree on the criteria that indicate acute deterioration in physiological and mental state. Identify the thresholds to trigger escalation of care before acute deterioration becomes severe, and thresholds to trigger a call for emergency assistance when acute deterioration is severe. Use the escalation mapping tool available from the Commission's website to match the thresholds and parameters that indicate acute physical deterioration to the appropriate response.

Mapping tools can also be used for developing a local escalation protocol for deterioration in a person's mental state. Use the signs described in tools such as the mental health triage tool to set thresholds for escalation in response to observed or reported changes in a person's mental state. Consider local clinical capacity and access to mental health expertise to decide whether the response can be implemented by the treating team, or referral should be made to a clinical psychiatry liaison or other available service. Engage the patient, and their carer and family in shared decision making about escalation of care. Patient pain and distress that are unable to be managed using available treatments may indicate acute deterioration that needs urgent

treatment. Include pain and distress as a criterion for escalation in the protocol.

Patients may show signs of clinical deterioration other than those identified in the escalation protocol, and there is evidence that clinician worry or concern may precede deterioration in vital signs.[368] Include clinician worry or concern as a criterion for escalation in the protocol.

Develop policies and guidance

Develop policies and provide training to guide clinicians in preventing and responding to severe aggressive behaviour and violence. When developing policies and responses to severe behavioural disturbance, provide specific guidance on appropriate responses for older patients, highlighting that:

- Behavioural disturbances are commonly associated with delirium or dementia
- Behavioural disturbances may be related to fear, communication difficulties or an unfamiliar setting (in which case, de-escalation strategies and involvement of family members can be successful)
- Sedation should be avoided, and any use should be in line with age-specific evidence; over-sedation can have serious adverse effects, such as dehydration, falls, respiratory depression, pneumonia and death[241]
- Clinicians should refer to specialist older people's mental health services, if possible.

Refer to the 'Minimising patient harm' criterion in the Comprehensive Care Standard for further detail on preventing delirium and managing cognitive impairment; predicting, preventing and managing self-harm, suicide, aggression and violence; and minimising restrictive practices.

Localise escalation policies that consider the size, role, location and available resources of different services within the organisation. For example, escalation protocols in the emergency department may differ significantly from escalation protocols in the dialysis unit or the mental health unit. Different escalation protocols may be needed for different groups of patients – for example, children may need different escalation protocols from adults.

Escalation protocols can be complex, involving multiple steps and different communication pathways. Develop a flow diagram to summarise escalation processes and provide clinicians with a quick reference tool. Display posters of the escalation flow diagram near telephones in clinical areas, or provide clinicians with identification tag cards for quick reference.

Action 8.7

The health service organisation has processes for patients, carers or families to directly escalate care

Intent

Patients, family members and carers can directly escalate care.

Key task

- Develop and implement a system for patients, carers and families to directly escalate care.

Strategies for improvement

Use the actions about health literacy from the Partnering with Consumers Standard to guide the development of a system for patients, family members and carers to access help when they are concerned that a patient is acutely deteriorating. It is important that the system enables patients, carers and family members to access help independently of the team that is directly providing care for the person of concern.

Work with consumer advisors and clinicians to identify the criteria for escalating care, the mechanism for calling for help, and the response that will be provided. Examples of criteria for escalating care are:

- Concern about a patient who is getting worse, not doing as well as expected or not improving
- Concern that 'something is not right'.[369]

Ensure that the system can be activated easily and independently. Methods for activating the system might include calling an emergency number from internal facility telephones or from a mobile telephone, using an emergency call button, or using a designated phone number that is only for patient, carer and family escalation.

Provide written and verbal information about the system for patient, carer and family escalation on admission, and display details about when and how to use the system in public areas.

Depending on the mechanisms used for patients, carers and families to escalate care, it may be necessary to train non-clinical members of the workforce (such as ward clerks and switchboard operators) to ensure that calls are directed to the appropriate responder(s). Developing scripted questions can help non-clinical members of the workforce triage calls correctly.

Responders may need extra training to manage patient and family escalation calls. For example, skills in communication and conflict resolution may be needed to manage situations where communication between the patient, family or carer, and the team that is providing care has become problematic.

Several Australian states have established patient, carer and family member escalation systems, such as the New South Wales REACH program and Queensland's Ryan's Rule.

Action 8.8

The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance

Intent

The health service organisation has mechanisms for the workforce to escalate care.

Key task

Provide the workforce with mechanisms to escalate care and call for emergency assistance.

Strategies for improvement

Provide mechanisms to escalate care and call for emergency assistance, and ensure that these are consistent and effective. Multiple mechanisms may be necessary in escalation systems to allow different responses to varying levels or types of deterioration. These mechanisms may include:

- Paging systems
- Dedicated mobile, on-call and emergency telephone numbers
- Electronic alerting systems
- Bedside or centralised alarms.

Consider the following issues when deciding on the mechanisms to use:

- Avoid changes in the system at different times of the day and on different days of the week
- Develop processes for responders to hand over shared equipment, such as pagers or mobile phones, between shifts
- Provide backup systems in the event of equipment failure
- Develop processes for maintaining equipment
- Provide training about how to use the mechanisms for escalating care, including for new, casual, locum and agency members of the workforce.

Action 8.9

The workforce uses the recognition and response systems to escalate care

Intent

Members of the workforce take prompt action to deal with acute deterioration.

Key task

- Escalate care when acute deterioration is recognised.

Strategies for improvement

Provide orientation, education and training for the workforce so that they understand their individual roles, responsibilities and accountabilities in the recognition and response systems. Use evaluation data to identify trends and potential training gaps, so that training and education can be effectively targeted.

Topics to cover in education for non-clinical members of the workforce (such as ward clerks, porters, cleaners and food service workers) include how to escalate care if they are concerned about a patient, and how to respond if a patient or family member asks for help.

