

**AUSTRALIAN COMMISSION  
ON SAFETY AND QUALITY IN HEALTH CARE**

**Practice-level indicators of safety  
and quality for primary health  
care specification (2012)**

**Version 1.0**

**FINAL**

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## **DOCUMENT INFORMATION**

This document is the specification of the practice-level indicators of safety and quality for primary health care.

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This specification is provided for testing and comments by jurisdictions and private primary care practitioners.

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# Introduction

## Purpose

The purpose of this document is to provide a specification for the recommended national set of practice-level indicators of safety and quality for primary health care which will support the generation of these indicators by primary healthcare practitioners and/or services/practices.

## Context

The Australian Commission on Safety and Quality in Health Care (the Commission) was established by Australian Health Ministers to lead and coordinate improvements in safety and quality in health care at a national level. Under the National Health Reform Act 2011 ([http://www.austlii.edu.au/au/legis/cth/consol\\_act/nhra2011216/](http://www.austlii.edu.au/au/legis/cth/consol_act/nhra2011216/)), the Commission is required to develop indicators relating to healthcare safety and quality.

In 2011, the Commission undertook in depth research and wide consultation to identify practice-level indicators of safety and quality for primary health care [1],[2]. The project resulted in support for 35 indicators in the dimensions of:

- accessibility
- appropriateness
- acceptability/patient participation
- effectiveness
- coordination of care
- continuity of care
- safety.

This document contains specifications for these 35 indicators.

## Acknowledgments

Elizabeth Hanley at the Commission led the work on the development of the practice-level indicators of safety and quality for primary health care. Deniza Mazevska at Health Policy Analysis developed this specification, working closely with Elizabeth Hanley and Neville Board at the Commission.

Organisations and peak bodies participating in the consultation processes during 2011 include: The Royal Australian College of General Practitioners, the Consumers Health Forum of Australia, the Australian Government Department of Health and Ageing, ACSQHC Primary Care Committee representatives, Australian Dental Association, Royal College of Nursing Australia, Australian Practice Nurses' Association, NPS, the Royal College of Physicians, Australian College of Rural and Remote Medicine, NSW Health, Queensland Health, ACT Health, SA Health, Department of Health Victoria, Department of Health and Human Services Tasmania, Department of Health Northern Territory and the Australian Council on Healthcare Standards. Academics and representatives of allied health

associations and quality improvement organisations also contributed to the consultation processes.

## Caveats

This draft of the specification has not been tested on primary health care services' data. It is provided to experts in advance of that work being done.

## Scope

According to the Australian Primary Health Care Research Institute (APHCRI) [3], 'primary health care' is:

*“socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation.”*

(p.20)

'Practice-level' refers to organisations, teams and individual practitioners providing primary health care services at the service unit, practice or local level.

Recommendations regarding indicators for general practice are outside of this project's scope. The Royal Australian College of General Practitioners (RACGP) has conducted a dedicated project to develop indicators for general practice [4].

Safety and quality practice-level indicators are measures or markers of the quality of care delivered by primary healthcare providers at the service unit, practice or local level. Practice-level indicators are intended to support continuous quality improvement through monitoring of trends over time, and to identify issues or significant variances in one or more dimensions of quality of care. These indicators should be generated and reviewed routinely by providers at the local level.

The national set of practice-level indicators of safety and quality is designed for voluntary inclusion in quality improvement strategies at the local practice or service level. It is intended that primary health care services will choose a 'local bundle' of indicators from the national indicator set as a tool to assess and monitor the service's improvement in different dimensions of quality, and particular aspects of care, pathways or conditions. The components of a local bundle of indicators may vary over time, depending on local circumstances, priorities for quality improvement, patient needs, and concurrent state and national reporting obligations applicable to the service.

# Guiding principles

1. Practice-level indicators of safety and quality for primary health care are intended for voluntary use in quality improvement strategies at the local practice or service level, and are not designed to serve as performance indicators.
2. “*Quality is complex and multidimensional. No single group of indicators is likely to capture all perspectives on, or all dimensions of, quality.*” [5] (p. 1) Services should choose a local bundle of indicators from the national set of practice-level indicators of safety and quality to support their focus on certain dimensions of quality, a range of process and outcome measures, and particular aspects of care, pathways or conditions.
3. The components of the local bundle of indicators will vary over time, depending on local circumstances, priorities for quality improvement, client needs and the service’s scope of practice.
4. State and national reporting obligations, as well as the local scope of practice, will determine which other specific clinical, professional and health service standards and indicators are also applicable to the practice or service.
5. Practice-level indicators of safety and quality should be:
  - clearly defined
  - supported by a clear rationale
  - achievable and relevant for primary health care practice
  - easily collected, preferably from existing datasets
  - reliable and valid
  - attributable to actions in primary health care
  - free from obvious unintended consequences.
6. The national set of practice-level indicators of safety and quality for primary health care should reflect:
  - that safe and high-quality care is consumer centred, driven by information and organised for safety [6]
  - the significance of the communications between healthcare providers involved in a patient’s care [7]
  - the defining characteristics of primary healthcare practice as identified by Starfield, Shi, and Macinko [8]:
    - first-contact care
    - person-focused care over time
    - comprehensive care
    - coordinated care.

7. The national set of practice-level indicators of safety and quality for primary health care should:

- cover those aspects of primary health care and client issues that are broadly applicable across settings, disciplines and geographic locations
- consist of a core set of indicators of safety and quality from which every practice or service can select a local bundle of indicators.



