National Safety and Quality
Health Service Standards

User Guide for Acute and Community Health Service Organisations that Provide Care for Children

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Disclaimer

Contents

Introduction

All National Safety and Quality Health Service (NSQHS) Standards (second edition) apply to health service organisations that provide care for children.

This user guide identifies strategies that health service organisations that provide care for children may use to help implement actions from the second edition of the NSQHS Standards.

In this user guide, the term 'children' refers to neonates, children, adolescents and young people, unless otherwise stated.

Children are defined in many Australian Government, state and territory legislative and regulatory instruments. These definitions vary widely. When a health service organisation applies legislative or regulatory requirements, the definition used in the relevant instruments must be applied.

Children who receive health care usually do so with the involvement of their family. The term 'family' should be interpreted broadly to include those who are closest to the patient in knowledge, care and affection. It includes parents, siblings, grandparents, aunts, uncles, cousins, friends, kin and carers. It also includes guardianship arrangements and extended familial relationships. For children under the care of a state or territory, arrangements should be put in place to ensure that they are suitably supported.

In Australia, the types of health service organisations that provide care for children vary widely. Health services may be provided by acute services (such as hospitals) and community services that are dedicated to children. Alternatively, they may be provided by acute and community services that provide care to all age groups, including children and adults. A large proportion of health services for children are also provided in general practices and primary care settings. This guide has been developed to support acute and community health service organisations that provide care for children.

The physical, mental, emotional, developmental and intellectual needs of children are very different from those of adults, and these needs change with time. Because of this, children are among the most vulnerable groups in the healthcare setting. Health service organisations that provide care for children should consider the different risks of harm faced by children compared with adults. This can be done by providing access to quality health care that is in line with children's evolving capabilities, maturity and independence.[1]

To support health service organisations to provide safe and high-quality care for children, the Australian Commission on Safety and Quality in Health Care (the Commission) has collaborated with Children's Healthcare Australasia to develop the *National Safety and Quality Health Service Standards User Guide for Acute and Community Health Service Organisations that Provide Care for Children*. As the peak body for hospitals and health service organisations providing health care for children and young people in Australia and New Zealand, the Board of Children's Healthcare Australasia has endorsed this user guide.

This user guide identifies areas in which special consideration is required by health service organisations providing care for children. This information is linked to criteria in the NSQHS Standards (2nd ed.). The user guide provides suggestions on how health service organisations may approach implementation of the NSQHS Standards (2nd ed.) when planning, implementing and evaluating services for children.

National Safety and Quality Health Service Standards

The NSQHS Standards were developed by 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 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.

How to use this user guide

All of the NSQHS Standards apply to all health service organisations, including those that provide care for children. However, there are some specific approaches that health services that provide care for children may use when implementing the NSQHS Standards. These suggested approaches are described in this user guide.

The suggested approaches in this user guide are grouped by the relevant NSQHS Standard, followed by criteria, and then item (which describes groups of actions, as per the NSQHS Standards).

The Commission has developed service-specific guides to assist health service organisations to align their patient safety and quality improvement programs using the framework of the NSQHS Standards. Guides include the Guide for Hospitals, the Guide for Day Procedure Services, and the Guide for Multi-Purpose Services and Small Hospitals.

The suggested approaches in this user guide are not mandatory. User guides such as this provide supplementary information for health service organisations on specific topics that can be used alongside service-specific guidance.

Organisations can choose improvement strategies that apply in their local context. These strategies should be meaningful, useful and relevant to the organisation's governance, structure, workforce and consumers.

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

The four criteria that make up this standard are:
- Governance, leadership and culture
- Patient safety and quality systems
- Clinical performance and effectiveness
- Safe environment for the delivery of care.

All of these criteria have suggested approaches to implement the Clinical Governance Standard that are specific to health service organisations that provide care for children. The suggested approaches are grouped under these criteria and described in this chapter.

The Clinical Governance Standard, along with the Partnering with Consumers Standard, make up the requirements for a comprehensive clinical governance framework.

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[2] and *National Safety and Quality Health Service Standards Guide for Governing Bodies*.[3]

Why does this standard need special consideration by health service organisations that provide care for children?

If a health service organisation is to be child safe, child friendly and child aware, it should consider the broader healthcare setting and its own suitability to provide care for children.[4,5] To do this, health service organisations need to monitor and review the care provided to children to ensure thorough and effective clinical governance. Further, the workforce requires specific knowledge, skills and expertise in areas of child health and wellbeing, growth and development, parenting support, and working in partnership with children and their families.[6]

Effective governance in health service organisations that provide care for children ensures that:

- The rights of children are promoted and protected using the Charter on the Rights of Children and Young People in Healthcare Services in Australia[7]
- Children and their families are given opportunities to provide feedback on their experience of care to improve the quality of healthcare services
- The workforce has the relevant skills, knowledge, experience and access to clinical guidelines to provide safe child- and family-focused health care
- The workforce has access to, and complies with, relevant paediatric clinical guidelines
- The setting is suited to and safe for children
- Environments in which children receive care are safe, and meet their physical, mental and psychosocial needs.

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.[8]

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 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.[2]

Suggested approaches

Governance, leadership and culture

The workforce is required to clearly understand, and be equipped for, their roles and responsibilities in caring for children. This could be achieved by outlining roles and responsibilities in position descriptions, duty statements or employment contracts for clinicians responsible for providing care for children.

Health service organisations delivering health services to children should embed strategies that support a child-safe culture and organisation through leadership on:

- Creating a child safety policy or statement of commitment to child safety
- Creating a code of conduct that establishes clear expectations for appropriate behaviour with children
- Using screening, supervision, training and other human resource practices that reduce the risk of child mismanagement or abuse from the workforce[9]
- Developing a culturally safe workplace
- Building a workforce that is supported to fulfil their roles and responsibilities.

There are large disparities in health outcomes between Aboriginal and Torres Strait Islander children and other Australian children, including life expectancy, birth weight, child hospitalisation, youth trauma and rates of chronic disease.[10] Health service organisations need to ensure that they meet the needs of all Aboriginal and Torres Strait Islander children and their families. To do this, high-quality, evidence-based child and family health services delivered to Aboriginal and Torres Strait Islander people must be informed by a holistic approach that recognises the diversity and strengths of Aboriginal and Torres Strait Islander people and culture.[11]

Health service organisations should refer to the National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families when developing policy, designing programs and implementing services to meet the needs of Aboriginal and Torres Strait Islander children and families. The framework articulates a vision and principles for the delivery of child and family health services to Aboriginal and Torres Strait Islander children and families across Australia.[11]

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.

Suggested approaches

Policies and procedures

Policies, procedures and protocols should include processes for identifying children at risk of harm from health care. Specific consideration should be given to address the risks associated with children's privacy and safety, including:

- Minimising non-essential exposure of children to people not authorised to provide their care – for example, ensuring that the unit is secure and that there are processes to approve all visitors
- Implementing physical screening to promote privacy when possible – for example, screening of bench spaces used for nappy changes
- Promoting safe sleeping practices to prevent adverse events, such as
  - the use of cots and beds that are appropriate to the child's size
  - ensuring that there are no ligature or entrapment points on beds and cots
  - educating parents about safe practices
  - implementing strategies to prevent sudden unexpected death in infancy
- Developing organisational policies about co-sleeping arrangements based on the best available evidence and guidelines
- Detailing requirements for mandatory reporting
- Promoting children's rights to use electronic devices, but balancing this with the risks these devices pose to privacy and safety.

All members of the workforce, including any non-clinical members, who provide care or services to children should comply with relevant state or territory 'working with children check' schemes. A health service organisation may ensure this by:

- Reviewing workforce participation in required child protection training, and renewing checks against state and territory requirements
- Ensuring that every relevant member of the workforce undertakes a working with children check, criminal record check or police background check on recruitment and on an ongoing basis, as per state or territory requirements
- Reviewing workforce members' disciplinary, complaints and conditions history.

Organisations should consider introducing activities that develop the resilience and capacities of children outside the care setting. This may include education, play, mental stimulation and physical activity.

Measurement and quality improvement

Recording and analysising data to adequately recognise issues affecting children, and then responding appropriately, are important for health service organisations that provide care for children. Information about adverse events and safety investigations should be analysed for each age-specific grouping, developmental stage and service context.

To optimise the collection and analysis of data relating to children, health service organisations may consider:

- Ensuring that data are collected on the age, and physical and emotional developmental stage of each child
- Ensuring that personnel assessing adverse event information are knowledgeable and skilled in the care of specific age and developmental groupings
- Ensuring analysis of adverse events data about whether the physical setting was appropriate, given the child's size and developmental stage.

Incident management systems and open disclosure

When an adverse event involves a child, the clinical team, together with the family, will need to make an informed assessment of what the child should be told about the event. In the case of young people who may have legal competency, the team will need to weigh up the young person's maturity in the decision-making process.

The clinical team should assess the involvement of young people in the open disclosure process on a case-by-case basis, taking account of whether the child is mature enough to receive the information, and considering the wishes of the young person and the family, if appropriate.[12]

Feedback and complaints management

Feedback on the experiences of the child and family is an essential part of the quality improvement system. However, for children, opinions and views about experiences of health care are often sought from families rather than the child.[13,14] While there are some circumstances in which proxy feedback is necessary, such as for very young children, health service organisations should consider how children can express their views in ways that are appropriate to their developmental stage and age.[14] This may include:

- Reviewing consumer feedback systems and removing barriers that prevent children from providing feedback
- Using child-specific tools and technology such as animations, pictures and visual scales for the collection of feedback from children
- Engaging children and their families in focus groups to design surveys suitable for children
- Seeking out children's opinions and preferences about providing feedback.

Clinical performance and effectiveness

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

Suggested approaches

Credentialing and scope of clinical practice

Credentialing and defining the scope of clinical practice are essential processes to ensure that the workforce has the relevant knowledge, skills, experience and expertise to deliver safe, high-quality care. Processes for credentialing and defining the scope of clinical practice should specifically look at and document clinicians authorised to care for children.[15] To do this, review panels should include clinicians with relevant paediatric skills and experience.