Topics to cover in education for clinicians include:

- Recognising parameters and thresholds that indicate acute deterioration, including criteria for patient pain and distress, and clinician concern or worry
- Identifying escalation actions when thresholds indicating acute deterioration are reached
- Processes and mechanisms for escalating care
- The role and capacity of responders
- What to do if the expected response is delayed or does not adequately deal with the problem
- Communication skills such as graded assertiveness
- Professional behaviours in successfully operating recognition and response systems.

Effective escalation of care relies on effective communication. A large amount of information may be communicated to many clinicians when acute deterioration occurs. There are risks to patient safety if information is not comprehensive, relevant and clearly understood.[209] Develop standardised and structured communication prompts and tools for clinicians to use when escalating care, in accordance with the requirements of the Communicating for Safety Standard.

Resources to support handover of critical information are available from the Commission's website.

Provide education and training for responders about expected professional behaviours, and effective teamwork and communication skills, to foster positive experiences for members of the workforce who escalate care.

Provide processes for members of the workforce to routinely give feedback about their experiences of escalating care, and use this information to improve escalation protocols.

CRITERION: Responding to acute deterioration

> *Appropriate and timely care is provided to patients whose condition is acutely deteriorating.*

In addition to ensuring that monitoring and escalation systems are in place and working well, response systems must be in place. Response systems ensure that all patients who acutely deteriorate receive a timely and appropriate response. Timeliness should be determined by a risk assessment process that weighs up the clinical risks for patients when acute deterioration occurs and the frequency with which episodes of acute deterioration occur in the organisation. Appropriateness should also be determined by a risk assessment process that weighs up the clinical risks for patients and the capacity of the organisation to respond when acute deterioration occurs. This means that response systems in acute tertiary hospitals will differ significantly from response systems in remote clinics or free-standing day surgeries.

Regardless of setting, most response systems will include at least two levels of response as part of the graded escalation process. When acute deterioration is recognised early, senior nurses or attending doctors (or both) may respond. For more serious deterioration, a rapid response from clinicians with advanced skills in the management of acute deterioration is required. This rapid response might be provided by a medical emergency team with critical care expertise, a single clinician with advanced clinical assessment and resuscitation skills, or an external service such as the ambulance service.

When acute deterioration in a person's mental state occurs, rapid referral to a consultation liaison psychiatry service is required. If consultation liaison is not locally available, the health service organisation needs to work with relevant specialist services to provide this response.

Further resources may be needed to ensure that the chosen response system is effective and that responders are competent in the necessary skills. Consider scope of clinical practice when designing the response system, and the roles and responsibilities of response providers.

As a minimum, the outline of the roles and responsibilities of response providers should identify the person who:

- Is responsible for ensuring that equipment for providing emergency assistance will reach the patient
- Is responsible for directing and coordinating the multiple activities and treatments needed when providing emergency assistance
- Is responsible for communicating the outcome of the call to the healthcare team, the patient, and their carers and family
- Has authority to make transfer decisions and refer to other clinicians, as required
- Is responsible for documenting the care provided
- Is accountable for handing over critical information for ongoing care.

Also identify the roles and responsibilities of the clinicians who escalate care. These may include:

- Remaining with the patient and starting further assessments, emergency interventions and other therapies while awaiting the response provider(s)
- Providing structured handover of information on the patient's clinical condition and reasons for escalating care
- Ensuring that the attending medical officer or team is aware of the patient's acute deterioration and, if they are not already present, attend to assist, if possible.

Include information about the roles and responsibilities of response providers and clinicians who escalate care in education programs and orientation sessions about the recognition and response systems.

Action 8.10

The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration

Intent

Clinicians have the skills and knowledge to deal with deterioration, as appropriate for their role.

Key task

- Develop systems to ensure that clinicians are competent in the skills required to respond to patients whose condition is deteriorating.

Strategies for improvement

This action means different things for people in different roles and settings. It applies to both the workforce providing the initial response while awaiting help, and to the response team who bring extra skills to the patient. Take a risk assessment approach to identify and prioritise training needs.

Clinicians who provide clinical care need skills in providing essential emergency interventions for common causes and symptoms of life-threatening physiological deterioration while awaiting help. These include skills in essential emergency management of conditions such as airway obstruction, hypoxia, respiratory distress or suppression, arrhythmia, hypotension, fluid overload, seizures and sepsis.

Clinicians who provide clinical care need skills in responding to aggressive behaviour when attempts to de-escalate the situation have failed and there is potential harm to the patient or to others.

Clinicians working in specific specialties or settings may need training in extra skills to provide an immediate response while awaiting help. For example, clinicians working in a coronary care unit need cardiac resuscitation skills, while those working in maternity settings need skills in managing obstetric emergencies.

Clinicians who have particular roles also need training in other skills. For example, medical emergency team responders need advanced clinical assessment skills and competence in specialist procedures such as intubation.

Clinicians who respond to acute deterioration also require non-technical skills such as graded assertiveness, negotiating patient goals of care, communicating bad news and team leadership.[353]

Action 8.11

The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support

Intent

Expert input and assistance is available to manage acute physiological deterioration.

Key task

- Provide a system to ensure rapid access to advanced life support for patients who acutely deteriorate.

Strategies for improvement

Ensure that response systems include provision for rapid access to at least one clinician with advanced life support skills at all times. Develop and maintain rosters to enable rapid access to this clinician at all times. In most large health services, this clinician will be accessed through the rapid response system.

Establish clinicians' competence in advanced life support with evidence of relevant qualifications (for example, advanced life support certification compliant with Australian Resuscitation Council guidelines[370] or medical qualifications in specialties such as anaesthesia and critical care). Establish competence in paediatric advanced life support for responders in services that provide care to children.

More clinicians may require training so this level of care can be provided 24 hours a day and when key clinicians are absent.

Clinicians need regular opportunities to practise and maintain their skills so that they retain competence.[371,372] Put systems in place to provide evidence of clinicians' ongoing competence in advanced life support. This may require the organisation to provide access to formal advanced life support training for clinicians. Further benefits can be gained by providing opportunities for members of rapid response teams to train together, and practise using non-technical skills such as leadership, teamwork and communication while managing simulated scenarios of acute deterioration.