# Recommended national set of practice-level indicators

Dimension	Indicator	Description	Indic. #
Accessibility	First contact to service wait time	The percentage of clients whose wait from first contact to first service is within the locally agreed timeframe	1
	First contact to service wait time for high-priority clients	The percentage of clients who are high priority according to locally agreed criteria, and whose wait from first contact to first service is within the locally agreed timeframe	2
	Eligible clients who received an appointment	The percentage of eligible clients requesting an appointment who received an appointment	3
	Non-attendance at appointment	The percentage of clients who did not arrive for an appointment, and who were followed-up	4
Appropriateness	Health summary	The percentage of regular clients with a comprehensive health summary, including information on allergies, current/past medical history, medications and risk factors, which was updated within the previous 12 months	5
	Timely initial needs identification	The percentage of clients whose initial needs identification was conducted, within the locally agreed timeframe	6
	Client assessment	The percentage of clients assessed, using validated assessment and screening tools appropriate to the scope of practice and the client's needs	7
	Complete care plan	The percentage of clients with multiple or complex needs who have a complete care plan	8
	Recalls and reminders	The percentage of clients with a complete care plan who were given recalls or reminders as recommended in the care plan	9
	Adherence to clinical guidelines	The percentage of clients with complete care plans that are in accordance with agreed clinical guidelines	10
	Timely review of care plan	The percentage of clients with a recorded care plan that is reviewed within four weeks of the planned review date	11
	Medication review	The percentage of regular clients whose medicines have been reviewed by a healthcare practitioner in accordance with locally agreed guidelines	12
	Interpreter services	The percentage of clients requiring an interpreter who were provided with interpreter services at the first service	13
	Cultural and linguistic diversity awareness/sensitivity	The percentage of the service's eligible workforce who have received cultural competency training	14
Acceptability/ client participation	Self-rated health	The percentage of regular clients who have completed a validated self-rated health status instrument that informs their health care	15
	Patient experience survey	The percentage of regular clients who have been given a patient experience survey within the previous 12 months, (using a standard patient experience instrument that informs the service's quality improvement)	16

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Dimension	Indicator	Description	Indic. #
	Patient experience survey response rate	The percentage of regular clients who have responded to a patient experience survey within the previous 12 months (using a standard patient experience instrument, that informs the service's quality improvement)	17
	Satisfaction with patient experience	The percentage of regular clients who are very satisfied with specified elements of their patient experience within the previous 12 months (using a standard patient experience instrument)	18
	Client / carer complaints response	The percentage of client and carer complaints responded to within the service's nominated timeframe from receipt of complaint	19
	Client partnership in quality improvement	The percentage of clients who have been invited to contribute to quality improvement activities based on the results of the patient experience survey	20
	Client / carer engagement in care	The percentage of clients (and/or carers) who have discussed information about the purpose, treatment options, benefits, risks and costs of care, with a healthcare practitioner	21
Effectiveness	Client improvement / stabilisation	The percentage of regular clients whose condition has improved, or stabilised (for conditions where improvement or stabilisation is expected)	22
	Self-rated client improvement / stabilisation	The percentage of regular clients whose condition has improved, or stabilised (for conditions where improvement or stabilisation is expected) as measured through a validated self rated health status instrument that informs their individual care	23
	Goals of care attainment	The percentage of goals met in the timeframe stated for attainment of each goal, for clients with a care plan	24
	Goals of care partially attained	The percentage of goals partially met in the timeframe stated for attainment of each goal, or appropriately renegotiated, for clients with a care plan	25
Coordination of care	Referral process	The percentage of service referrals that are made in accordance with the service's policy for referral processes (for appropriateness and timeliness)	26
	Referral content	The percentage of service referrals that contain appropriate identifying, clinical and contact information and a current medication list (if relevant to the service).	27
	Allocation of a 'key contact' person/care coordinator	The percentage of clients with multiple or complex needs who are allocated a 'key contact person' or care coordinator, according to locally agreed guidelines, and are given their contact details	28
	Timely communication to healthcare practitioners	The percentage of clients where timely reporting of care assessments or outcomes was communicated to all relevant healthcare practitioners involved in the client's care	29
Continuity of care	Timely review and follow-up of diagnostic results	The percentage of clients whose diagnostic results were reviewed by a healthcare practitioner and acted on in a timely manner in accordance with agreed guidelines	30
	Medication reconciliation	The percentage of clients whose medication list has been reconciled against the service's patient health record	31
Safety	Adverse drug reactions and medication allergies	The percentage of clients whose known adverse drug reactions and medication allergies are documented in the service's patient health record	32

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Dimension	Indicator	Description	Indic. #
	Patient safety incidents investigations	The percentage of the service's documented patient safety incidents (i.e. near misses or errors, and adverse events that result in harm) where an investigation has been completed in accordance with local policy	33
	Patient safety incidents follow-up	The percentage of the service's documented patient safety incidents (i.e. near misses or errors, and adverse events that result in harm) where action is taken to reduce risks identified through the investigation	34
	Infection control	The percentage of the service's eligible workforce who have received infection control training within the previous 12 months	35

# Best practice in primary health care

The Commission's research and consultation process in relation to the development of the practice-level indicators of safety and quality in primary care identified some elements of best practice in this sector. This suggests that these should be measured in practice-level quality improvement activities, where practicable. These elements include, but are not limited to the following:

- Health professionals should use the best evidence available to inform their clinical practice (National Safety and Quality Health Service (NSQHS) Standard 1).
- Care provided by the clinical workforce is guided by current best practice, as agreed by the appropriate body (NSQHS Standard 1).
- Over time, the characteristics and social determinants of health of the local community/service population should be identified, reported and analysed to inform service planning and quality improvement.
- The service is able to demonstrate effectiveness of clinical treatment using outcome measures.
- The service is able to demonstrate evidence of providing appropriate coordinated care to ensure that patients are guided through the correct care pathway, and attend the most appropriate service providers in the most appropriate timeframe.
- Patient safety incidents are recognised, reported and analysed, and this information is used to improve safety systems (NSQHS Standard 1).
- Patient rights are respected and their engagement in their care is supported (NSQHS Standard 1).
- Patients and carers are supported by the health service organisation to actively participate in the improvement of the patient experience and patient health outcomes (NSQHS Standard 2).
- The service should support a collaborative approach to service delivery.
- Patients should receive a complete assessment, considering all relevant health issues, at the beginning of every episode of care and this should be reviewed each year.
- Care plans and care coordinators should be in place for all patients with multiple or complex needs, such as chronic conditions.
- Strategies for the prevention and control of healthcare associated infection care are developed and implemented (NSQHS Standard 3).
- The clinical workforce accurately records a patient's medication history and this history is available throughout the episode of care (NSQHS Standard 4).