Evidence-based care

The health service organisation should ensure that clinicians have ready access, either electronically or in hard copy, to clinical guidelines that meet the needs of children. Health service organisations should assess the effectiveness of clinical guidelines and support clinicians to use the best available evidence to provide safe, high-quality care.[16]

CRITERION: Safe environment for the delivery of care

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

Suggested approaches

Safe environment

Projects to design or redevelop care environments should take into account relevant feedback, and the physical, mental and psychosocial needs of children and their families. Health service organisations should consider:

- Accommodating children separately from adults to meet their unique needs and minimise the risks of harm
- Providing access to facilities for approved family members to accompany a child, including rooming-in
- Ensuring that spaces for children and their families are culturally safe and appropriate
- Providing age-appropriate environments that incorporate bright colours and soft edges
- Providing dedicated communal play areas with play equipment that is age and developmentally appropriate, and in good working order
- Using equipment that meets relevant national or international safety standards and is designed to meet children's needs, including size and developmental age (for example, the height and placement of cots, toilets, sinks and hand sanitiser)[4]
- Implementing service-specific policies on the requirements for visiting children for employees, visitors and volunteers to minimise children's exposure to risks

- Eliminating ligature, strangulation or entrapment risks for smaller bodies and limbs
- Minimising restrictions on movement of children, especially for children with developmental delay or mental illness
- Designing spaces to prevent adverse events relating to self-harming actions – for example, by installing safety glass
- Minimising exposure to potentially distressing sights or sounds
- Considering lighting requirements, including ensuring good lighting in areas where medications are dispensed and adjustable lighting to take into account children's sleeping and resting needs.

Children can experience fear when exposed to new surroundings. To mitigate this risk, health service organisations may provide children with separate spaces that make use of the approaches outlined above. These spaces may be included in areas such as emergency departments, medical imaging departments and operating theatres.

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 valuable 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

The four criteria that make up this standard and require consideration by all health service organisations are:

- 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.

The following criteria have suggested approaches to implement the Partnering with Consumers Standard that are specific to health service organisations that provide care for children:

- Partnering with patients in their own care
- Health literacy
- Partnering with consumers in organisational design and governance.

The suggested approaches are grouped under these criteria and described in this chapter.

The Partnering with Consumers Standard, along with the Clinical Governance Standard, make up the requirements for a comprehensive clinical governance framework.

Why does this standard need special consideration by health service organisations that provide care for children?

Partnering with children and their families may require different approaches to partnering solely with adults because:

- Children are more dependent than adults
- Children have more possible developmental states
- There is greater variability in children's capacity to be involved in partnerships.

The delivery of care across the age and developmental spectrum for children has many implications for health service delivery, development of health literacy, child–family interaction, and the systems used for gathering and acting on feedback. Children and their families have a vital role to play, not only in making (or assisting the child to make) decisions about the health care needed for the child, but also in providing ongoing care to the child during and following their stay in hospital.

Engaging children and their families in the child's care can present challenges to the workforce because of the child's:

- Level of maturity and capacity to understand
- Previous experiences of health care
- Personality and behavioural characteristics
- Cultural background
- Primary language (and that of their family)
- Illness, injury or condition
- Needs and wants versus those of their family.

In addition, all states and territories have different legislative provisions on informed consent based on age, which inform local policy.

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.

Suggested approaches

Healthcare rights and informed consent

The Charter on the Rights of Children and Young People in Healthcare Services in Australia (the Charter) was developed to specifically cover the rights of children when receiving health care.[7] The Charter outlines 11 rights aimed at ensuring that the care provided to children is appropriate and acceptable. Three key principles underpin the Charter:

- The primary consideration should be the child's best interests
- All children are to be listened to and taken seriously
- The family is recognised as the fundamental decision-making unit in a child's life.[7]

To improve the care provided to children, health service organisations may consider adopting the Charter. This would include:

- Allocating responsibility for implementation of the Charter to a senior individual or committee
- Building the requirements of the Charter into the organisation's safety and quality systems, and processes of care for children
- Displaying the Charter in areas within the organisation frequented by children, such as paediatric units or play areas
- Providing accessible copies of the Charter in formats that meet community needs, especially for those with limited capacity to read and comprehend complex written text
- Providing education about the Charter to new members of the workforce responsible for providing care for children
- Using the Charter as the basis for discussions between clinicians and children about care planning and treatment

- Using play-based techniques when appropriate
- Adding specific questions relating to the Charter to consumer experience surveys.

Children may not have the legal or developmental capability to consent. Therefore, policies for consent could consider:

- Criteria for determining whether a child is competent and can provide consent, and the family's role in providing consent
- The circumstances in which it is the right of a mature child to refuse treatment
- The roles and responsibilities of clinicians when obtaining consent from children
- The processes to follow and language to use when obtaining consent
- Legislative requirements and the legal constraints on children providing consent at different ages, and how they vary across states and territories
- Requirements for documenting consent obtained from a child
- The family's role in providing consent
- Engagement and participation of families, legal guardians, consumer advocates and other support group representatives in developing the health service organisation's systems and processes for obtaining consent
- Issues arising when the parents of a child are separated, or there are court orders in place
- Issues when there is a dispute between the parents or family and the child about treatment
- The role of informed assent from children
- The inclusion of children in health-related research.

Clinicians should understand their roles and responsibilities for obtaining informed consent from children, and have the education and training required to perform their role. These roles and responsibilities include:

- Understanding the legal and ethical obligations concerning clinical decision-making and obtaining consent
- Using age-appropriate strategies for engaging with children, and providing information about the benefits and risks of care

- Meeting obligations for confidentiality of clinical decisions in ways that take into account legal, moral, religious and ethical issues.

Sharing decisions and planning care

When care is to be provided to children, it is usually the family that gives consent. However, to reduce the risk of aggression and fright, the child must assent (agree) to the care. This requires the child to understand the condition and its treatment at a level appropriate to their maturity. Obtaining assent requires careful communication, and may include[17]:

- Supporting the child to understand their condition in a way that is appropriate to their developmental age
- Talking with the child and explaining what can be expected during their care
- Using clinical judgement and experience to assess the child's understanding of their condition and the care they can expect to receive, and how they respond to this information
- Seeking agreement from the child to the care that is planned
- Giving serious consideration to the child's view
- Informing the child whenever care is to be delivered without assent, or against the child's preferences.

As children become adolescents, they should be allowed to take greater responsibility for determining their health care so that they move towards becoming the primary decision-maker.

As with informed consent, obtaining assent should be an iterative and interactive process in which information, goals and preferences are shared, and joint decisions are made.[17]

CRITERION: Health literacy

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

Suggested approaches

Communication that supports effective partnerships

To support shared decision making that includes children and their families, policies, procedures and protocols for communicating and engaging with children and their families should be based on principles that:

- Are appropriate to the child's age and developmental stage
- Build trust between the child and their family and clinicians
- Promote active listening and discussion about care preferences
- Provide timely information about treatment options, risks and the expected outcomes
- Include support from interpreters and other appropriate language services
- Enable, support and accept decision-making by the child and their family
- Include systems and processes to gain consent to share information with schools and other service providers to meet the child's ongoing care needs
- Use interpreter services when necessary, and ensure that children themselves are not used as interpreters.

Children and their families should receive information about their health care that takes into account their level of health literacy. This information may relate to:

- Details about the benefits, risks and complications of different treatment options, including the administration and effects of different medicines and treatments
- Explanations of procedures or tests
- Infection prevention and control measures, such as the use of gowns or masks, hand sanitiser and handwashing techniques
- Education, advice and instructions for children and their families and any third-party providers about self-care and the management of risk factors
- Information on the long-term effects of treatment and medicines.

Health service organisations could use, identify or develop age-appropriate tools and resources to use when communicating with children and their families about the child's health care. Examples include:

- Providing information on what to expect before admission
- Using play-based approaches, perhaps including dolls and teddies, when providing information to children
- Breaking down information into smaller elements and sharing those elements over time
- Playing instructional or demonstrative videos and using apps to explain planned treatments or procedures that might take place in hospital
- Using play therapy, music therapy and diversionary techniques to support children during procedures
- Using distraction rooms or professionals trained in distraction techniques
- Providing a picture dictionary of medical terms with simple definitions of diseases, instruments and medicines.

CRITERION: Partnering with consumers in organisational design and governance

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

Suggested approaches

Partnerships in healthcare governance planning, design, measurement and evaluation

Consumer partnerships should aim to be representative of the community served by the health service organisation, especially those consumers who may be vulnerable or difficult to engage, such as children. It is important that there is appropriate engagement and consultation with children and their families on systems and processes that affect them and the care they receive.

Health service organisations may consider having a governance structure that:

- Effectively engages children and their families
- Has representation from children and their families to assist with the development, quality improvement and review of health services provided to children across the health service – for example, in emergency departments, mental health units and imaging units
- Includes mechanisms to maximise engagement with children, including one-off events, feedback through social media, and ongoing participation on boards and committees
- Includes the views of children and their families when planning new facilities or redesigning existing ones
- Reviews membership and terms of reference of committees and governing bodies to ensure that children and young people are represented
- Identifies local community or advocacy groups representing children, and engages them in discussions about consumer engagement strategies

- Consults with children and families to get feedback informally through discussions in waiting areas, at the bedside during clinical handover or as part of discharge procedures
- Creates a 'critical friends' group for paediatric-specific units or wards made up of past paediatric service users and their families.

Health service organisations could consider incorporating the views of children into training and education programs by:

- Inviting consumers with experience of caring for children or their families to speak to the workforce
- Displaying messages or artwork about a child's experience of care in training and education materials
- Sharing with the workforce the results of child consumer feedback surveys, focus group sessions and interviews
- With appropriate consent, filming children talking about what is important to them in health care, and using these videos to educate the workforce.

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

The four criteria that make up this standard and should be considered by all health service organisations are:

- 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.

The following criteria have suggested approaches to implement the Preventing and Controlling Healthcare-Associated Infection Standard that are specific to health service organisations that provide care for children:

- Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship
- Infection prevention and control systems
- Antimicrobial stewardship.

The suggested approaches are grouped under these criteria and described in this chapter.

Why does this standard need special consideration by health service organisations that provide care for children?

When caring for children, health service organisations require evidence-based infection prevention and control processes. These are largely set out in the Preventing and Controlling Healthcare-Associated Infection Standard. Some risks that relate to children require specific precautions because of:

- Children's immature immune systems and the different ways that infections affect children[18,19]
- Children having lower reserves and greater susceptibility than adults if they get an infection
- Children spreading infectious material by the nature of their play, or because they are too young to perform their own hand or respiratory hygiene.[20]

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.

Suggested approaches

Surveillance

Health service organisations are better able to design improvement strategies if they know which groups of consumers are affected by which infections, and how badly. By ensuring that data about healthcare-associated infections are collected with enough detail to enable analysis by relevant demographic characteristics, better systems can be put in place more quickly.

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.

Suggested approaches

Standard and transmission-based precautions

Common healthcare-associated infections that affect children include respiratory tract infections, gastrointestinal infections, intravascular catheter-related bloodstream infections and urinary tract infections.[18] Strategies to prevent these infections should be based on the same principles of prevention as in the adult population; however, there are some that require additional consideration for children.