Action 8.12

The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated

Intent

Care for patients whose mental state is deteriorating is escalated safely and effectively.

Key tasks

- Develop a protocol for escalating care when a person's mental state is deteriorating, which includes designation of roles and responsibilities for members of the healthcare workforce and time frames for response
- Develop partnerships with other relevant organisations if responding to acute deterioration in a person's mental state is outside the scope of the health service organisation
- Ensure that members of the workforce are aware of, and use, the escalation protocol.

Strategies for improvement

Ensure that there is a clear process for escalating care when deterioration in a person's mental state is recognised, which includes:

- Designation of roles and responsibilities for members of the healthcare workforce
- Time frames for response.

Tailor the escalation protocol to the specific health setting, taking into account:

- The size, location and role of the setting
- The available resources, including the clinical workforce skill mix
- The capacity to engage specialist help.

Large tertiary hospitals typically have consultation liaison psychiatry services available internally. Ensure that all members of the workforce are aware of how to contact the service when they recognise deterioration in a patient's mental state. Many consultation liaison services provide templates for referral that support effective communication and enable reviews to be prioritised across the hospital. Support consultation liaison processes with education for the workforce. Consultations can provide opportunities for further education and upskilling of the workforce.

For organisations that do not have consultation liaison services on site, develop and maintain local partnerships to enable rapid referral. This may involve linking with the local community mental health service, a general practitioner or on-call psychiatrists.

Provide access to essential psychiatric medications at all times.

Provide members of the clinical workforce with access to legal advice relating to delivery of treatment under mental health and other relevant legislation.

Support referral processes with systems to encourage appropriate documentation about the person's mental state at transitions of care, and to reduce the burden of documentation and data collection when possible.

Action 8.13

The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration

Intent

Patients who need other services to resolve the cause of their acute deterioration are rapidly referred to these services.

Key tasks

- Map the causes of acute deterioration against the capacity of the health service organisation to provide for their definitive management
- If the organisation is not able to provide definitive care, develop systems for rapid referral of patients with acute deterioration to other services.

Strategies for improvement

Definitive management means that the patient receives the best possible treatment for decisively resolving the cause of their acute deterioration. Acute deterioration may be the outcome of a disease process, medical intervention or condition that is not able to be effectively managed by the health service organisation where the patient is. This means that systems need to be developed to rapidly refer patients to other services.

Identify common causes of acute deterioration using data from the recognition and response systems. These may include common presentations and causes of acute physiological deterioration, such as[340,373-375]:

- Airway obstruction and respiratory depression associated with issues such as neurological events or opioid overdose
- Altered level of consciousness associated with issues such as neurological events, abnormal blood glucose or delirium
- Respiratory distress associated with issues such as fluid overload, sepsis or exacerbations of existing lung disease
- Arrhythmias
- Hypotension associated with conditions such as
  - sepsis
  - dehydration
  - post-surgical bleeding
  - postpartum maternal haemorrhage
  - cardiac failure
- Medicine side effects, interactions or related complications such as allergies or errors.

Map the common causes of acute deterioration against the capacity of the service to provide definitive management for each of them. For example, psychosis may be a relatively common cause of acute deterioration in mental state in the emergency department, but may be unable to be effectively managed in another service; a system for rapid referral to specialist mental health services would be required. Similarly, presentations of multi-organ failure associated with sepsis may be a relatively common cause of acute physiological deterioration and require a system for rapid referral to a tertiary intensive care service.

Develop processes for rapid referral between services within the health service organisation (for example, mental health services, palliative care, intensive care) and for rapid referral to external acute healthcare services. Include processes for the safe transport of patients in the referral systems. Referral to external services for definitive treatment of acute deterioration may also require referral to emergency transport services.

Resources

Key Commission documents for implementing recognition and response systems

A Better Way to Care: Safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital

Delirium Clinical Care Standard

National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration

A Guide to Support Implementation of the National Consensus Statement

National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state

National Consensus Statement: Essential elements for safe and high-quality end-of-life care

National Consensus Statement: Essential elements for safe and high-quality paediatric end-of-life care

Observation charts

ACT Health – Compass

Australian Commission on Safety and Quality in Health Care – Observation and response charts

NSW Health – Standard observation charts

SA Health – Sample observation charts

Victorian Children's Tool for Observation and Response (ViCTOR)

Acronyms and abbreviations

Term	Definition
ACT	Australian Capital Territory
ADR	adverse drug reaction
AMS	antimicrobial stewardship
BPMH	best possible medication history
CMI	consumer medicine information
Commission	Australian Commission on Safety and Quality in Health Care
MMP	medication management plan
NBA	National Blood Authority
NIMC	national inpatient medication chart
NSQHS Standards	National Safety and Quality Health Service Standards
NSW	New South Wales
PBM	patient blood management
PBS HMC	Pharmaceutical Benefits Scheme hospital medication chart
RBC	red blood cell
SA	South Australia
TGA	Therapeutic Goods Administration
WA	Western Australia

Glossary

If appropriate, glossary definitions from external sources have been adapted to fit the context of the NSQHS Standards.

acute deterioration: physiological, psychological or cognitive changes that may indicate a worsening of the patient's health status; this may occur across hours or days.

advance care plan: a plan that states preferences about health and personal care, and preferred health outcomes. An advance care planning discussion will often result in an advance care plan. Plans should be made on the person's behalf and prepared from the person's perspective to guide decisions about care.[376]

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.[344]

adverse drug event: harm associated with any dose of a medicine.

adverse drug reaction: a response to a medicine that is noxious and unintended, and occurs at doses normally used or tested in humans for the prophylaxis, diagnosis or therapy of disease, or for the modification of physiological function.[377] An allergy is a type of adverse drug reaction.

adverse event: an incident that results, or could have resulted, in harm to a patient or consumer. A near miss is a type of adverse event. *See also* near miss

alert: warning of a potential risk to a patient.