- Referral processes and transfer of information between health professionals and services should support effective continuity and follow-up of care.

These elements of best practice have guided the selection of the final practice-level indicators of safety and quality for primary health care. Some elements are already included in the National Safety and Quality Health Service Standards [9] (as noted alongside the elements listed above), and to avoid duplication, were not included in this set.

## Considerations for use

Practice-level indicators of safety and quality for primary health care are designed for voluntary inclusion in quality improvement strategies at the local service level.

A service's choice of a local bundle of practice-level indicators will depend on local circumstances, priorities for quality improvement, client needs and the service's scope of practice.

Services may choose to focus on a particular group of clients; for example, clients who have multiple needs or have a chronic illness. Services may have concerns or uncertainty about the quality of a particular aspect of service; for example, referrals or care planning, which will also influence the selection of indicators.

It is likely that the local bundle will consist of a small number of indicators. Services may:

- use the same local bundle to monitor trends over time
- cycle periodically through a range of local bundles of indicators
- select some indicators initially, and add others as part of the quality improvement strategy for subsequent years.

Data in relation to some indicators may be collected routinely by services, either on an ongoing basis (e.g. recording of the date and time of the first contact for each client, and the date and time of each of their subsequent appointments), or around a specific activity (e.g. number of clients issued with a 'patient experience survey' and number responding, or number of staff participating in infection control training). However, not all data for indicators presented in this document will be collected routinely by services. In this case, the service will need to extract these data, for example, from audits of patient health records.

Depending on the volumes of clients seen by the service relevant to the indicator, the service may elect to audit a sample of records rather than extract data relating to all clients that fit the specifications for the indicator. An example of this is measurement of clients who were given recalls or reminders to action goals in their care plan. If a sample is undertaken, random sampling is preferable to eliminate bias of records selected.

Time frames for the derivation of specific indicators need particular consideration, as indicators will vary as to the time periods that the data to construct them will relate to. Relevant time periods may be:

- **A reference period.** This is a time-range during which data to derive the indicator relate to (e.g. a month, a quarter, a six-month period, a year). The length of the period selected will be guided by the nature of the indicator and the volumes of clients seen by the service relevant to the indicator. The less frequent the event or condition measured by the indicator (i.e. given client volumes), the longer the time frame. An example of an indicator that lends itself to a reference period is *The percentage of clients whose wait from first contact to first service is within the locally agreed timeframe (#1)*. Also, some indicators have an inbuilt reference period in their description (e.g. *The percentage of the service's eligible workforce who have received infection control training within the previous 12 months, #35*).
- **A specific time point.** This involves the selection of a specific time point for which the numerator and denominator are derived. An example of an indicator that lends itself to a specific time point is *The percentage of clients whose known adverse drug reactions and medication allergies are documented in the service's patient health record (#32)*. For this indicator, the service may select a particular day on which to conduct this audit, and extract records of clients with known adverse drug reactions and medication allergies (e.g. using a reference such as an electronic client registration system, or a survey of staff identifying these clients) to see whether they are recorded in their health record.

In these specifications, guidance in relation to time frames, and where sampling might be a better approach than deriving the indicator for the entire population of the service's clients, has been provided for each indicator.

Table 1 provides a worked example of a local bundle of quality indicators that could be used by services in assessing their standard of quality in caring for clients with multiple or complex care needs. A balanced set of indicators allows the service to measure different aspects of clients with multiple or complex care needs care across a range of quality dimensions.

**Table 1: Worked example — assessing quality of care for clients with complex care needs**

Dimension	Indicator	Description	#
Accessibility	First contact to service wait time for high-priority clients	The percentage of clients who are high priority according to locally agreed criteria, and whose wait from first contact to first service is within the locally agreed timeframe	2
Appropriateness	Complete care plan	The percentage of clients with multiple or complex needs who have a complete care plan	8
Appropriateness	Recalls and reminders	The percentage of clients with a complete care plan who were given recalls or reminders as recommended in the care plan	9
Co-ordination of care	Allocation of a 'key contact' person/care coordinator	The percentage of clients with multiple or complex needs who are allocated a 'key contact person' or care coordinator, according to locally agreed guidelines, and are given their contact details	28
Acceptability/client participation	Self-rated health	The percentage of regular clients who have completed a validated self-rated health status instrument that informs their health care	15
Effectiveness	Client improvement/stabilisation	The percentage of regular clients whose condition has improved, or stabilised (for conditions where improvement or stabilisation is expected)	22

# Conventions

This document uses the term 'service' to denote a service, practice or team.

The term 'client' has been used to denote 'patient' or 'consumer' for ease of presentation in this document. The exception is when information has been taken from another source.

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## **Part 1: Accessibility indicators**

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## 1 First contact to service wait time

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### Identifying and definitional attributes

<i>Short name:</i>	First contact to service wait time
<i>Description:</i>	The percentage of clients whose wait from first contact to first service is within the locally agreed timeframe.
<i>Dimension:</i>	Accessibility
<i>Rationale:</i>	Access is a core dimension of a strong primary care system [8]. It is associated with “ <i>continuity, comprehensiveness, quality, equity in health, population health, quality of professional life, client satisfaction, costs and strength of primary care</i> ” [10].

### Collection and usage attributes

*Computation description:* For a contact to be regarded as a ‘first contact’, it should be an approach to the service by a person (or their carer on their behalf) seeking an appointment regarding a presenting issue/ problem (i.e. as opposed to seeking information) that may be in relation to:

- an issue/ problem that has not been previously managed /treated by the service for that person
- an existing issue/problem that has not been managed / treated by the service for that person for a (locally agreed) timeframe after which a new assessment is required (e.g. 12 months).

A ‘contact’ may occur via a physical presentation of the person to request a service, or telephone call/receipt of a written request for service by the person, or a carer on their behalf. All first contacts (i.e. physical presentation, telephone call, written request) for a service should be recorded for the valid application of this indicator.