The methods for collecting specimen samples in children may be different from those used in adults. Therefore, the development of policies on specimen collection from children may be required – for example:

- Ensuring that the clinician is competent in collecting specimens from children
- Balancing the reduction in the risk of transmission of infectious diseases by performing the collection procedure in the child's bed area with the need to keep the bed area a safe, secure space that is free from medical procedures.

Strict adherence to standards and transmission-based precautions is key to reducing the risk of transmitting respiratory infections. This includes the use of:

- Personal protective equipment
- Procedures for commencing and discontinuing isolation
- Outbreak management strategies that consider the use and cleaning of bathrooms, play areas and common areas, as well as contact with families, siblings and other visitors.

Consideration should also be given to the compromised barrier and immune function of the skin of premature babies, including the increased risk of damage. This is because damaged skin can act as a portal for infection to enter the bloodstream.[19] The use of topical skin antiseptics, including isopropyl alcohol, povidone-iodine and chlorhexidine, requires special consideration by health service organisations that provide care for children. Complications from misuse or over-use of skin antiseptics on children, especially premature babies, include chemical burns, local irritation, contact dermatitis and systemic absorption.[21,22] In extreme cases, absorption of antiseptic agents can lead to thyroid or central nervous system disturbance.[22,21] Health service organisations should consider the latest evidence on use of antiseptics on children when developing policies guiding their use in the clinical context.

The management of respiratory infections also requires special consideration by services that provide care for children, because some children, such as those with cystic fibrosis, are at greater risk of contracting and spreading respiratory infections. The consequences of a child with cystic fibrosis acquiring a respiratory infection can be serious and can include permanent deterioration of lung function.[23] An example of a strategy to reduce airway infections in children is to implement a policy whereby children with opportunistic infections (such as *Burkholderia cepacia* complex) are not cared for by members of the workforce who are caring for children who are immunocompromised or with a multidrug-resistant infection (such as *Mycobacterium abscessus*).[23]

Strategies to reduce the chance of transmitting respiratory viruses to vulnerable children, including those in neonatal intensive care, include:

- Implementing policies on the leave or deployment of unwell or non-immune clinicians and other members of the workforce
- Ensuring that healthcare workers are immunised against common respiratory and airborne transmitted diseases, including influenza, pertussis, measles, varicella and diphtheria, and that immunisation is offered to non-immunised members of the workforce[19,24]
- Discouraging unwell visitors, including siblings, from visiting children
- Implementing policies on respiratory hygiene, including 'cough etiquette'.[23]

Whooping cough is another type of respiratory infection that needs special consideration by health service organisations that provide care for children, as it can lead to serious illness and even death in newborns and infants who have not yet completed the recommended vaccination schedule.[20] Adults and adolescents may contract whooping cough without realising it, making them more likely to unknowingly pass the infection to others with low or no immunity, such as children.[20,24] Community outbreaks of whooping cough pose a risk because of the high concentration of susceptible patients, and the relatively large numbers of clinicians, family and visitors who have frequent and close contact with patients who are contagious or susceptible to infection, especially neonates.[20]

Some strategies to reduce the spread of whooping cough in services that provide care for children include:

- Developing workforce vaccination policies and procedures
- Developing management policies and procedures for members of the workforce diagnosed with whooping cough
- Limiting the access that the workforce and visitors have to wards with children, especially to neonatal intensive care units
- Implementing isolation policies for children with known or suspected whooping cough
- Discouraging family and other visitors from contact with children in hospital other than their own during increased whooping cough activity[20]

- Recognising the difficulties in diagnosing whooping cough in children
- Developing policies on post-exposure prophylaxis measures.[20]

Invasive medical devices

The prevention of catheter-related bloodstream infections requires special consideration when inserting, removing and replacing catheters, including umbilical catheters.[19] For the use of intravenous devices, policies and protocols may be needed that cover dwelling times, placement, safety devices, the use of pathology collections (including blood culture collections) and volumes to be collected.

Clean environment

Toys, including those used as therapeutic aids, collect and store microorganisms, and may be a source of infection for children. Therefore, health service organisations may consider:

- Ensuring that any toys in areas that provide care for children can be easily cleaned with a neutral detergent and dried
- Cleaning toys regularly, including between patients
- Avoiding the use of toys that retain water and are difficult to clean (such as some soft toys); if these toys are used, health service organisations may consider limiting their use to a single patient only
- Undertaking a risk assessment of toys and therapeutic aids that cannot easily be cleaned to find the best strategy to prevent and control the spread of infection, including discarding a toy if it cannot be cleaned[23]
- Cleaning books, tablets and laptops.

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.

Suggested approaches

Antimicrobial stewardship

Antimicrobial prescribing for children in hospitals is common. One Australian study reported that nearly half of children in large tertiary hospitals were prescribed at least one antimicrobial, with variable levels of appropriateness of prescribing.[25] In neonatal intensive care units, the critical condition of patients may lead to frequent or prolonged treatment with antimicrobials. This will bring with it the associated risks of harm from adverse drug reactions and development of antimicrobial resistance.[19]

Many of the principles governing antimicrobial stewardship (AMS) in adult patients are applicable to paediatric settings, including neonatal intensive care units. They are described in detail in the NSQHS Standards. However, there are some important differences in antimicrobial prescribing, dispensing, administration and monitoring for children compared with adults. These include:

- Differences in the absorption, distribution, metabolism and excretion of medicines in children at different ages
- Changes in weight because of growth
- Variable doses of medicines for children, which are commonly based on weight
- Potential difficulties associated with administering medicines to children.

In services that provide care for children, the AMS policy should include guidance on:

- Identifying conditions and circumstances for which paediatric specialist advice should be sought
- Knowing when to seek the advice of paediatric infectious diseases experts, and how to obtain this advice

- Obtaining clinical microbiology advice
- Accessing evidence-based paediatric- and neonatal-specific national or local antimicrobial prescribing guidelines and clinical pathways (for example, sepsis pathways)
- Understanding the antimicrobial prescribing restrictions for children and the procedure for obtaining approval for use of restricted agents
- Reviewing the health service organisation's approved list of medicines or formulary to ensure that antimicrobials are available in dosage forms and formulations that are suitable for use in children.

Those prescribing, dispensing and administering antimicrobials should:

- Check the appropriateness of the prescribed dose in an up-to-date and evidence-based reference text
- Verify all dose calculations (using a calculator) and the actual dose
- Discuss and clarify the reason for the medicine's use, the correct dose and instructions for administration with the child's family, and if appropriate show how to measure and administer the dose.

Services that provide care for children may ensure that the AMS team includes clinicians with paediatric specialist expertise to provide advice and support on selecting and developing AMS strategies for children, and to provide guidance on child-specific issues. If on-site paediatric specialist expertise is not available, this expertise could be sought from the AMS team at a specialist paediatric hospital, or through a network arrangement with a statewide specialist paediatric network.

Specific point-of-care interventions that could be provided as part of post-prescription review of antimicrobial orders for children include:

- Optimising antimicrobial dosing
- Decreasing duration of therapy
- Intravenous-to-oral switching.

Monitoring and analysis of antimicrobial use are critical to understanding patterns of prescribing, and their influence on patient safety and antimicrobial resistance, and to identify where to direct efforts to improve the AMS program. Antimicrobial use can be measured in terms of quantity, expenditure and quality (for example,

appropriateness of prescribing according to guidelines).

The usual measure of quantity of antimicrobial use in adult hospitals, the defined daily dose (DDD) per 1,000 occupied bed days, is not suitable for children. Days of therapy (DOTs) and antimicrobial costs may be more relevant options for monitoring the quantity of antimicrobial use in children. Whichever measure is used, hospitals should ensure that the measures and the methods of data collection are consistent across the patient population.

There is currently no national antimicrobial usage surveillance program suitable for children. However, the Commission's Antimicrobial Use and Resistance in Australia (AURA) National Coordination Unit is currently undertaking work, in partnership with the National Antimicrobial Utilisation Surveillance Program, that will support the measurement of antimicrobial use in children and enable benchmarking of use across paediatric units (see also the AURA website).

The quality of prescribing can be assessed through participation in the National Antimicrobial Prescribing Survey.[26] Other indicators of quality of antimicrobial use relevant to paediatric populations are the Antimicrobial Stewardship Clinical Care Standard Indicators and the antibiotic therapy indicators in the National Quality Use of Medicines Indicators for Australian Hospitals.[27]

Finally, health service organisations that provide care for children should consider auditing documentation of weight and dose calculations for antimicrobials on the medication chart (see also the Medication Safety Standard). This could be part of a general medication chart audit.

Medication Safety Standard
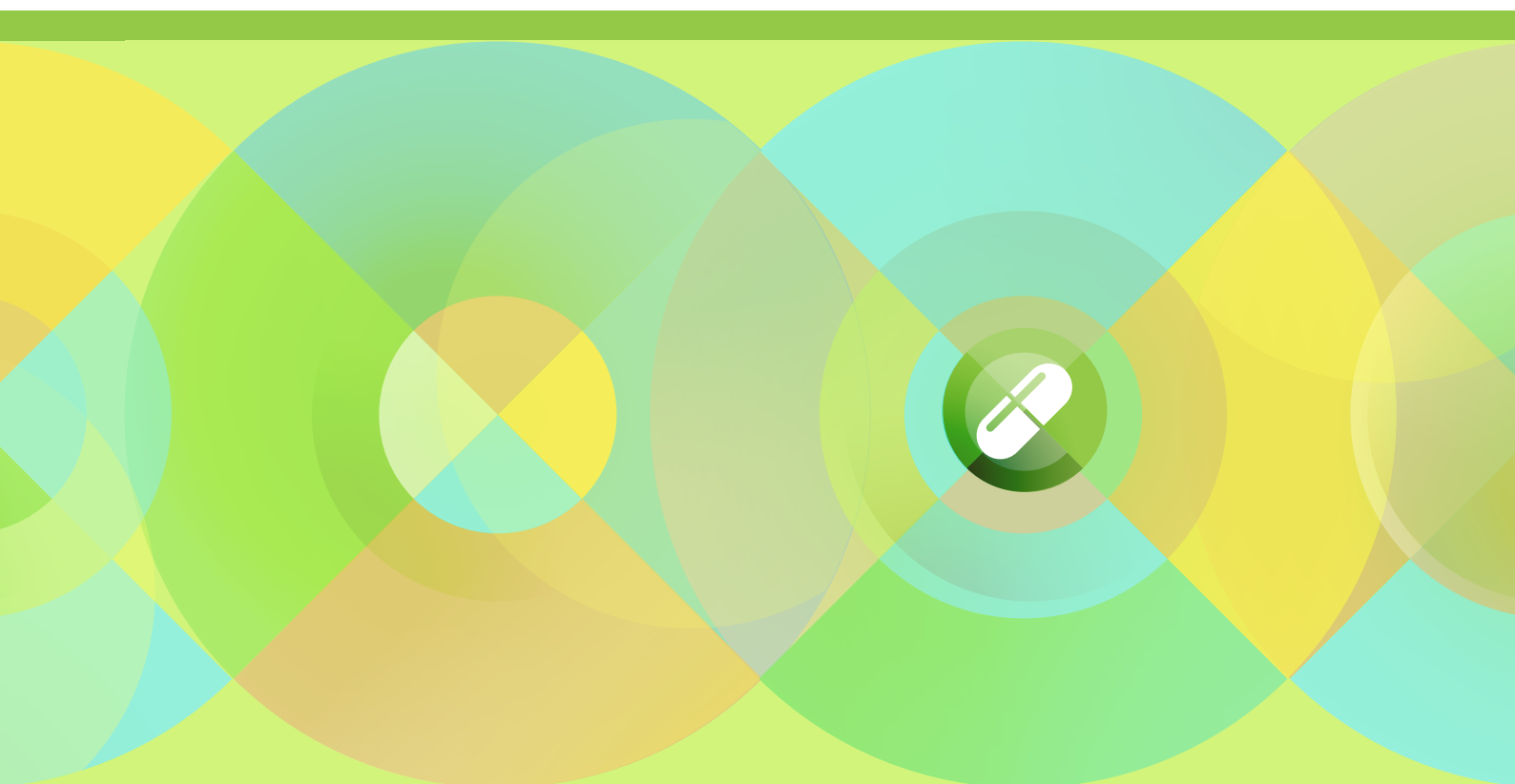
Medication Safety Standard