allergy: occurs when a person's immune system reacts to allergens in the environment that are harmless for most people. Typical allergens include some medicines, foods and latex.[378] An allergen may be encountered through inhalation, ingestion, injection or skin contact. A medicine allergy is one type of adverse drug reaction.

antimicrobial: a chemical substance that inhibits or destroys bacteria, viruses or fungi, and can be safely administered to humans and animals.[379]

antimicrobial resistance: failure of an antimicrobial to inhibit a microorganism at the antimicrobial concentrations usually achieved over time with standard dosing regimens.[379]

antimicrobial stewardship: an ongoing effort by a health service organisation to reduce the risks associated with increasing antimicrobial resistance and to extend the effectiveness of antimicrobial treatments. It may incorporate several strategies, including monitoring and review of antimicrobial use.[379]

approved identifiers: items of information accepted for use in identification, including family and given names, date of birth, sex, address, healthcare recordnumber and Individual Healthcare Identifier. Health service organisations and clinicians are responsible for specifying the approved items for identification and procedure matching. Identifiers such as room or bed number should not be used.

aseptic technique: a technique that aims to prevent microorganisms on hands, surfaces and equipment from being introduced to susceptible sites. Unlike sterile techniques, aseptic techniques can be achieved in typical ward and home settings.[380]

assessment: a clinician's evaluation of a disease or condition based on the patient's subjective report of the symptoms and course of the illness or condition, and the clinician's objective findings. These findings include data obtained through laboratory tests, physical examination and medical history; and information reported by carers, family members and other members of the healthcare team. The assessment is an essential element of a comprehensive care plan.[238]

audit (clinical): a systematic review of clinical care against a predetermined set of criteria.[381]

Australian Charter of Healthcare Rights: specifies the key rights of patients when seeking or receiving healthcare services. It was endorsed by health ministers in 2008.[53]

Australian Open Disclosure Framework: endorsed by health ministers in 2013, it provides a framework for health service organisations and clinicians to communicate openly with patients when health care does not go to plan.[11]

best possible medication history: a list of all the medicines a patient is using at presentation. The list includes the name, dose, route and frequency of the medicine, and is documented on a specific form or in a specific place. All prescribed, over-the-counter and complementary medicines should be included. This history is obtained by a trained clinician interviewing the patient (and/or their carer) and is confirmed, where appropriate, by using other sources of medicines information.[382]

best practice: when the diagnosis, treatment or care provided is based on the best available evidence, which is used to achieve the best possible outcomes for patients.

best-practice guidelines: a set of recommended actions that are developed using the best available evidence. They provide clinicians with evidence-informed recommendations that support clinical practice, and guide clinician and patient decisions about appropriate health care in specific clinical practice settings and circumstances.[383]

blood management: a process that improves outcomes for patients by improving their medical and surgical management in ways that boost and conserve their own blood, and ensure that any blood and blood products patients receive are appropriate and safe.

blood products: the products derived from fresh blood – red blood cells and platelets, fresh frozen plasma, cryoprecipitate and cryodepleted plasma, plasma-derived blood products, and recombinant blood products.

business decision-making: decision-making regarding service planning and management for a health service organisation. It covers the purchase of building finishes, equipment and plant; program maintenance; workforce training for safe handling of equipment and plant; and all issues for which business decisions are taken that might affect the safety and wellbeing of patients, visitors and the workforce.

care pathway: a complex intervention that supports mutual decision-making and organisation of care processes for a well-defined group of patients during a well-defined period.[384]

carer: a person who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail or aged. An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are paid, a volunteer for an organisation, or caring as part of a training or education program.[385]

clinical care standards: nationally relevant standards developed by the Australian Commission on Safety and Quality in Health Care, and agreed by health ministers, that identify and define the care people should expect to be offered or receive for specific conditions.

clinical communication: the exchange of information about a person's care that occurs between treating clinicians, patients, carers and families, and other members of a multidisciplinary team. Communication can be through several different channels, including face-to-face meetings, telephone, written notes or other documentation, and electronic means. *See also* effective clinical communication, clinical communication process

clinical communication process: the method of exchanging information about a person's care. It involves several components, and includes the sender (the person who is communicating the information), the receiver (the person receiving the information), the message (the information that is communicated) and the channel of communication. Various channels of communication can be used, including verbal (face to face, over the phone, through Skype), written and electronic.[386] Sending and receipt of the information can occur at the same time, such as verbal communication between two clinicians, or at different times, such as non-verbal communication during which a clinician documents a patient's goals, assessments and comprehensive care plan in the healthcare record, which is later read by another clinician.

clinical governance: an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of safe, effective and high-quality services. Clinical governance systems provide confidence to the community and the healthcare organisation that systems are in place to deliver safe and high-quality health care.

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.[387]

clinical information system: a computerised healthcare record and management system that is used by clinicians in healthcare settings. Clinical information systems are typically organisation-wide, have high levels of security and access, and have roles and rights (for example, prescribing medicines, reviewing laboratory results, administering intravenous fluids) specified for each clinical and administrative user. Clinical information systems enable electronic data entry and data retrieval by clinicians.[388]

clinical leaders: clinicians with management or leadership roles in a health service organisation who can use their position or influence to change behaviour, practice or performance. Examples are directors of clinical services, heads of units and clinical supervisors.

clinician: a healthcare provider, trained as a health professional, including registered and non-registered practitioners. Clinicians may provide care within a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They include nurses, midwives, medical practitioners, allied health practitioners, technicians, scientists and other clinicians who provide health care, and students who provide health care under supervision.

cognitive impairment: deficits in one or more of the areas of memory, communication, attention, thinking and judgement. This can be temporary or permanent. It can affect a person's understanding, their ability to carry out tasks or follow instructions, their recognition of people or objects, how they relate to others and how they interpret the environment. Dementia and delirium are common forms of cognitive impairment seen in hospitalised older patients.[238] Cognitive impairment can also be a result of several other conditions, such as acquired brain injury, a stroke, intellectual disability, licit or illicit drug use, or medicines.