A ‘first service’ is a service for a client meeting the above criteria, and is in relation to the issue/problem for which the appointment was sought.

When the appointment is made for the client by the service, and the client subsequently changes the appointment to another date due to personal reasons, the ‘first contact’ date should be changed to reflect the date that the change was made. However, if the service changes the appointment date due to issues not initiated by the client, then the first contact date should remain.

A 'locally agreed timeframe' is one which is:

- agreed by members of the service
- informed by clinical judgement (it may also reference an external benchmark)
- may be program specific (i.e. not necessarily applicable to the whole service)
- documented by the service
- reviewed periodically to ensure that it aligns with best practice.

This indicator is best calculated for a reference period.

*Computation:*

100 x (numerator ÷ denominator)

*Numerator:*

Number of clients whose wait from first contact to first service is within the locally agreed timeframe during the reference period.

*Numerator criteria:*

Inclusions

- Clients who have received their first service during the reference period.

AND

- Whose wait time from first contact to first service is within the locally agreed timeframe.

*Denominator:*

Number of clients with a first contact during the reference period.

*Denominator criteria:*

Inclusions

- Clients who have received their first service during the reference period.

*Comments:*

This indicator has two key limitations:

- The indicator uses the first service as the 'trigger' for measuring the time from first contact to first service. This means that at the time point chosen to derive this indicator, there may be clients who are still waiting for their first service. Those clients will not be included in the results for this indicator at that time point.
- While the percentage of clients seen within the locally agreed timeframe from first contact to first service may be high, those not seen within this time period may have very long waits. This is not measured by this indicator.

## References

*Reference documents:*

Kringos, DS, Boerma, WG, Hutchinson, A, van der Zee, J & Groenewegen, PP 2010, 'The breadth of primary care: a systematic literature review of its core dimensions', *BMC Health Services Research*, vol. 10, no. 65, pp. 1-13.

Starfield, B, Shi, L & Macinko, J 2005, 'Contribution of primary care to health systems and health', *Milbank Quarterly*, vol. 83, no. 3, pp. 457-502.

## 2 First contact to service wait time for high-priority clients

### Identifying and definitional attributes

<i>Short name:</i>	First contact to service wait time for high-priority clients
<i>Description:</i>	The percentage of clients who are high priority according to locally agreed criteria, and whose wait from first contact to first service is within the locally agreed timeframe.
<i>Dimension:</i>	Accessibility
<i>Rationale:</i>	Access is a core dimension of a strong primary care system [8]. It is associated with “ <i>continuity, comprehensiveness, quality, equity in health, population health, quality of professional life, client satisfaction, costs and strength of primary care</i> ” [10].

### Collection and usage attributes

<i>Computation description:</i>	<p>For a contact to be regarded as ‘high priority’, it should be:</p> <ul style="list-style-type: none"><li>• for a client requiring imminent attention/treatment, based on clinical need (according to pre-defined criteria – see below)</li><li>• assessed as such at first contact.</li></ul> <p>Criteria used to classify clients as ‘high priority’ should be:</p> <ul style="list-style-type: none"><li>• agreed by members of the service</li><li>• documented</li><li>• reviewed periodically to ensure that they align with best practice.</li></ul> <p>If a client does not meet the criteria for ‘high priority’ at first contact, but subsequently their issue/problem exacerbates and they (or a carer) contact the service to convey the client’s new circumstances, the client should be reassessed against the criteria for ‘high priority’. If they are reclassified to this category as a result of this process, then their first contact should be changed to reflect the date on which the reassessment occurred. If the client is reassessed as not meeting the criteria for high priority, then the date of the initial contact should remain as the first contact.</p> <p>For a contact to be regarded as a ‘first contact’, it should be an approach to the service by a person (or their carer on their behalf) seeking an appointment regarding a</p>
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presenting issue/ problem (i.e. as opposed to seeking information) that may be in relation to:

- an issue/ problem that has not been previously managed /treated by the service for that person
- an existing issue/problem that has not been managed / treated by the service for that person for a (locally agreed) timeframe after which a new assessment is required (e.g. 12 months).

A 'contact' may occur via a physical presentation of the person to request a service or telephone call/receipt of a written request for service by the person, or a carer on their behalf. All first contacts (i.e. physical presentation, telephone call, written request) for a service should be recorded for the valid application of this indicator.

A 'first service' is a service for a client meeting the above criteria, and is in relation to the issue/problem for which the first contact was sought.

When the appointment is made for the client by the service, and the client subsequently changes the appointment to another time due to personal reasons, the 'first contact' date should be changed to reflect the time that the change was made. However, if the service changes the appointment date due to issues not initiated by the client, then the first contact date should remain as is.

A 'locally agreed timeframe' is one which is:

- agreed by members of the service
- informed by clinical judgement (it may also reference an external benchmark)
- may be program specific (i.e. not necessarily applicable to the whole service)
- documented by the service
- reviewed periodically to ensure that it aligns with best practice.

This indicator is best calculated for a reference period.

*Computation:*

$100 \times (\text{numerator} \div \text{denominator})$

*Numerator:*

Number of high priority clients whose wait from first contact to first service is within the locally agreed timeframe during the reference period.

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<i>Numerator criteria:</i>	<u>Inclusions</u> <ul style="list-style-type: none"><li>• High priority clients who have received their first service during the reference period.</li></ul> AND <ul style="list-style-type: none"><li>• Whose wait time from first contact to first service is within the locally agreed timeframe.</li></ul>
<i>Denominator:</i>	Number of high priority clients with a first contact during the reference period.
<i>Denominator criteria:</i>	<u>Inclusions</u> <ul style="list-style-type: none"><li>• High priority clients who have received their first service during the reference period.</li></ul>
<i>Comments:</i>	This indicator has two key limitations: <ul style="list-style-type: none"><li>• The indicator uses the first service as the ‘trigger’ for measuring the time from first contact to first service. This means that at the time point chosen to derive this indicator, there may be clients who are still waiting for their first service. Those clients will not be included in the results for this indicator at that time point.</li><li>• While the percentage of clients being seen within the locally agreed timeframe from first contact to first service may be high, those not seen within this time period may have very long waits. This is not measured by this indicator.</li></ul>

## References

*Reference documents:* No further references.