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

The four criteria that make up this standard and require consideration by all health service organisations are:
- Clinical governance and quality improvement to support medication management
- Documentation of patient information
- Continuity of medication management
- Medication management processes.

The following criteria have suggested approaches to implement the Medication Safety Standard that are specific to health service organisations that provide care for children:
- Clinical governance and quality improvement to support medication management
- Continuity of medication management
- Medication management processes.

The suggested approaches are grouped under these criteria and described in this chapter.

Why does this standard need special consideration by health service organisations that provide care for children?

Children are more susceptible to harm from medicines because:

- The absorption, distribution, metabolism and excretion of medicines in children varies with age
- Children's weight varies with growth and changing activity levels
- The dosage of medications for children is often nonstandardised and weight-dependent
- There may be difficulties associated with administering medications to children
- Children's capacity to communicate medication problems when they occur is variable.

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.

Suggested approaches

Integrating clinical governance

To reduce the risk of harm from medicines, health service organisations that provide care for children could implement policies to ensure the use of:

- Validated paediatric medication charts, such as the Paediatric National Inpatient Medication Chart[28]
- Independent double-check of paediatric medicines and calculations by a second clinician before administration[29,30]
- Child-based protocols, formulary approval processes and evaluation processes for 'off-label' medicine use[31,32]
- Burettes to deliver intravenous fluids
- Safe, non-disrupted medication preparation areas.

Evidence shows that incorrect recording of a child's weight can contribute to incorrect dose calculation.[33] To reduce this risk, health service organisations that provide care for children may consider ensuring that:

- A child's height, length and weight are documented and dated upon admission
- Accurate, current weight in kilograms is documented clearly on all medication charts
- Processes are in place to regularly weigh children and then track any variation in weight during an episode of care
- Estimated weights are not used except in life-saving situations; when they are used, use of tools to estimate weight should be considered
- Regularly calibrated age-appropriate medical-grade weighing scales are available in all areas that provide care for children.

The health service organisation should ensure that clinicians caring for children have the skills to accurately and safely calculate dosage and volumes of medicines for children. If necessary, training and awareness programs should be available to improve clinician competency.

Health service organisations should also ensure that all clinicians who prescribe are equipped with knowledge and skills in the main general principles of safe prescribing and medicines use in the children.

Partnering with consumers

Medicine dosing errors at home are more likely to occur when there are low levels of health literacy.[34] It is estimated that approximately 40% of adults have the level of health literacy that enables them to meet the challenges of everyday life.[35] Therefore, health service organisations may consider ensuring that the person taking responsibility for care at home, whether adult or child, knows how to accurately and safely administer medicines.[36] For some populations, including people from culturally and linguistically diverse backgrounds, and Aboriginal and Torres Strait Islander people, medicines information may need to be translated into other languages and presented in a form that is meaningful. This translation of information can reduce the risk of a medicine-related adverse event following discharge.

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.

Suggested approaches

Information for patients

Health service organisations should ensure that high-quality medicines-related information is available to children and their families. This helps them better understand their roles and responsibilities for medication management, and assists with pharmacovigilance.* It includes presenting information on medicines in graphic, photographic or pictorial form, which has been shown to improve the safe use of medicines by people with low health literacy.[34]

Health service organisations should evaluate the content and usefulness of medicines-related information to ensure its suitability for children and family members by:

- Involving children and their families in the development of locally produced materials and approaches to distribution
- Inviting children and their families to provide feedback on available medicines-related information
- Using this feedback to improve medicines-related information materials and distribution practices.

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* Pharmacovigilance is the science and procedures relating to the detection, assessment, understanding and prevention of adverse effects or any other drug-related problem.[37]

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.

Suggested approaches

Information and decision support tools for medicines

Health service organisations should ensure that:

- Appropriate dosing guidelines for medicines used for children are readily available to clinicians – for example, weight-based resuscitation dosage guidelines
- Age- and weight-based guidelines are available and used for the administration of all medicines for children, regardless of route
- The standard set of medicines-related reference materials, including children's medicines information and dosing guidelines, is available for use by all clinicians who prescribe, dispense and administer medicines to children.

Health service organisations should ensure that appropriate paediatric reference texts and guidelines are available in case more detailed information on optimising paediatric prescribing is needed or special patient cohorts must be dealt with. For example:

- When dosing obese children, use of 'ideal weight' may be more appropriate for some medicines
- When dosing older children (or those over 40–50 kg), care should be taken to ensure that the upper dose limits for adults are not exceeded.

High-risk medicines

It is important for health service organisations to review relevant literature, data and information on medication safety incidents to identify any high-risk medicines that require specific management guidelines for children.[38,39]

Take extra care with children to ensure that the correct dose of a high-risk medicine is administered. To further improve the management of high-risk medicines and meet the safety needs of children, health service organisations could:

- Make a list of high-risk medicines specific to children
- Identify related policies, procedures and protocols for the administration of high-risk medicines to children – for example, syringes for administration of medication should have minimal dead space[40]
- Implement an independent double-check policy for administration of paediatric medicines
- Ensure that guidelines and decision support tools for the prescribing and administration of high-risk medicines to children are readily available and used by clinicians
- Check with the child and their family that they fully understand the medication order and administration of the medicines before a high-risk medicine is taken home; families and children play a major role in identifying medication errors before they occur, and early detection can prevent a medication error causing harm.

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

The four criteria that make up this standard and require consideration by all health service organisations are:

- Clinical governance and quality improvement to support comprehensive care
- Developing the comprehensive care plan
- Delivering comprehensive care
- Minimising patient harm.

All of these criteria have suggested approaches to implement the Comprehensive Care Standard that are specific to health service organisations that provide care for children. The suggested approaches are grouped under these criteria and described in this chapter.

Why does this standard need special consideration by health service organisations that provide care for children?

Children are at greater risk of harm than many other patient groups because of their age, developmental capacity and reduced ability to speak up for themselves. Their physical, cognitive and mental health needs also vary considerably from those of adults, with family being fundamental to their decision-making and wellbeing. These characteristics bring with them complexities that require special consideration by clinicians to determine children's expressed goals of care, and the effect of their health issues on their life and health outcomes.

CRITERION: Clinical governance and quality improvement to support comprehensive care

Systems are in place to support clinicians to deliver comprehensive care.

Suggested approaches

Integrating clinical governance

Implementing quality improvement systems could include providing members of the workforce and families with access to training and education that cover topics such as:

- Screening, assessing, preventing and managing physical, cognitive and mental health conditions in children
- Cross-team planning for complex patients
- Advance care planning for children, including taking into account special circumstances, such as the child's and their family's wishes and activity levels.

Designing systems to deliver comprehensive care

Health service organisations that operate in rural settings should consider the availability of on-site expertise in paediatrics. If this is not available, the health service organisations should ensure that there is access to 24-hour paediatric-specific advice and guidance, and ongoing education for the workforce.

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.

Suggested approaches

Screening of risk

When developing comprehensive care plans for children, health service organisations should consider the use of validated, age-appropriate physical, cognitive and mental health screening and assessment tools to identify children at risk, including those who will require trauma-informed care.

Screening of risk requires consideration of a child's cognitive and mental health needs because:

- They may have an existing or recently acquired condition that affects their cognitive functioning, including their language, thinking, judgement, memory and behaviour
- They may experience global developmental delay or a diverse variety of specific cognitive difficulties, which may increase their risk of harm
- They may be seriously ill and at risk of developing acute cognitive impairment or delirium[41]
- The presentation, causes and appropriate management of mental illness may be very different from those of adults
- They may be more likely to exhibit disturbed behaviour, such as aggression, because of
  - age-related variations in cognition, interpersonal skills, impulse control and defence mechanisms
  - developmental delays and learning difficulties
  - mental health disorders such as separation anxiety
  - loss of meaningful contact with family
  - restrictions on their ability to play[42]
  - trauma resulting from domestic violence.

Screening will also require assessment of parental status and capability, other dependent children, and family support needs and how these may affect the child receiving care.

The screening and assessment tools used should be evidence based, and appropriate to the child's age and development, and the process of screening should engage children and their families.

Developing the comprehensive care plan

The process of care planning should take into account the preferences of the child and their family. When developing a comprehensive care plan for children, clinicians should also consider their innate needs, including their need for attachment, which allows them to connect with and gain reassurance from their family during times of need or distress.[43] Children who have family who respond sensitively to their needs during such times have better outcomes relating to emotional and social development, mental health and educational achievement.[43] Health service organisations should ensure that strategies to support, develop and enrich attachment are used and are tailored to the child's developmental age – for example:

- Supporting skin-to-skin touch soon after birth
- Supporting breastfeeding practices
- Enabling supportive touch from family members during procedures
- Enabling families to provide their own meals, toys, clothing and bedding
- Providing rooming-in facilities (if appropriate)
- Enabling flexible visiting arrangements
- Enabling family members to accompany a child through transitions of care – for example, to the medical imaging department.

Developing the comprehensive care plan involves planning for discharge from the health service organisation. Health service organisations that provide care for children should consider:

- Engaging with families about care required post-discharge
- Identifying any services, equipment and follow-up that may be needed to safely send the child home
- Developing processes to ensure that follow-up arrangements are made before a child is discharged from the health service, including communications with general practitioners and other providers of primary care
- Developing processes to ensure prompt referrals – for example, mandatory reporting of suspected child abuse and neglect to government authorities as per state and territory requirements
- Developing processes to inform the family and other providers and agencies, such as schools and childcare centres, of ongoing care requirements.