cold chain management: the system of transporting and storing temperature-sensitive medicines and other therapies, such as blood and blood products, within their defined temperature range at all times, from point of origin (manufacture) to point of administration, to ensure that the integrity of the product is maintained.

communicable: an infection that can be transferred from one person or host to another.

comprehensive care: health care that is based on identified goals for the episode of care. These goals are aligned with the patient's expressed preferences and healthcare needs, consider the impact of the patient's health issues on their life and wellbeing, and are clinically appropriate.

comprehensive care plan: a document describing agreed goals of care, and outlining planned medical, nursing and allied health activities for a patient. Comprehensive care plans reflect shared decisions made with patients, carers and families about the tests, interventions, treatments and other activities needed to achieve the goals of care. The content of comprehensive care plans will depend on the setting and the service that is being provided, and may be called different things in different health service organisations. For example, a care or clinical pathway for a specific intervention may be considered a comprehensive care plan.

consumer: a person who has used, or may potentially use, health services, or is a carer for a patient using health services. A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision-making processes.[389]

contemporaneously (documenting information): recording information in the healthcare record as soon as possible after the event that is being documented.[390]

credentialing: the formal process used by a health service organisation to verify the qualifications, experience, professional standing, competencies and other relevant professional attributes of clinicians, so that the organisation can form a view about the clinician's competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments.[391]

critical equipment: items that confer a high risk for infection if they are contaminated with any microorganism, and must be sterile at the time of use. They include any objects that enter sterile tissue or the vascular system, because any microbial contamination could transmit disease.[112]

critical information: information that has a considerable impact on a patient's health, wellbeing or ongoing care (physical or psychological). The availability of critical information may require a clinician to reassess or change a patient's comprehensive care plan.

current medicines list: *See* medicines list

decision support tools: tools that can help clinicians and consumers to draw on available evidence when making clinical decisions. The tools have a number of formats. Some are explicitly designed to enable shared decision making (for example, decision aids). Others provide some of the information needed for some components of the shared decision-making process (for example, risk calculators, evidence summaries), or provide ways of initiating and structuring conversations about health decisions (for example, communication frameworks, question prompt lists).[202] *See also* shared decision making

de-escalation strategies: psychosocial techniques that aim to reduce violent or disruptive behaviour. They are intended to reduce or eliminate the risk of violence during the escalation phase, using verbal and non-verbal communication skills. De-escalation is about establishing rapport to gain the patient's trust, minimising restriction to protect their self-esteem, appearing externally calm and self-aware in the face of aggressive behaviour, and intuitively identifying creative and flexible interventions that will reduce the need for aggression.[256]

definitive management: the treatment plan for a disease or disorder that has been chosen as the best one for the patient after all other choices have been considered.[392]

delirium: an acute disturbance of consciousness, attention, cognition and perception that tends to fluctuate during the day.[393] It is a serious condition that can be prevented in 30–40% of cases, and should be treated promptly and appropriately. Hospitalised older people with existing dementia are at the greatest risk of developing delirium. Delirium can be hyperactive (the person has heightened arousal; or can be restless, agitated and aggressive) or hypoactive (the person is withdrawn, quiet and sleepy).[175]

deterioration in mental state: a negative change in a person's mood or thinking, marked by a change in behaviour, cognitive function, perception or emotional state. Changes can be gradual or acute; they can be observed by members of the workforce, or reported by the person themselves, or their family or carers. Deterioration in a person's mental state can be related to several predisposing or precipitating factors, including mental illness, psychological or existential stress, physiological changes, cognitive impairment (including delirium), intoxication, withdrawal from substances, and responses to social context and environment.

diversity: the varying social, economic and geographic circumstances of consumers who use, or may use, the services of a health service organisation, as well as their cultural backgrounds, religions, beliefs, practices, languages spoken and sexualities (diversity in sexualities is currently referred to as lesbian, gay, bisexual, transgender and intersex, or LGBTI).

effective clinical communication: two-way, coordinated and continuous communication that results in the timely, accurate and appropriate transfer of information. Effective communication is critical to, and supports, the delivery of safe patient care.

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 clinician or team.[344]

end of life: the period when a patient is living with, and impaired by, a fatal condition, even if the trajectory is ambiguous or unknown. This period may be years in the case of patients with chronic or malignant disease, or very brief in the case of patients who suffer acute and unexpected illnesses or events, such as sepsis, stroke or trauma.[394]

environment: the physical surroundings in which health care is delivered, including the building, fixtures, fittings, and services such as air and water supply. Environment can also include other patients, consumers, visitors and the workforce.

episode of care: a phase of treatment. There may be more than one episode of care within the one hospital stay. An episode of care ends when the principal clinical intent changes or when the patient is formally separated from the facility.[395]

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.[344]

fall: an event that results in a person coming to rest inadvertently on the ground or floor, or another lower level.[396]

goals of care: clinical and other goals for a patient's episode of care that are determined in the context of a shared decision-making process.

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

governing body: a board, chief executive officer, organisation owner, partnership or other highest level of governance (individual or group of individuals) that has ultimate responsibility for strategic and operational decisions affecting safety and quality in a health service organisation.

guidelines: clinical practice guidelines are systematically developed statements to assist clinician and consumer decisions about appropriate health care for specific circumstances.[397]

haemovigilance: a set of surveillance procedures covering the entire blood transfusion chain, from the donation and processing of blood and its components, to their provision and transfusion to patients, to their follow-up. It includes monitoring, reporting, investigating and analysing adverse events related to the donation, processing and transfusion of blood, as well as development and implementation of recommendations to prevent the occurrence or recurrence of adverse events.[398]

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

health care: the prevention, treatment and management of illness and injury, and the preservation of mental and physical wellbeing through the services offered by clinicians, such as medical, nursing and allied health professionals.[11]

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.[112]

healthcare record: includes 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.

health literacy: the Australian Commission on Safety and Quality in Health Care separates health literacy into two components – individual health literacy and the health literacy environment.

Individual health literacy is the skills, knowledge, motivation and capacity of a consumer to access, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action.