### 3 Eligible clients who received an appointment

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#### Identifying and definitional attributes

<i>Short name:</i>	Eligible clients who received an appointment
<i>Description:</i>	The percentage of eligible clients requesting an appointment who received an appointment.
<i>Dimension:</i>	Accessibility
<i>Rationale:</i>	Access is a core dimension of a strong primary care system and is multi-faceted. Increasing unmet demand over time may signal the need for review of policy or processes in the service or broader region.

#### Collection and usage attributes

<i>Computation description:</i>	<p>An 'appointment' is a mutually agreed time between the client and the service for the client to receive a service.</p> <p>An 'eligible' client is one that meets the 'intake criteria' for the service.</p> <p>'Intake criteria' in turn need to be:</p> <ul style="list-style-type: none"><li>• agreed by members of the service</li><li>• documented</li><li>• reviewed periodically to ensure that they align with best practice.</li></ul> <p>A 'request' for an appointment may occur as an approach to the service by a person physically or via telephone call/receipt of a written request (by the client, or a carer on behalf of the client). All requests for an appointment (i.e. physical presentation, telephone call, written request) should be recorded for the valid application of this indicator.</p> <p>For a client to have 'received' an appointment, they need to have secured a mutually agreed time between the service and themselves for an assessment and/or treatment of their presenting issue/problem. A record of whether or not an appointment has been made for each eligible client following a request for one also needs to be kept for the valid application of this indicator.</p> <p>This indicator is best calculated for a reference period.</p>
<i>Computation:</i>	$100 \times (\text{numerator} \div \text{denominator})$

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*Numerator:* Number of eligible clients requesting an appointment who received an appointment during the reference period.

*Numerator criteria:* Inclusions

- Eligible clients who requested an appointment during the reference period.

AND

- Who have received an appointment during the reference period.

*Denominator:* Number of eligible clients requesting an appointment during the reference period.

*Denominator criteria:* Inclusions

- Eligible clients requesting an appointment during the reference period.

*Comments:* For this indicator to be reliable, record keeping of requests for appointments by clients and recording of appointments needs to be thorough.

## **References**

*Reference documents:* No further references.



## 4 Non-attendance at appointment

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### Identifying and definitional attributes

<i>Short name:</i>	Non-attendance at appointment
<i>Description:</i>	The percentage of clients who did not arrive for an appointment who were followed up.
<i>Dimension:</i>	Accessibility
<i>Rationale:</i>	Follow-up of non-attendance can provide important information for services about the reasons for this. For example, client satisfaction with the service and/or accessibility.

### Collection and usage attributes

<i>Computation description:</i>	<p>An 'appointment' is a mutually agreed time between the client and the service for the client to receive a service.</p> <p>'Did not arrive for an appointment' refers to situations where the client does not turn up for a booked appointment, and has not given notice at any time prior to the appointment of non-attendance.</p> <p>'Followed up' means that the client was contacted by the service (by person-to-person telephone contact, text message, letter, card or other means) after they did not arrive for an appointment.</p> <p>This indicator is best calculated for a reference period.</p>
<i>Computation:</i>	$100 \times (\text{numerator} \div \text{denominator})$
<i>Numerator:</i>	Number of clients that did not arrive for an appointment during the reference period who were followed up.
<i>Numerator criteria:</i>	<p><u>Inclusions</u></p> <ul style="list-style-type: none"><li>• Clients who had an appointment during the reference period.</li></ul> <p>AND</p> <ul style="list-style-type: none"><li>• Who did not arrive for the appointment.</li></ul> <p>AND</p> <ul style="list-style-type: none"><li>• Who did not give notice prior to the appointment of non-attendance.</li></ul> <p>AND</p> <ul style="list-style-type: none"><li>• Who were followed up.</li></ul>

*Denominator:* Number of clients that did not arrive for an appointment during the reference period.

*Denominator criteria:*

Inclusions

- Clients who had an appointment during the reference period.
- AND
- Who did not arrive for the appointment.
- AND
- Who did not give notice prior to the appointment of non-attendance.

*Comments:* For this indicator to be reliable, record keeping of booked appointments, tracking of changes to appointments, and documentation of follow-up of clients need to be thorough.

**References**

*Reference documents:* No further references.

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## **Part 2: Appropriateness indicators**

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## 5 Health summary

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### Identifying and definitional attributes

<i>Short name:</i>	Health summary
<i>Description:</i>	The percentage of regular clients with a comprehensive health summary, including information on allergies, current/past medical history, medications and risk factors, which was updated within the previous 12 months.
<i>Dimension:</i>	Appropriateness
<i>Rationale:</i>	A comprehensive health summary provides essential health information to better support continuity of care.

### Collection and usage attributes

<i>Computation description:</i>	A 'comprehensive health summary' should: <ul style="list-style-type: none"><li>• be documented in the client's record (electronic or paper)</li><li>• include information on:<ul style="list-style-type: none"><li>• allergies (or indicating 'nil' allergies)</li><li>• current/past medical history</li><li>• medication history</li><li>• risk factors</li></ul></li></ul> OR <ul style="list-style-type: none"><li>• information as required under other guidelines / obligations applicable to the service regarding the content of the health summary.</li></ul>
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The health summary can be maintained by a practitioner at the primary health care service generating this indicator, or it may be maintained by another health professional outside of the service. In both cases, it should meet the above criteria for a 'comprehensive health summary'.

'Updated in the previous 12 months' means that there is a comprehensive health summary documented on the client's record that is dated no more than 12 months prior to the reference period for the indicator.

'Regular clients' are clients defined as such by the primary health care service. The definition is generally based on a minimum number of visits over a specific period of time. As a guide, someone who has visited the primary health care

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service three or more times in the previous two years may be regarded as a regular client<sup>1</sup>.

This indicator is best calculated for a reference period.