When developing a comprehensive care plan, health service organisations need to consider how to support children whose gender identity and expression differ from the gender assigned at birth. Health service organisations can refer to the *Australian Standards for Care and Treatment Guidelines for Transgender and Gender Diverse Children and Adolescents*.[44]

Health service organisations should also consider implementing trauma-informed care to recognise the impact that traumatic events have on a child's wellbeing. Clinicians should be aware of, and seek to prevent, the trauma occurring, and avoid triggers that can lead to traumatisation and re-traumatisation.[45] Providing trauma-informed care involves:

- Understanding the impact of trauma on children and the family
- Providing care in a place that is physically and emotionally safe
- Ensuring the workforce is culturally competent and can implement practices that are respectful of cultural backgrounds
- Helping children who have been victims of trauma regain control of their day-to-day lives
- Including communities in governance processes and decision-making about the design of services
- Promoting safe relationship-building as part of healing and recovery.[46]

Health service organisations can improve the planning and delivery of care for children with complex care needs, including those with a developmental delay, intellectual disability, mental health condition or chronic disease, by:

- Developing care plan templates that are readily accessible and can be tailored to children's individual needs
- Providing guidance on the best way to deal with common conditions
- Documenting the most effective method of engaging with children and their families
- Limiting the time children spend in unfamiliar environments to reduce agitation and the potential for aggression
- Considering the number and types of tests required and whether these can be performed at home.

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.

Suggested approaches

Using the comprehensive care plan

Health service organisations providing care for children need to work together with the child and their family to ensure that care is delivered in the most acceptable manner. This helps prevent the child feeling frightened, which may influence future healthcare-associated anxiety. The child and their family should be involved in the child's care whenever possible, such as when procedures are performed and during clinical handover – unless the child expresses a wish otherwise.

Comprehensive care at the end of life

Delivering end-of-life care requires special consideration and sensitivity from health service organisations that provide care for children.[47] In advance care planning, the needs of children are different from those of adults because of the need to:

- Ensure that the needs of the child and other organisations that provide care, such as schools and preschools, are met
- Involve and coordinate clinicians and non-clinical support members of the workforce with specialised skills in child and family health care, including general practitioners and other members of the primary care workforce
- Understand and anticipate the different responses of children to symptoms and treatments
- Deal with family and societal expectations that children will outlive their parents
- Deal with the uncertainty of prognoses for children and a tendency to focus on cure-oriented treatment.[48]

When end-of-life care is provided to children, the health service organisation should consider having policies, procedures and protocols to:

- Consult with children and their families when developing advance care plans that cover the child's and their family's preferences for future care
- Consider the legal capacity of children to make decisions about their care, understand their prognosis and express a view
- Ensure that clinicians understand their legal and ethical obligations, including determining the child's capacity to understand and be involved in clinical decisions about end-of-life care
- Implement advance care plans that have been developed in the community
- Document advance care plans in the child's healthcare record
- Inform clinicians in the care team of the existence of advance care plans
- Periodically review or amend advance care plans.

When end-of-life care services for children are not available, the health service organisation should ideally have processes to refer children to appropriate services or build networks to obtain prompt specialist advice.[47]

CRITERION: Minimising patient harm

Patients at risk of specific harm are identified, and clinicians deliver targeted strategies to prevent and manage harm.

Suggested approaches

Preventing and managing pressure injuries

Children may be at an increased risk of pressure injury because they may:

- Have an increased body temperature
- Have high or low body mass index and/or birth weight
- Be unable to verbalise their pain or discomfort
- Be incontinent
- Have immature skin
- Have mobility-limiting conditions or a neurological impairment
- Engage in active play that may inadvertently cause friction and self-harm
- Have medical devices that are firmly secured to reduce the risk of unintentional or intentional removal because of the active nature of children.[49,50]

To minimise the risk of harm from pressure injuries in children, health service organisations may:

- Develop a child-specific policy, procedure or protocol on friction or pressure injuries
- Describe and use prevention strategies and practices
- Develop processes to identify patients who are at risk of friction or pressure injuries through an initial assessment, and require regular and repeat assessments

- Ensure the use of validated, age-appropriate risk screening and assessment tools to determine children's risk of developing a pressure injury and implement relevant mitigation strategies – for example
  - the Glamorgan Pressure Injury Screening Tool (which includes a Paediatric Pressure Injury Risk Assessment Scale)[51]
  - the Modified Braden Q Scale[52]
  - the Neonatal Skin Risk Assessment Scale for Predicting Skin Breakdown (NSRAS)[53]
- Agree on risk-based care pathways and monitor their use
- Provide information to families on the prevention and ongoing management of pressure injuries, as many factors that cause childhood pressure injury may be present on discharge – for example, spina bifida, low birth weight and naso-gastric feeding tubes.

Preventing falls and harm from falls

Reducing the risk of falls for children requires special consideration because of:

- The different environmental factors that may influence a child's risk of falling compared with an adult's risk of falling, such as the height of beds and cots, and entrapment between mattresses and bed or cot sides
- Differences in physical factors, including coordination and body strength, and different communication skills of children compared with adults.

To minimise the risk of harm to children from falls, health service organisations may consider:

- Providing education and support to children and their families to identify risks and help prevent falls, including information on falls risk factors such as co-sleeping, the influence of medication and sedation, changes in blood pressure in adolescents, and reduced mobility during rehabilitation or recovery from injury and illness
- Educating families on the risks of harm from falls at home and in the community.

Nutrition and hydration

To ensure proper nutrition and hydration of children, health service organisations may consider:

- Implementing processes to deal with allergies, including for complementary feeds
- Using child-specific fluid management balance and measurement charts
- Providing child-friendly foods that are both nutritious and attractive to children
- Using strategies that prevent children from disconnecting intravenous or feeding tubes
- Preventing the accidental interchange between enteral and intravenous equipment.

Preventing delirium and managing cognitive impairment

Many of the prevention and management strategies used for the adult population are relevant to children, such as a supportive environment and the active involvement of families.[41] To minimise the risk of harm from cognitive impairment in children, health service organisations may also consider:

- Identifying children with cognitive impairment, understanding their specific communication and additional care needs, and implementing an individualised plan to minimise risks of harm and distress
- Identifying children at risk of delirium and incorporating delirium prevention strategies into the plan
- Assessing for delirium when there is any change to behaviour or thinking, and investigating and treating the causes of delirium
- Assessing and investigating changes in cognitive function, and treating the cause of cognitive impairment if appropriate
- Providing delirium information to families of children at risk of, or with, delirium; this may include information about cognitive impairment and other condition-specific information
- Ensuring clear communication with primary care providers at transitions, and when referring children for further assessment and treatment – especially when previously undiagnosed neurocognitive problems or learning problems are identified.[41]

Predicting, preventing and managing self-harm and suicide

Strategies to prevent and respond to suicide and self-harm should be appropriate to children, young people and adolescents.

Suicide prevention for Aboriginal and Torres Strait Islander children requires special consideration by health service organisations that provide care for children because the suicide rate among Aboriginal and Torres Strait Islander people aged 5 to 14 was 7.5 times that of other Australian children in 2011–2015.[54] Therefore, health service organisations should consider:

- Implementing relevant recommendations and success factors identified in the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project final report[55]
- Referring to the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, which outlines strategies to build strengths and resilience in children and families to reduce the risk of suicide and self-harm.[56]

Predicting, preventing and managing aggression and violence

Children are at risk of experiencing negative physical and psychological outcomes as a result of coercive interventions such as restraint and seclusion.[42,57] Therefore, health service organisations should employ child-specific strategies to de-escalate aggression among children that are based on principles of:

- Non-violence
- No restriction
- Fostering therapeutic relationships between clinicians and patients[57]
- Focusing on actively engaging children in their own care
- Including the family in the development of safe, long-term management strategies.

Health service organisations may consider developing policies, procedures and protocols on the acceptable and appropriate use of alternatives to restraint and seclusion to manage behaviours of concern in children. For example, health service organisations may consider 'sensory approaches' specifically tailored to children to minimise the

chance of aggression and other behaviours of concern.[58] Such approaches can be used to alter a child's arousal level, making them alert or relaxed.[58] The success of sensory approaches depends on the child.[58] Some examples of sensory approaches to deal with aggression in children include:

- A calming setting with space to move around freely
- Therapeutic touch.

Therapeutic touch does not restrict movement, but rather provides a calming reassurance to children, especially when coupled with calming words, practical engagement strategies and practical refocusing. Organisations should set clear boundaries on what is appropriate and inappropriate therapeutic touch.

There are substantial risks associated with placing adolescents and young people with challenging behaviours, such as aggression, into adult mental health units. In such circumstances, health service organisations should be informed by relevant state and territory policy frameworks, and consider having policies in place to mitigate these risks.[59] Preparations may include:

- Conducting a formal risk assessment of the unit, other patients and the child, including the likelihood of the risks occurring and consequences for the child
- Considering the conditions and their suitability for the child
- Obtaining clear agreements between the adult mental health service, the emergency department, and the child and adolescent mental health unit on care.[59]

Minimising restrictive practices: restraint; minimising restrictive practices: seclusion

There are marked risks associated with the use of restraint and seclusion in children, including injury and even death.[57] The principles of minimising and, if possible, eliminating the use of restraint and seclusion of children are the same as those for adults. However, the risks of harm are increased for children because of their high level of mobility and the possibility they have not perceived the consequences before acting. The key to minimising use of restrictive practices is to be alert to changes in a person's behaviour or demeanour that may suggest deterioration in their mental state. Strategies to engage and redirect behaviours may need to be considered to provide opportunities for both structured (for example, art) and unstructured (for example, going for a walk) diversion.

Whenever the use of restraint or seclusion does occur, health service organisations should follow policy that:

- Complies with relevant state or territory legislation on consent, restraint and seclusion
- Supports the review and removal of restraint as soon as practicably possible.

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

The five criteria that make up this standard and require consideration by all health service organisations are:
- 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.

The following criteria have suggested approaches to implement the Communicating for Safety Standard that are specific to health service organisations that provide care for children:
- Correct identification and procedure matching
- Communication at clinical handover
- Communication of critical information.

The suggested approaches are grouped under these criteria and described in this chapter.

Why does this standard need special consideration by health service organisations that provide care for children?

Health service organisations implementing strategies for safe communication need to consider:

- The role of family members in communicating with children
- The widely varied levels of communication skills and understanding of children
- The involvement of children and their family at transitions of care.[60]

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.