The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the healthcare system, which affect the ways in which consumers access, understand, appraise and apply health-related information and services.[77]

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

higher risk (patients at higher risk of harm): a patient with multiple factors or a few specific factors that result in their being more vulnerable to harm from health care or the healthcare system. Risk factors may include having chronic clinical conditions; having language barriers; being of Aboriginal or Torres Strait Islander background; having low health literacy; being homeless; or being of diverse gender identities and experiences, bodies, relationships and sexualities (currently referred to as lesbian, gay, bisexual, transgender and intersex, or LGBTI).

high-risk medicines: medicines that have an increased risk of causing significant patient harm or death if they are misused or used in error. High-risk medicines may vary between hospitals and other healthcare settings, depending on the types of medicines used and patients treated. Errors with these medicines are not necessarily more common than with other medicines. Because they have a low margin of safety, the consequences of errors with high-risk medicines can be more devastating.[149,399] At a minimum, the following classes of high-risk medicines should be considered:

- Medicines with a narrow therapeutic index
- Medicines that present a high risk when other system errors occur, such as administration via the wrong route.

hygienic environment: an environment in which practical prevention and control measures are used to reduce the risk of infection from contamination by microbes.

incident (clinical): an event or circumstance that resulted, or could have resulted, in unintended or unnecessary harm to a patient or consumer; or a complaint, loss or damage. An incident may also be a near miss. *See also* near miss

infection: the invasion and reproduction of pathogenic (disease-causing) organisms inside the body. This may cause tissue injury and disease.[115]

informed consent: a process of communication between a patient and clinician about options for treatment, care processes or potential outcomes. This communication results in the patient's authorisation or agreement to undergo a specific intervention or participate in planned care.[400] The communication should ensure that the patient has an understanding of the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.[401]

injury: damage to tissues caused by an agent or circumstance.[402]

invasive medical 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.

involuntary treatment: when people are detained in hospital or compulsorily treated in the community under mental health legislation, for assessment or provision of appropriate treatment or care.[167]

jurisdictional requirements: systematically developed statements from state and territory governments about appropriate healthcare or service delivery for specific circumstances.[397] Jurisdictional requirements encompass a number of types of documents from state and territory governments, including legislation, regulations, guidelines, policies, directives and circulars. Terms used for each document may vary by state and territory.

leadership: having a vision of what can be achieved, and then communicating this to others and evolving strategies for realising the vision. Leaders motivate people, and can negotiate for resources and other support to achieve goals.[403]

local community: the people living in a defined geographic region or from a specific group who receive services from a health service organisation.

mandatory: required by law or mandate in regulation, policy or other directive; compulsory.

medication error: any preventable event that may cause or lead to inappropriate medication use or patient harm, while the medicine is in the control of the clinician, patient or consumer. Such events may be related to professional practice; healthcare products; procedures and systems, including prescribing; order communication; product labelling, packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.[404,405]

medication management: practices used to manage the provision of medicines. Medication management has also been described as a cycle, pathway or system, which is complex and involves a number of different clinicians. The patient is the central focus. The system includes manufacturing, compounding, procuring, dispensing, prescribing, storing, administering, supplying and monitoring the effects of medicines. It also includes decision-making, and rules, guidelines, support tools, policies and procedures that are in place to direct the use of medicines.[123]

medication reconciliation: a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines, and matching the medicines the patient should be prescribed to those they are actually prescribed. Any discrepancies are discussed with the prescriber, and reasons for changes to therapy are documented and communicated when care is transferred. Medication review may form part of the medication reconciliation process.

medication review: a systematic assessment of medication management for an individual patient that aims to optimise the patient's medicines and outcomes of therapy by providing a recommendation or making a change.[406] Medication review may be part of medication reconciliation.

medicine: a chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental wellbeing of people. These include prescription, non-prescription, investigational, clinical trial and complementary medicines, irrespective of how they are administered.[407]

medicine-related problem: any event involving treatment with a medicine that has a negative effect on a patient's health or prevents a positive outcome. Consideration should be given to disease-specific, laboratory test–specific and patient-specific information. Medicine-related problems include issues with medicines such as:

- Underuse
- Overuse
- Use of inappropriate medicines (including therapeutic duplication)
- Adverse drug reactions, including interactions (medicine–medicine, medicine–disease, medicine–nutrient, medicine–laboratory test)
- Noncompliance.[408,409]

medicines list: prepared by a clinician, a medicines list contains, at a minimum:

- All medicines a patient is taking, including over-the-counter, complementary, prescription and non-prescription medicines; for each medicine, the medicine name, form, strength and directions for use must be included[123]
- Any medicines that should not be taken by the patient, including those causing allergies and adverse drug reactions; for each allergy or adverse drug reaction, the medicine name, the reaction type and the date on which the reaction was experienced should be included.

Ideally, a medicines list also includes the intended use (indication) for each medicine.

It is expected that the medicines list is updated and correct at the time of transfer (including clinical handover) or when services cease, and that it is tailored to the audience for whom it is intended (that is, patient or clinician).[410]

mental state: *See* deterioration in mental state

minimum information content: the content of information that must be contained and transferred in a particular type of clinical handover. What is included as part of the minimum information content will depend on the context and reason for the handover or communication.[274]

multidisciplinary team: a team including clinicians from multiple disciplines who work together to deliver comprehensive care that deals with as many of the patient's health and other needs as possible. The team may operate under one organisational umbrella or may be from several organisations brought together as a unique team. As a patient's condition changes, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient.[411] Multidisciplinary care includes interdisciplinary care. (A discipline is a branch of knowledge within the healthcare system.[412])