*Computation:*

100 x (numerator ÷ denominator)

*Numerator:*

Number of regular clients within the reference period with a comprehensive health summary, which was updated within the previous 12 months.

*Numerator criteria:*

Inclusions

- Regular clients within the reference period, with a comprehensive health summary.

AND

- Whose summary was updated in the previous 12 months.

*Denominator:*

Number of regular clients within the reference period with a comprehensive health summary.

*Denominator criteria:*

Inclusions

- Regular clients within the reference period, with a comprehensive health summary.

*Comments:*

No further comments.

**References**

*Reference documents:*

No further references.

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<sup>1</sup> See data element concept '*Person—regular client indicator*' [METeOR identifier 436653 <http://meteor.aihw.gov.au/content/index.phtml/itemId/181162>].

## 6 Timely initial needs identification

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### Identifying and definitional attributes

<i>Short name:</i>	Timely initial needs identification
<i>Description:</i>	The percentage of clients whose initial needs identification was conducted, within the locally agreed timeframe.
<i>Dimension:</i>	Appropriateness
<i>Rationale:</i>	<i>“Initial needs identification promotes client centred problem identification and service coordination” [11] (p. 3)</i>

### Collection and usage attributes

*Computation description:* ‘Initial needs identification’ is *“an initial assessment process where the underlying issues as well as presenting issues are uncovered to the extent possible. It is not a diagnostic process but is a determination of the consumer’s risk, eligibility and priority for service and a balancing of the service capacity and the consumer needs.” [12] (p. 34)*

Initial needs identification:

- begins within a locally agreed timeframe, at or following referral or intake<sup>2</sup>, however, needs identification can be ongoing [13]
- is an approach agreed by the service, using or based on a standard tool/ set of tools
- is appropriate to the service being provided
- is reviewed periodically to ensure that it aligns with best practice.

A ‘locally agreed timeframe’ is one which is:

- agreed by members of the service
- informed by clinical judgement (it may also reference an external benchmark)
- may be program specific (i.e. not necessarily applicable to the whole service)

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<sup>2</sup> Initial needs identification may begin at referral or intake, but information is progressively collected and updated as the client moves through the service. It should be noted that initial needs identification *“is a live process that involves all of the contacts a person has with the service system and that continues beyond initial contact” [13].*

- documented by the service
- reviewed periodically to ensure that it aligns with best practice.

This indicator is best calculated for a reference period.

*Computation:*

100 x (numerator ÷ denominator)

*Numerator:*

Number of clients who had an initial needs identification conducted within the locally agreed timeframe during the reference period.

*Numerator criteria:*

Inclusions

- Clients who had an initial needs identification conducted during the reference period.

AND

- Whose initial needs identification was within the locally agreed timeframe.

*Denominator:*

Number of clients who had an initial needs identification conducted during the reference period.

*Denominator criteria:*

Inclusions

- Clients who had an initial needs identification conducted during the reference period.

*Comments:*

This indicator measures *timely* initial needs identification. It does not measure the quality or completeness of the initial needs identification.

Also, this indicator may not be relevant to all services. Some may choose not to do initial needs identifications, or it may be inappropriate for the type of service.

## References

*Reference documents:*

Aged Community and Mental Health Division (2001). *Better Access to Services A Policy and Operational Framework*. Melbourne, Victorian Government Department of Human Services.

Owen, A & Eagar, K 2002, *Initial Needs Identification in South Australian Primary Care: How and Why*, Centre for Health Service Development, University of Wollongong, Sydney.

## 7 Client assessment

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### Identifying and definitional attributes

<i>Short name:</i>	Client assessment
<i>Description:</i>	The percentage of clients assessed, using validated screening and assessment tools appropriate to the scope of service and the client's needs.
<i>Dimension:</i>	Appropriateness
<i>Rationale:</i>	Client assessment will inform the development of an appropriate care plan.

### Collection and usage attributes

<i>Computation description:</i>	<p>Client 'assessment' is "a <i>decision-making methodology that collects, weighs and interprets relevant information about the client. Assessment is not an end in itself but part of a process of delivering care and treatment. It is an investigative process using professional and interpersonal skills to uncover relevant issues and to develop a care plan.</i>" [12] (p. 29).</p> <p>Clients should receive a complete assessment, considering all relevant health issues, at the beginning of each phase of care/treatment. This should subsequently be reviewed as appropriate for the service and the client's needs, but no longer than annually.</p> <p>Client assessment should be undertaken using validated screening and assessment tools appropriate to the scope of service and the client's needs. The tools may be specific to a profession, but some are used across disciplines. The tools should be reviewed periodically to ensure that the ones used align with best practice.</p> <p>This indicator is best calculated for a reference period.</p>
<i>Computation:</i>	$100 \times (\text{numerator} \div \text{denominator})$
<i>Numerator:</i>	Number of clients presenting for a first service during the reference period who had an assessment undertaken using validated screening and assessment tools appropriate to the scope of service and the client's needs.



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<i>Numerator criteria:</i>	<u>Inclusions</u> <ul style="list-style-type: none"><li>• Clients presenting for a first service during the reference period.</li></ul> AND <ul style="list-style-type: none"><li>• Who had an assessment undertaken using validated screening and assessment tools appropriate to the scope of service and the client's needs.</li></ul>
<i>Denominator:</i>	Number of clients presenting for a first service during the reference period.
<i>Denominator criteria:</i>	<u>Inclusions</u> <ul style="list-style-type: none"><li>• Clients who have received their first service during the reference period.</li></ul>
<i>Comments:</i>	Although it is important to use validated assessment and screening tools, “[p]ractice should continue to be guided by practitioners’ clinical and professional expertise and not by the application of specific data collection forms and assessment tools.” [12] (p. 11)
<b>References</b>	
<i>Reference documents:</i>	Aged Community and Mental Health Division (2001). <i>Better Access to Services A Policy and Operational Framework</i> . Melbourne, Victorian Government Department of Human Services.