Suggested approaches

Correct identification and procedure matching

It is common for children to remove identification bands, either accidentally or intentionally. Removing identification bands is relatively easy for children because of their small size, the anatomy and muscle tone of their ankles and wrists, and patterns of movement during play. Health service organisations may consider having processes in place to:

- Ensure the correct and ongoing identification of each child
- Restore the identification band as soon as possible
- Restrict all procedures and treatments for children until the band is replaced and the child's identity confirmed.

The organisation-wide patient identification and procedure matching system should outline policies, procedures and protocols for ensuring that children can be correctly identified when:

- Identification bands cannot be worn
- Identification bands are lost or accidentally removed
- Children do not have the capacity to identify themselves
- Children are unaccompanied by their family.[†]

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† Mothers and babies should only be separated when clinically indicated.

There is a small but important risk of identification errors occurring whenever breastmilk is expressed and stored in a health service organisation.[61] Several factors increase the risk of administration error when dealing with expressed breastmilk. These include the separation of women and their babies, babies of multiple births, and relocating infants to different bed spaces. The system for collection, storage and use of expressed breastmilk should include highly reliable processes for correct identification of mother and baby, including:

- Using rooming-in as a strategy for mother and baby so that they stay together throughout the patient journey
- Using double identification bands (for example, on wrist and ankle) with information that includes name, date of birth and patient number specific to the relevant state or territory
- Labelling and verification of containers at the time of collection and before use
- Using a double-check policy for breastmilk
- Obtaining and documenting consent from a parent or appropriate family member for the use of expressed breastmilk, including discussion of the effect that any medicines administered to the mother may have on the child.

CRITERION: Communication at clinical handover

Processes for structured clinical handover are used to effectively communicate about the health care of patients.

Suggested approaches

Clinical handover

Health service organisations should consider basing policies and procedures for clinical handover on a child-focused model of care that maximises opportunities for participation in handover by children and their families. To do this, health service organisations may support clinicians to:

- Assess the family's ability to provide ongoing care and provide information in a way that ensures that it is understood
- Educate families to detect deterioration, administer medicines, and find relevant primary and community services
- Provide relevant information for families to pass on to schools and childcare services
- Develop handover processes that allow the child and family appropriate and effective participation in clinical handover.

To ensure that transitions of care are safe and effective, health service organisations must have standardised processes in place and may consider having specific systems in place, especially at high-risk transition points, such as from:

- Neonatal intensive care units or special care to the paediatric setting or home
- Paediatric services to services for adolescents and young people
- Services for young people to adult services.

Patient discharge summaries are important tools to ensure best care of paediatric patients; however, research shows that they are often incomplete or not available to primary care physicians at the first follow-up appointment after a child's hospitalisation.[62] Addressing the accuracy and timeliness of discharge documentation improves the transfer of information between clinicians, and can reduce adverse events.[63,64] A suggested strategy to achieve this is to explain the contents and provide a copy of the discharge letter to the child and family at the time of discharge.

Systems to effectively communicate critical information and risks when they emerge or change are used to ensure safe patient care.

Suggested approaches

Communicating critical information

Health service organisations should consider developing policies and procedures that outline:

- Types of critical information likely to be received and actions to be taken in response
- Methods for communicating critical information to the responsible clinician and multidisciplinary team
- Methods for communicating critical clinical information to families and carers
- Time frames for communicating critical information
- Standardised templates to support communication of critical information
- Methods for rapid escalation of concerns.

Blood Management Standard
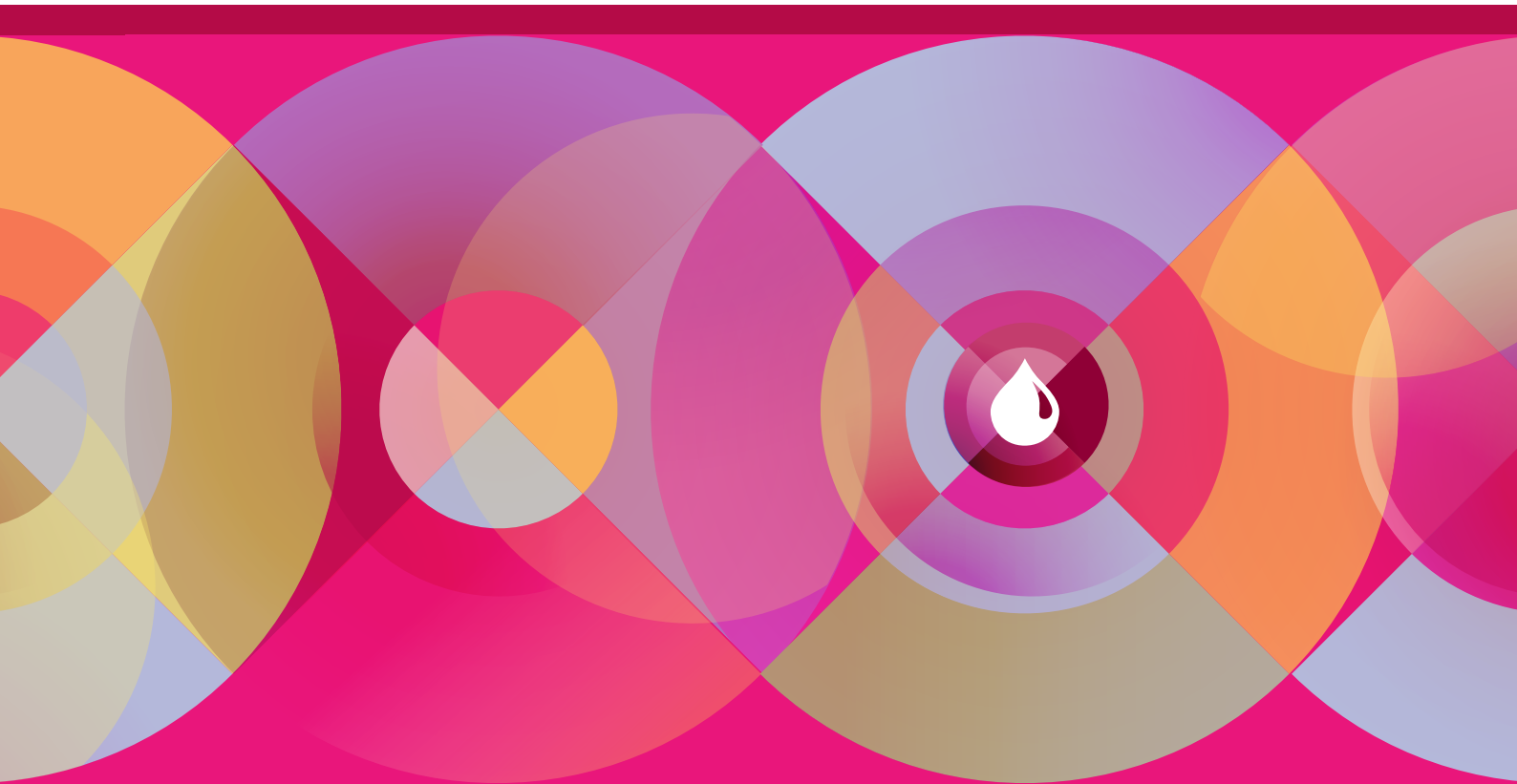
Blood Management Standard

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

The three criteria that make up this standard and require consideration by all health service organisations are:
- 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.

The following criterion has suggested approaches to implement the Blood Management Standard that are specific to health service organisations that provide care for children:
- Clinical governance and quality improvement to support blood management.

The suggested approaches are grouped under this criterion and described in this chapter.

Why does this standard need special consideration by health service organisations that provide care for children?

The administration and use of blood and blood products to children present more risks because of the size, developmental age, communication skills and cognitive ability of children.[65] The Australian and New Zealand Society of Blood Transfusion recommends that health service organisations using blood and blood products to care for children tailor policies, procedures and protocols to the specific needs of this group.

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.

Suggested approaches

Integrating clinical governance

Health service organisations should ensure that patient blood management policies and procedures are based on child-specific best-practice guidelines and current evidence, including:

- Using a restrictive transfusion strategy
- Reducing the need for red blood cell transfusion and exchange transfusion.[66]

Partnering with consumers

In addition to suggested approaches to gain informed consent outlined in the Partnering with Consumers Standard, health service organisations could consider:

- Ensuring that the length of time that the consent to administer blood and blood products remains valid is specified, especially for children who may be chronically ill
- Taking action if children or their family refuse the use of blood or blood products – for example, Jehovah's witnesses
- Taking action in circumstances in which consent cannot be obtained.[65]

The health service organisation could also audit patient clinical records to identify levels of compliance with transfusion consent policies, procedures and protocols, and areas for improvement.

8

Recognising and Responding to Acute Deterioration Standard
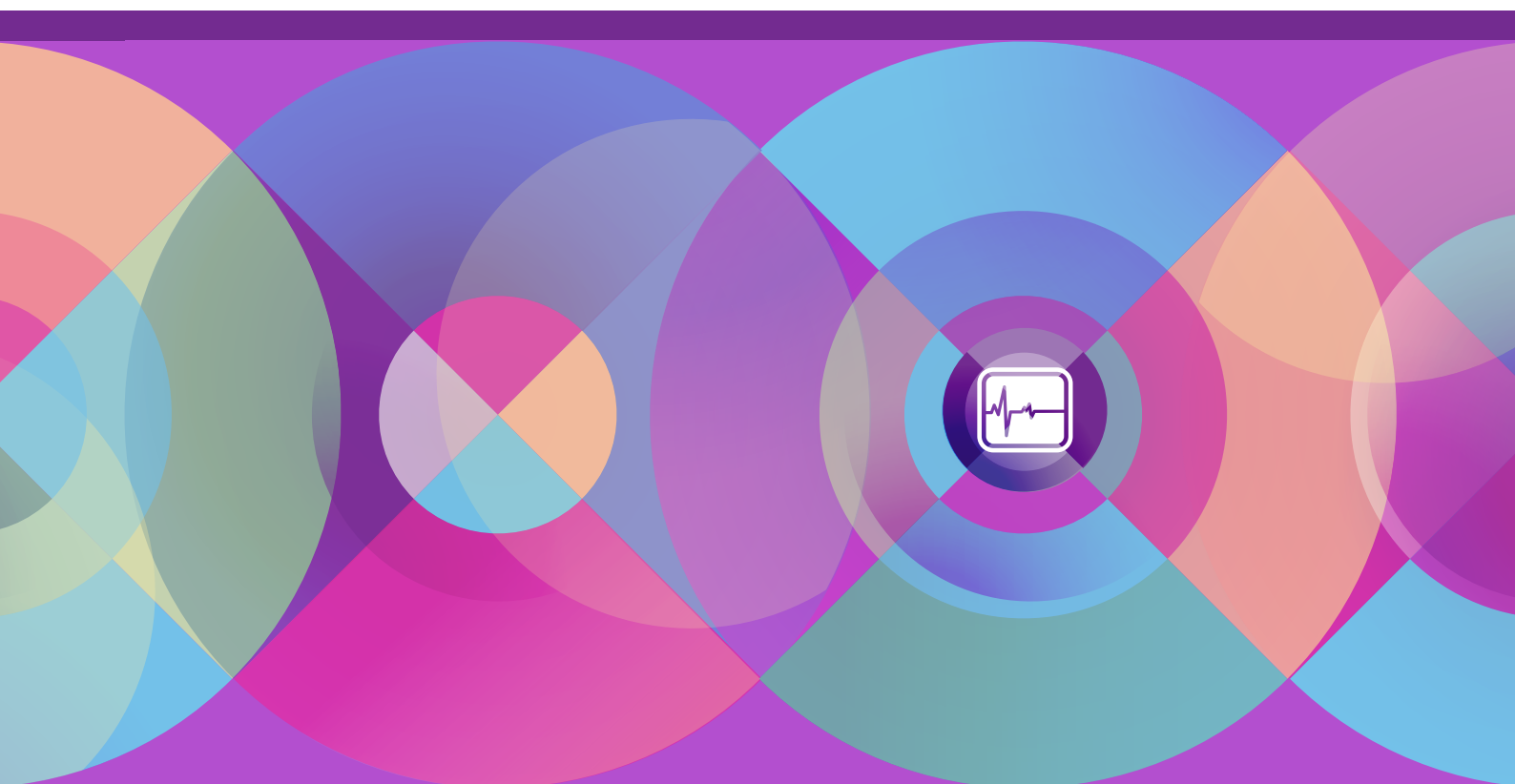
Recognising and Responding to Acute Deterioration Standard