My Health Record (formerly known as a personally controlled electronic health record): the secure online summary of a consumer's health information, managed by the System Operator of the national My Health Record system (the Australian Digital Health Agency). Clinicians are able to share health clinical documents to a consumer's My Health Record, according to the consumer's access controls. These

may include information on medical history and treatments, diagnoses, medicines and allergies.[413]

national patient identifier: a unique 16-digit number that is used to identify individuals who receive or may receive health care in the Australian healthcare system. Also known as an Individual Healthcare Identifier (IHI).[413]

national provider identifier: a unique 16-digit number that is used to identify individual clinicians or organisations that deliver health care in the Australian healthcare setting. For individuals, it is also known as a Healthcare Provider Identifier – Individual (HPI-I); for organisations, it is also known as a Healthcare Provider Identifier – Organisation (HPI-O).[413]

near miss: an incident or potential incident that was averted and did not cause harm, but had the potential to do so.[414]

open disclosure: an open discussion with a patient and carer about an incident that resulted in harm to the 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.[415]

organisation-wide: intended for use throughout the health service organisation.

orientation: a formal process of informing and training a worker starting in a new position or beginning work for an organisation, which covers the policies, processes and procedures applicable to the organisation.

outcome: the status of an individual, group of people or population that is wholly or partially attributable to an action, agent or circumstance.[402]

partnership: a situation that develops when patients and consumers are treated with dignity and respect, when information is shared with them, and when participation and collaboration in healthcare processes are encouraged and supported to the extent that patients and consumers choose. Partnerships can exist in different ways in a health service organisation, including at the level of individual interactions; at the level of a service, department or program; and at the level of the organisation. They can also exist with consumers and groups in the community. Generally, partnerships at all levels are necessary to ensure that the health service organisation is responsive to patient and consumer input and needs, although the nature of the activities for these different types of partnership will depend on the context of the health service organisation.

patient: a person who is receiving care in a health service organisation.

person-centred care: an approach to the planning, delivery and evaluation of health care that is founded on mutually beneficial partnerships among clinicians and patients.[416] Person-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of person-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care.[43] Also known as patient-centred care or consumer-centred care.

point of care: the time and location of an interaction between a patient and a clinician 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.

pressure injuries: injuries of the skin and/or underlying tissue, usually over a bony prominence, caused by unrelieved pressure, friction or shearing. They 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, which are specific to an organisation.

procedure matching: the processes of correctly matching patients to their intended care.

process: a series of actions or steps taken to achieve a particular objective.[417]

program: an initiative, or series of initiatives, designed to deal with a particular issue, with resources, a time frame, objectives and deliverables allocated to it.

protocol: an established set of rules used to complete tasks or a set of tasks.

purpose-driven communication: communication in which all the parties involved in the communication process have a shared understanding of why the communication is taking place (for example, to

gather, share, receive or check information), what action needs to be taken and who is responsible for taking that action.

quality improvement: the combined efforts of the workforce and others – including consumers, patients and their families, researchers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development.[418] Quality improvement activities may be undertaken in sequence, intermittently or continually.

regularly: occurring at recurring intervals. The specific interval for regular review, evaluation, audit or monitoring needs to be determined for each case. In the NSQHS Standards (2nd ed.), the interval should be consistent with best practice, risk based, and determined by the subject and nature of the activity.

responsibility and accountability for care: accountability includes the obligation to report and be answerable for consequences. Responsibility is the acknowledgement that a person has to take action that is appropriate to a patient's care needs and the health service organisation.[301]

restraint: the restriction of an individual's freedom of movement by physical or mechanical means.[258]

reusable device: a medical device that is designated by its manufacturer as suitable for reprocessing and reuse.[419]

risk: the chance of something happening that will have a negative impact. Risk is measured by the consequences of an event and its likelihood.

risk assessment: assessment, analysis and management of risks. It involves recognising which events may lead to harm in the future, and minimising their likelihood and consequences.[351]

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

safety culture: a commitment to safety that permeates all levels of an organisation, from the clinical workforce to executive management. Features commonly include acknowledgement of the high-risk, error-prone nature of an organisation's activities; a blame-free environment in which individuals are able to report errors or near misses without fear of reprimand or punishment; an expectation of collaboration across all areas and levels of an organisation to seek solutions to vulnerabilities; and a willingness of the organisation to direct resources to deal with safety concerns.[420]

scope of clinical practice: the extent of an individual clinician's approved clinical practice within a particular organisation, based on the clinician's skills, knowledge, performance and professional suitability, and the needs and service capability of the organisation.[391]

screening: a process of identifying patients who are at risk, or already have a disease or injury. Screening requires enough knowledge to make a clinical judgement.[421]

seclusion: the confinement of a patient, at any time of the day or night, alone in a room or area from which free exit is prevented.[258]

self-harm: includes self-poisoning, overdoses and minor injury, as well as potentially dangerous and life-threatening forms of injury. Self-harm is a behaviour and not an illness. People self-harm to cope with distress or to communicate that they are distressed.[422]

semi-critical equipment: items that come into contact with mucous membranes or non-intact skin, and should be single use or sterilised after each use. If this is not possible, high-level disinfection is the minimum level of reprocessing that is acceptable.[112]

service context: the particular context in which care is delivered. Health service delivery occurs in many different ways, and the service context will depend on the organisation's function, size and organisation of care regarding service delivery mode, location and workforce.[209]

shared decision making: a consultation process in which a clinician and a patient jointly participate in making a health decision, having discussed the options, and their benefits and harms, and having considered the patient's values, preferences and circumstances.[202]

standard: agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.[402]

standard national terminologies: a structured vocabulary used in clinical practice to accurately describe the care and treatment of patients. Healthcare providers around the world use specialised vocabulary to describe diseases, operations, clinical procedures, findings, treatments and medicines. In Australia, terminologies include SNOMED CT-AU and Australian Medicines Terminology.[18] Standard national terminologies are also referred to as clinical terminologies.

standard precautions: work practices that provide a first-line approach to infection prevention and control, and are used for the care and treatment of all patients.[419]

structured clinical handover: a structured format used to deliver information (the minimum information content), enabling all participants to know the purpose of the handover, and the information that they are required to know and communicate.[381]

substitute decision-maker: a person appointed or identified by law to make health, medical, residential and other personal (but not financial or legal) decisions on behalf of a patient whose decision-making capacity is impaired. A substitute decision-maker may be appointed by the patient, appointed for (on behalf of) the person, or identified as the default decision-maker by legislation, which varies across states and territories.[238]

surveillance: an epidemiological practice that involves monitoring the spread of disease to establish progression patterns. The main roles of surveillance are to predict and observe spread; to provide a measure for strategies that may minimise the harm caused by outbreak, epidemic and pandemic situations; and to increase knowledge of the factors that might contribute to such circumstances.[115]

system: the resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish a stated goal. A system:

- Brings together risk management, governance, and operational processes and procedures, including education, training and orientation
- Deploys an active implementation plan; feedback mechanisms include agreed protocols and guidelines, decision support tools and other resource materials
- Uses several incentives and sanctions to influence behaviour and encourage compliance with policy, protocol, regulation and procedures.