## 8 Complete care plan

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### Identifying and definitional attributes

<i>Short name:</i>	Complete care plan
<i>Description:</i>	The percentage of clients with multiple or complex needs who have a complete care plan.
<i>Dimension:</i>	Appropriateness
<i>Rationale:</i>	Care plans are linked to improved client outcomes through encouraging and empowering client self-management [14].

### Collection and usage attributes

*Computation description:* A 'complete care plan' is a documented plan of care for a specific client that contains all of the following elements:

- client stated/agreed issues/problems
- client stated/agreed objectives/goals
- client stated/agreed strategies/action
- review date of care plan
- timeframe for attainment of objectives/goals
- responsibilities for implementing strategies/action
- participants in development of care plan
- consumer acknowledgement (signed or verbal acknowledgement recorded)
- date care plan developed
- goal/objective attainment.

[15] (p. 9)

'Multiple or complex needs' refers to the clients':

- breadth of need (i.e. the client has multiple needs - more than one - that are interrelated or interconnected)
- depth of need (i.e. the client has profound, severe, serious or intense needs)
- complex needs (i.e. the client has multiple, interlocking needs that span health and social issues.

[16] (p. ii)

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This indicator is best calculated for a reference period.

*Computation:* 100 x (numerator ÷ denominator)

*Numerator:* Number of clients with multiple or complex needs during the reference period who have a complete care plan.

*Numerator criteria:* Inclusions

- Clients with multiple or complex needs documented on the patient record during the reference period.

AND

- Who have a complete care plan.

*Denominator:* Number of clients with multiple or complex needs during the reference period.

*Denominator criteria:* Inclusions

- Clients with multiple or complex needs documented on the patient record during the reference period.

*Comments:* No further comments.

## **References**

*Reference documents:* Victorian Healthcare Association 2008, *Clinical Indicators in Community Health*, Victorian Healthcare Association, Melbourne.

## 9 Recalls and reminders

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### Identifying and definitional attributes

<i>Short name:</i>	Recalls and reminders
<i>Description:</i>	The percentage of clients with a complete care plan who were given recalls or reminders as recommended in the care plan.
<i>Dimension:</i>	Appropriateness
<i>Rationale:</i>	Recall and reminder systems, along with other strategies, are associated with higher rates of delivery of preventive services in primary care services [17].

### Collection and usage attributes

*Computation description:* 'Recalls' or 'reminders' are systems or processes reminding clients of upcoming appointments or preventative measures due (e.g. immunisations, systematic preventive care for diabetes), or overdue preventative measures. They can be delivered by telephone (person-to-person or text), letter, postcard or other technology/means.

A 'complete care plan' is a documented plan of care for a specific client that contains all of the following elements:

- client stated/agreed issues/problems
- client stated/agreed objectives/goals
- client stated/agreed strategies/action
- review date of care plan
- timeframe for attainment of objectives/goals
- responsibilities for implementing strategies/action
- participants in development of care plan
- consumer acknowledgement (signed or verbal acknowledgement recorded)
- date care plan developed
- goal/objective attainment.

[15] (p. 9)

This indicator is best calculated for a reference period.

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<i>Computation:</i>	100 x (numerator ÷ denominator)
<i>Numerator:</i>	Number of clients with a complete care plan receiving a recall or reminder as recommended in the care plan, during the reference period.
<i>Numerator criteria:</i>	<u>Inclusions</u> <ul style="list-style-type: none"><li>• Clients with a complete care plan, with a recommended recall or reminder documented in the plan.</li></ul> AND <ul style="list-style-type: none"><li>• Who receive a recall or reminder during the reference period.</li></ul>
<i>Denominator:</i>	Number of clients with a complete care plan for whom there is a recommended recall or reminder during the reference period.
<i>Denominator criteria:</i>	<u>Inclusions</u> <ul style="list-style-type: none"><li>• Clients with a complete care plan.</li></ul> AND <ul style="list-style-type: none"><li>• For whom there is a recommended recall or reminder in the plan during the reference period.</li></ul>
<i>Comments:</i>	No further comments.

**References**

*Reference documents:* Victorian Healthcare Association 2008, *Clinical Indicators in Community Health*, Victorian Healthcare Association, Melbourne.

## 10 Adherence to clinical guidelines

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### Identifying and definitional attributes

<i>Short name:</i>	Adherence to clinical guidelines
<i>Description:</i>	The percentage of clients with complete care plans that are in accordance with agreed clinical guidelines.
<i>Dimension:</i>	Appropriateness
<i>Rationale:</i>	A care plan that is in accordance with agreed clinical guidelines helps to ensure that clients are getting the most appropriate care that aligns with the best, currently available evidence, and ensures that the care being provided is of a high standard.

### Collection and usage attributes

*Computation description:* A 'complete care plan' is a documented plan of care for a specific client that contains all of the following elements:

- client stated/agreed issues/problems
- client stated/agreed objectives/goals
- client stated/agreed strategies/action
- review date of care plan
- timeframe for attainment of objectives/goals
- responsibilities for implementing strategies/action
- participants in development of care plan
- consumer acknowledgement (signed or verbal acknowledgement recorded)
- date care plan developed
- goal/objective attainment.

[15] (p. 9)

'Agreed clinical guidelines':

- describe appropriate care based on the best currently available research
- set the standards for service in relation to a specific health problem/issue and reduce inappropriate variation in practice
- are applicable to this service, as agreed by members of the service

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- have been developed by members of the service or an external agency/group
- are documented
- are reviewed at specified intervals by members of the service for their continued validity.

This indicator is best calculated for a reference period.

*Computation:*

100 x (numerator ÷ denominator)

*Numerator:*

Number of clients during the reference period with a complete care plan that is in accordance with agreed clinical guidelines.

*Numerator criteria:*

Inclusions

- Clients who have a complete care plan during the reference period.

AND

- The care plan is in accordance with agreed clinical guidelines.

*Denominator:*

Number of clients during the reference period with a complete care plan.

*Denominator criteria:*

Inclusions

- Clients who have a complete care plan during the reference period.

*Comments:*

No further comments.