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

The three criteria that make up this standard and require consideration by all health service organisations are:

- Clinical governance and quality improvement to support recognition and response systems
- Detecting and recognising acute deterioration, and escalating care
- Responding to acute deterioration.

All of these criteria have suggested approaches to implement the Recognising and Responding to Acute Deterioration Standard that are specific to health service organisations that provide care for children. The suggested approaches are grouped under these criteria and described in this chapter.

Why does this standard need special consideration by health service organisations that provide care for children?

There are several physiological differences between children and adults. For example, a young child's airway is shaped in a way that can make intubation more difficult, they have a relatively higher metabolic and oxygen consumption rate, their circulating blood volume is higher, and stroke volume is small and relatively fixed.[67]

As we age, our vital signs mature, and the way that our bodies cope with acute illness or injury changes. Recognition of, and response to, acute deterioration in children is difficult because:

- Children's physiological responses to critical illnesses and treatments differ from those of adults
- During the progress of an acute illness, children may look relatively well before deteriorating very suddenly
- Even when children present with relatively minor illnesses, deterioration can occur rapidly.[68]

These factors have implications for clinicians who provide care for children.

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[69], *the* National Consensus Statement: Essential elements for safe and high-quality end-of-life care[70], *the* National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state[71], *and the Delirium Clinical Care Standard.*[72]

Suggested approaches

Integrating clinical governance

Although the *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state*[71] applies broadly across all healthcare services and age categories, it was developed with input from health service organisations providing care for children and should be applied in services providing care for children. It describes the processes of care, therapeutic practices and organisational supports required to detect and respond to deterioration in the mental health of a child.

Health service organisations that provide care for children rely on safety and quality systems, and clinical governance frameworks that ensure safe and appropriate recognition of, and response to, acute deterioration. Ideally, these systems should take into account the differing parameters required to recognise and respond to deterioration in various age groups so as to monitor risks, trends and changes over time. Suggested approaches to do this include designing a system that:

- Is based on best-practice guidelines and current evidence
- Is consistent with state or territory directives
- Includes requirements for the use of age-appropriate early warning observation charts
- Is tailored to the specific needs of children, including nominating clinicians with expertise in the most appropriate field to respond to instances of clinical deterioration
- Outlines governance arrangements, including specific roles, responsibilities and accountabilities for clinical leaders, executive sponsors and governing committees
- Is regularly reviewed by the relevant committee or group using performance information and feedback.

The training of clinicians responsible for providing care for children may include training in:

- Clinical assessment of the specified demographic
- Measurement and recording of vital signs using approved age-appropriate observation charts and equipment
- Basic and advanced paediatric and neonatal life support, if appropriate, or the ability to call such members of the workforce if required.

CRITERION: Detecting and recognising acute deterioration, and escalating care

Acute deterioration is detected and recognised, and action is taken to escalate care.

Suggested approaches

Escalating care

To ensure the appropriate escalation of care of children, health service organisations may consider specifying the following in their policies and procedures:

- Criteria for triggering a clinical review or medical emergency response
- Members of the workforce who are required to respond to calls for emergency response for specific age groups
- Mechanisms to contact suitably qualified and skilled resuscitation teams, such as paediatric or neonatal resuscitation teams
- Actions the workforce should take when responding to acute deterioration
- Processes for transfer (if required) to other healthcare facilities
- Arrangements with external organisations that form a part of the medical emergency response system
- Processes for escalating the care of children experiencing mental health issues
- Processes for monitoring and evaluating the efficacy of the recognition and response system specific to the age group.

Health service organisations should consider implementing a family-activated rapid response program, including for times when the family is concerned that 'something is not right' with their child. To ensure that family members can effectively use escalation systems, health service organisations may consider:

- Having a set of agreed triggers or reasons for families and children to escalate care
- Clearly identifying methods for activating the system
- Identifying clinicians responsible for responding to family and child concerns
- Describing the responding clinicians' roles and responsibilities
- Implementing measures and processes for evaluating the effectiveness of the system.

To support family involvement in escalation of care, families should be empowered and educated to use an escalation system. This may include:

- Providing education and orientation on admission
- Placing printed brochures or posters in prominent locations
- Broadcasting information about the system on television and audio services throughout the health service organisation
- Auditing the effectiveness of communication strategies to empower families to trigger the escalation process.

CRITERION: Responding to acute deterioration

Appropriate and timely care is provided to patients whose condition is acutely deteriorating.

Suggested approaches

Responding to deterioration

Equipment used during medical emergencies that involve children should be available in all areas where they receive care. The equipment should be:

- Available in a range of sizes appropriate to the demographic being treated
- Regularly checked and maintained as fit for purpose.

In addition, paediatric-specific dosing guidance should be available in the case of a child experiencing acute deterioration.

Resources

Clinical Governance Standard

Association for the Wellbeing of Children in Healthcare – *Standards for the Care of Children and Adolescents in Health Services* (refer to Section 2: Facilities)

Australian College of Children and Young People's Nurses (ACCYPN) – *Standards of Practice: ACCYPN standards of practice for children and young people's nurses* (2016)

Australian College of Midwives – *Position Statement on Bed-Sharing and Co-sleeping*

Australian Commission on Safety and Quality in Health Care – *National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health*

Australian Youth Affairs Coalition – *Where are You Going with That? Maximising young people's impact on organisational and public policy*

Bureau of Health Information NSW– Admitted Children and Young Patients Survey

Children's Healthcare Australasia – Paediatric safety and quality special interest groups

Australian Government Department of Health – National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families

Department of Health and Human Services, Victoria – Neonatal eHandbook

Department of Health and Human Services, Victoria – Victorian Healthcare Experience Survey

Hill MK, Pawsey M, Cutler A, Holt JL, Goldfeld SR. Consensus standards for the care of children and adolescents in Australian health services [position statement]. Med J Aust 2011;194:78–82.

Ombudsman for Children's Office, Ireland – *Child-Friendly Healthcare: A report commissioned by the Ombudsman for Children*

National Health and Medical Research Council – Australian clinical practice guidelines

NHS Wales – *Improving the Patient Experience: Friendly healthcare environments for children and young people*

NSW Health – Policies and guidelines

Queensland Department of Health – *Safe Infant Sleeping, Co-sleeping and Bed-Sharing* [guideline]

Royal Children's Hospital Melbourne – Clinical practice guidelines

UK National Paediatric Toolkit – Fabio the Frog

Partnering with Consumers Standard

Association for the Wellbeing of Children in Healthcare – *A Parents Guide to Hospitalisation*

Association for the Wellbeing of Children in Healthcare – Calico dolls: a process of play [blog]

Australian Law Reform Commission – *For Your Information: Australian privacy law and practice* (ALRC report 108). Chapter 68: Decision making by and for individuals under the age of 18

Australian Youth Affairs Coalition – *Where are You Going with That? Maximising young people's impact on organisational and public policy*

Children's Hospitals Australasia – Charter on the Rights of Children and Young People in Healthcare Services in Australia

Children's Health Queensland Hospital and Health Service – Children's health fact sheets

Cook Children's Medical Center – Making magic with medical supplies

Headspace (National Youth Mental Health Foundation) – *Evidence Summary: Shared decision making (SDM) for mental health – what is the evidence?*

NSW Health – Be in the know: rights of young people in healthcare

Office of the United Nations High Commissioner for Human Rights – Convention on the Rights of the Child

Women's and Children's Health Network – Consumer and community engagement: consumer healthcare rights

Women's and Children's Health Network – *Consumer Orientation Booklet: A guide to consumer engagement in the Women's and Children's Health Network (WCHN) of South Australia*

Women's and Children's Health Network – *Know Your Rights* [teens postcard]

Women's and Children's Health Network – *My Rights – Colouring-in Book*

Royal Australasian College of Physicians – *Working with Young People*

Royal Children's Hospital Melbourne – Be positive (B+): get ready for hospital

Royal Children's Hospital Melbourne, Children's Bioethics Centre – *Law, Ethics and Communication: A guide for giving information and obtaining informed consent for central venous access devices*

Preventing and Controlling Healthcare-Associated Infection Standard

State and territory, and paediatric network guidelines

Children's Health Queensland Hospital and Health Service

Other states and territories, and children's hospitals have published guidelines and resources to support antimicrobial stewardship programs and appropriate prescribing in paediatric settings. See also links provided in the Medication Safety Standard.