The workforce is both a resource in the system and involved in all elements of systems development, implementation, monitoring, improvement and evaluation.

timely (communication): communication of information within a reasonable time frame. This will depend on how important or time critical the information is to a patient's ongoing care or wellbeing, the context in which the service is provided and the clinical acuity of the patient.

traceability: the ability to trace the history, application or location of reusable medical devices. Some professional groups may refer to traceability as tracking.[419]

training: the development of knowledge and skills.

transfusion history: a list of transfusions a patient has had before presentation, including details of any adverse reactions to the transfusion and any special transfusion requirements. The completeness of the history will depend on the availability of information. It is expected that information will be obtained by reviewing any available referral information and interviewing the patient or their carer.

transitions of care: situations when all or part of a patient's care is transferred between healthcare locations, providers, or levels of care within the same location, as the patient's conditions and care needs change.[423]

transmission-based precautions: extra work practices used in situations when standard precautions alone may not be enough to prevent transmission of infection. Transmission-based precautions are used in conjunction with standard precautions.[112]

workforce: all people working in a health service organisation, including clinicians and any other employed or contracted, locum, agency, student, volunteer or peer workers. The workforce can be members of the health service organisation or medical company representatives providing technical support who have assigned roles and responsibilities for care of, administration of, support of, or involvement with patients in the health service organisation. *See also* clinician

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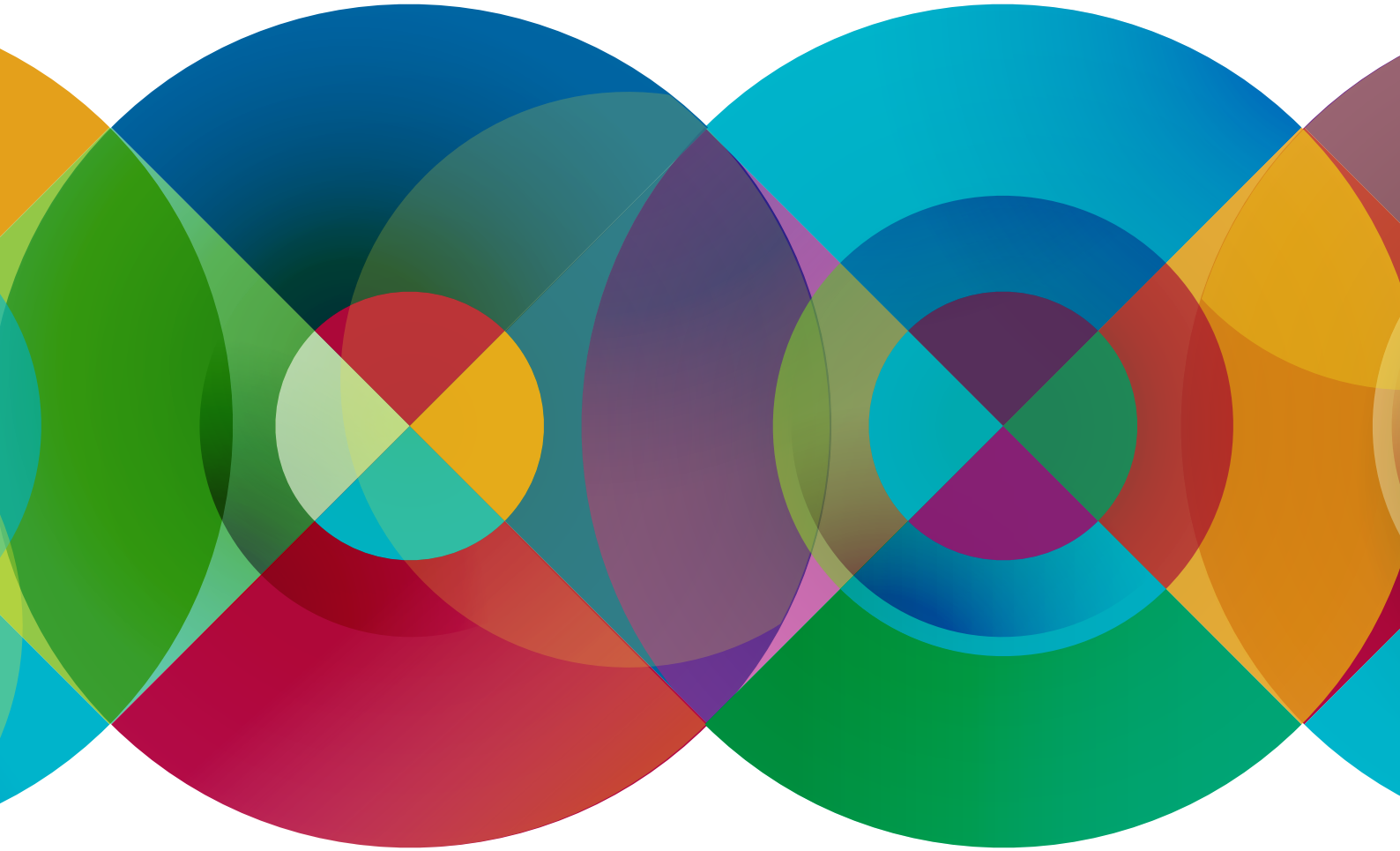

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