Resources to support monitoring of antimicrobial prescribing and use

Australian Commission on Safety and Quality in Health Care – AURA

National Antimicrobial Prescribing Survey

National Antimicrobial Utilisation Surveillance Program

NSW Clinical Excellence Commission The 5 × 5 Antimicrobial Audit

Resources for sepsis

NSW Clinical Excellence Commission – Sepsis Kills resources and tools for adult, paediatric, maternal or newborn patients

Resources for paediatric IV to oral switching

Australasian Society for Infectious Diseases/ANZPID Group

Medication Safety Standard

Australian Commission on Safety and Quality in Health Care – paediatric indicator 3.4 in *National Quality Use of Medicines Indicators for Australian Hospitals*

Australian Commission on Safety and Quality in Health Care – Paediatric national inpatient medication charts

Australian Medicines Handbook – *AMH Children's Dosing Companion* (online)

NSW Clinical Excellence Commission – Clinical incident management in the NSW public health system: Paediatrics

NSW Clinical Excellence Commission – *Medication Safety Self Assessment®*

Health Direct – Children's medicines

HNEkidshealth – Neonatal guidelines: Section 19: Medications

Institute for Safe Medication Practices Canada – *Advancing Opioid Safety for Children in Hospitals*

Medicines for Children – Practical and reliable advice about giving medicine to your child

Monash Children's Hospital – *Paediatric Emergency Medication Book*

NPS MedicineWise – How to give medicines to children

NPS MedicineWise Learning – National standard medication charts course

NSW Health – *Standards for Paediatric Intravenous Fluids* [guideline]

NSW Health – *Safe Administration of Liquid Medicines by Routes Other Than Injection* [policy directive]

Queensland Health – Maternity and neonatal clinical guidelines

SA Health – Neonatal medication guidelines

SA Health – *South Australian Paediatric Practice Guidelines: Pain management and opioid safety*

Royal Children's Hospital Melbourne – *Paediatric Injectable Guidelines*

Royal Children's Hospital Melbourne – *Medicines information*

Sydney Children's Hospitals Network – High Risk Medicines Register Policy

Comprehensive Care Standard

Australian Commission on Safety and Quality in Health Care – *National Consensus Statement: Essential elements for safe and high-quality paediatric end-of-life care*

Australian Wound Management Association – *Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury*

Braden QD Scale for assessment of immobility and device-related pressure ulcer risk in your pediatric population

NSW Clinical Excellence Commission – Paediatric fall risk assessment

NSW Clinical Excellence Commission – *Pressure Injury Prevention for Children in Hospital*

NSW Paediatric Palliative Care Programme

Palliative Care Australia – Health care professional's role in palliative care

Private Mental Health Consumer Carer Network

Royal Children's Hospital Melbourne – Falls: High risk management plan

Royal Children's Hospital Melbourne – Pressure injury prevention

Royal Children's Hospital Melbourne – Reference guide: Little Schmidy falls risk assessment

Tools for screening and assessing children

- Glamorgan paediatric pressure ulcer risk assessment scale[51]
- Braden Q scale for predicting paediatric pressure ulcer risk[52]
- Humpty Dumpty falls scale[73], which has been adapted by the NSW Clinical Excellence Commission[74]
- Little Schmidy falls risk assessment index.[75]

Western Australian Department of Health – *WA Pressure Injury Prevention and Management Clinical Guideline*

World Health Organization, UNICEF – *Baby-Friendly Hospital Initiative*

Communicating for Safety Standard

Agency for Clinical Innovation – *Key Principles for Transition of Young People from Paediatric to Adult Health Care*

Australian College of Midwives – Baby Friendly Hospital Initiative information pack for maternity facilities

NSW Clinical Excellence Commission – In Safe Hands

Royal Children's Hospital Melbourne Transition Support Service – What is adolescent transition?

Sydney Children's Hospitals Network – Trapeze: a supported leap into adult health

Blood Management Standard

Australian and New Zealand Society of Blood Transfusion Ltd, Royal College of Nursing Australia – *Guidelines for the Administration of Blood Products*

Department of Health and Human Services, Victoria – *Core Elements of Informed Consent for Transfusion (Blood and Blood Products)*

National Blood Authority – *Patient Blood Management Guidelines: Module 6 – neonatal and paediatrics*

Recognising and Responding to Acute Deterioration Standard

ACT Health – About Compass

Advanced Paediatric Life Support Australia

Australian Commission on Safety and Quality in Health Care – Delirium Clinical Care Standard

Australian Commission on Safety and Quality in Health Care – *National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration*

Australian Commission on Safety and Quality in Health Care – *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state*

Australian Commission on Safety and Quality in Health Care – *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*

Australian Commission on Safety and Quality in Health Care – *National Consensus Statement: Essential elements for safe and high-quality paediatric end-of-life care*

Bonafide CP, Localio AR, Roberts KE, Nadkarni VM, Weirich CM, Keren R. Impact of rapid response system implementation on critical deterioration events in children. JAMA Pediatr 2014;168:25–33.

Braden QD Scale for assessment of immobility and device-related pressure ulcer risk in your pediatric population

NSW Clinical Excellence Commission – Between the Flags

NSW Clinical Excellence Commission – REACH: Patient and family escalation

Gill FJ, Leslie GD, Marshall AP. Family initiated escalation of care for the deteriorating patient in hospital: family centred care or just 'box ticking'. Aust Crit Care 2016;29:195–200.

Gill FJ, Leslie GD, Marshall AP. The impact of implementation of family-initiated escalation of care for the deteriorating patient in hospital: a systematic review. Worldviews Evid Based Nurs 2016;13:303–13.

Monash Children's Hospital, State Government of Victoria, Royal Children's Hospital Melbourne –

ViCTOR: Victorian children's tool for observation and response

Queensland Health – Ryan's Rule: Consumer/family escalation process

Tibballs J, van der Jagt EW. Medical emergency and rapid response teams. Pediatr Clin North Am 2008;55:989–1010.

Western Australian Department of Health – *WA Pressure Injury Prevention and Management Clinical Guideline*

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.[76]

adverse drug event: harm associated with any dose of a medicine.

adverse event: an incident that results, or could have resulted, in harm to a patient or consumer.

antimicrobial: a chemical substance that inhibits or destroys bacteria, viruses or fungi, and can be safely administered to humans and animals.[77]

antimicrobial resistance: failure of an antimicrobial to inhibit a microorganism at the antimicrobial concentrations usually achieved over time with standard dosing regimens.[77]

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.[77]

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 they receive are appropriate and safe.

child: neonates, children, adolescents and young people. Children are defined in many ways in Australian Government, state and territory legislative and regulatory instruments. These definitions vary widely. When a health service organisation applies legislative or regulatory

requirements, the definition used in the relevant instrument must be applied.

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, families and carers, 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.

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.[78]

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.

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 consumer'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, families and carers 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 treatment 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.[79]

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.

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.[80]

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).

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.[81]

environment: the physical surroundings where 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.

family: those who are closest to the patient in knowledge, care and affection. This may include parents, siblings, grandparents, aunts, uncles, cousins and friends.[82] May also include 'carers'.

Aboriginal and Torres Strait Islander people have a complex system of family relationships, in which each person knows their kin and their land. Kinship defines roles and responsibilities for raising and educating children. When defining family for Aboriginal and Torres Strait Islander children, kinship relationships need to be considered.

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.

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.[83]

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.[35]

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 treatment or participate in planned care.[84] 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.[85]

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.[86]

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.[87]

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.[88] 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.[89] Also known as patient-centred care or person-centred care.

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

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.[80]

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.[90]

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.[91]

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.

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.

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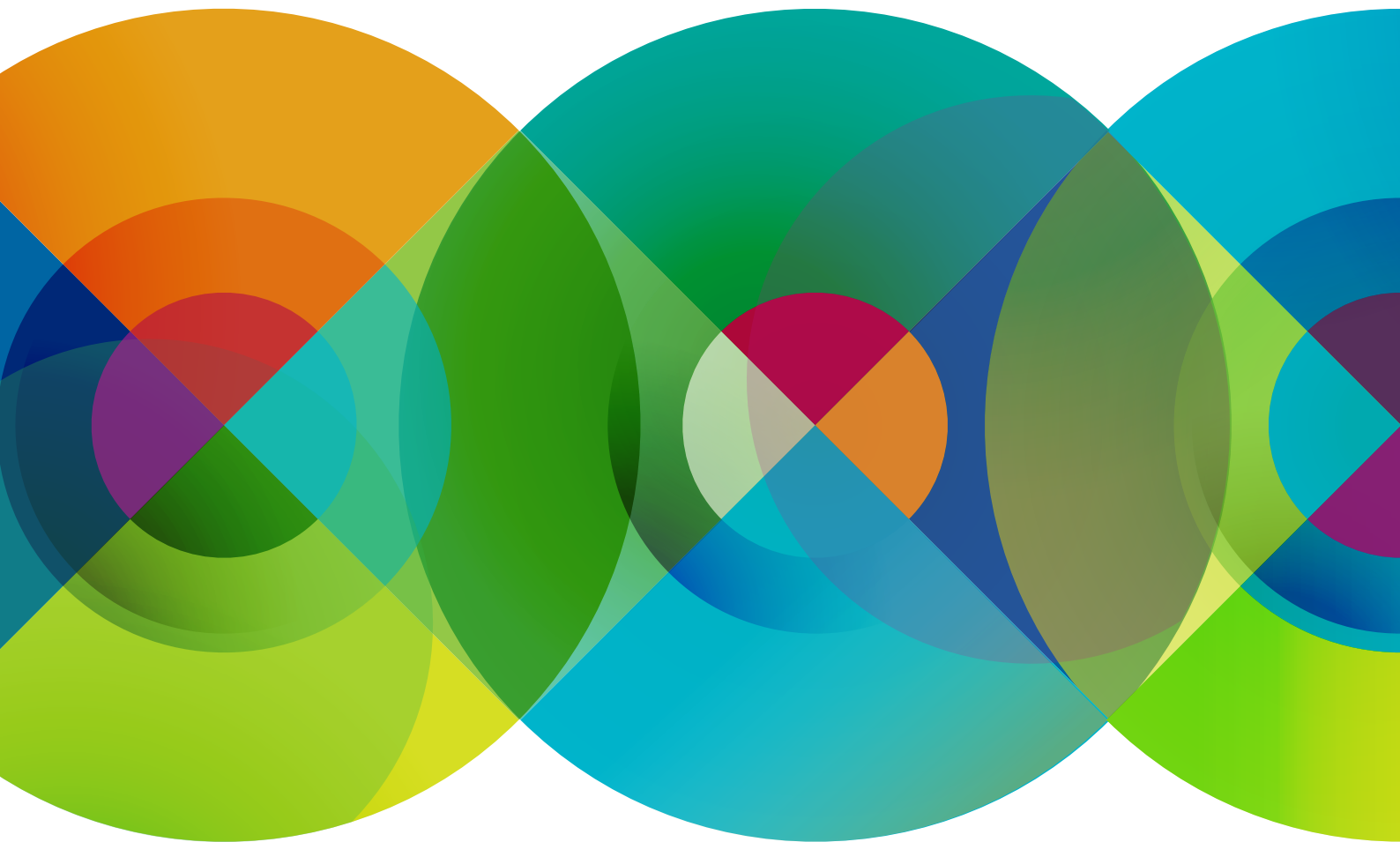
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