**References**

*Reference documents:*

Victorian Healthcare Association 2008, *Clinical Indicators in Community Health*, Victorian Healthcare Association, Melbourne.

## 11 Timely review of care plan

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### Identifying and definitional attributes

<i>Short name:</i>	Timely review of care plan
<i>Description:</i>	The percentage of clients with a recorded care plan that is reviewed within four weeks of the planned review date.
<i>Dimension:</i>	Appropriateness
<i>Rationale:</i>	Timely review of a client's care plan helps to ensure that the care plan continues to meet the client's needs.

### Collection and usage attributes

<i>Computation description:</i>	<p>A 'complete care plan' is a documented plan of care for a specific client that contains <u>all</u> of the following elements:</p> <ul style="list-style-type: none"><li>• client stated/agreed issues/problems</li><li>• client stated/agreed objectives/goals</li><li>• client stated/agreed strategies/action</li><li>• review date of care plan</li><li>• timeframe for attainment of objectives/goals</li><li>• responsibilities for implementing strategies/action</li><li>• participants in development of care plan</li><li>• consumer acknowledgement (signed or verbal acknowledgement recorded)</li><li>• date care plan developed</li><li>• goal/objective attainment.</li></ul>
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[15] (p. 9)

'Reviewed within four weeks of the planned review date' means that:

- the care plan has been reviewed no longer than four weeks following the date of review indicated in the plan
- there is documented evidence in the care plan of this review having taken place.

This indicator is best calculated for a reference period.

<i>Computation:</i>	100 x (numerator ÷ denominator)
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<i>Numerator:</i>	Number of clients during the reference period with a complete care plan that has been reviewed within four weeks of the planned review date.
<i>Numerator criteria:</i>	<p><u>Inclusions</u></p> <ul style="list-style-type: none"><li>• Clients who have a complete care plan during the reference period.</li></ul> <p>AND</p> <ul style="list-style-type: none"><li>• The care plan has been reviewed within four weeks post the planned review date, as indicated in the plan.</li></ul>
<i>Denominator:</i>	Number of clients during the reference period with a complete care plan, for whom a review of their plan is indicated during the reference period.
<i>Denominator criteria:</i>	<p><u>Inclusions</u></p> <ul style="list-style-type: none"><li>• Clients who have a complete care plan during the reference period.</li></ul> <p>AND</p> <ul style="list-style-type: none"><li>• Clients for whom a review of their care plan <u>is</u> indicated during the reference period.</li></ul> <p><u>Exclusions</u></p> <ul style="list-style-type: none"><li>• Clients for whom a review of their care plan is <u>not</u> indicated during the reference period.</li></ul>
<i>Comments:</i>	No further comments.

**References**

<i>Reference documents:</i>	Victorian Healthcare Association 2008, <i>Clinical Indicators in Community Health</i> , Victorian Healthcare Association, Melbourne.
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## 12 Medication review

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### Identifying and definitional attributes

<i>Short name:</i>	Medication review
<i>Description:</i>	The percentage of regular clients whose medicines have been reviewed by a healthcare practitioner in accordance with locally agreed guidelines.
<i>Dimension:</i>	Appropriateness
<i>Rationale:</i>	Prescribing of multiple medications is a potential issue for some clients, which can contribute to significant morbidity and mortality due to contraindications and/or overdose.

### Collection and usage attributes

<i>Computation description:</i>	Medication review “ <i>is a critical review of all prescribed, over-the-counter and complementary medications undertaken to optimise therapy and minimise medication-related problems</i> ” [18].
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‘Medicines have been reviewed’ means that:

- an accurate medication history of the client has been obtained
- the health practitioner has examined the purpose and actual use of each of the client’s medications
- there is shared health practitioner-client confirmation of the findings and follow up actions
- follow-up is actioned, as indicated.

(Adapted from [19]).

Medication review and follow-up may require referral of the client to a community pharmacy/accredited pharmacist, in which case the health practitioner must provide the relevant clinical information required for this review, with the client’s consent.

‘Locally agreed guidelines’ are:

- agreed by members of the service
- informed by clinical judgement (they may also reference external guidelines)
- documented by the service
- reviewed periodically to ensure that it aligns with

best practice.

'Regular clients' are clients defined as such by the primary health care service. The definition is generally based on a minimum number of visits over a specific period of time. As a guide, someone who has visited the primary health care service three or more times in the previous two years may be regarded as a regular client<sup>3</sup>.

This indicator is best calculated for a reference period.

*Computation:*

100 x (numerator ÷ denominator)

*Numerator:*

Number of regular clients during the reference period who have had their medicines reviewed according to locally agreed timeframes.

*Numerator criteria:*

Inclusions

- Regular clients during the reference period who have had their medicines reviewed according to locally agreed guidelines.

*Denominator:*

Number of regular clients during the reference period.

*Denominator criteria:*

Inclusions

- Regular clients during the reference period.

*Comments:*

Medication review should only be conducted by a pharmacist, or a GP in conjunction with a pharmacist.

## References

*Reference documents:*

No further references.

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<sup>3</sup> See data element concept '*Person—regular client indicator*' [METeOR identifier 436653 <http://meteor.aihw.gov.au/content/index.phtml/itemId/181162>].

## 13 Interpreter services

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### Identifying and definitional attributes

<i>Short name:</i>	Interpreter services
<i>Description:</i>	The percentage of clients requiring an interpreter who were provided with interpreter services at the first service.
<i>Dimension:</i>	Appropriateness
<i>Rationale:</i>	<i>“Language barriers in the healthcare setting can lead to problems such as delay or denial of services, issues with medication management, and underutilization of preventive services. Difficulty in communication also may limit clinicians’ ability to understand [client] symptoms and effectively provide treatment. Moreover, existing research suggests the quality of communication between patients and providers is strongly associated with providers’ ability to deliver better and safer care for [limited English proficiency] [clients]. Language services, such as translation and interpretation, can facilitate this communication and thus improve healthcare quality, the patient experience, adherence to recommended care, and ultimately health outcomes.” [20] (p. 1)</i>

### Collection and usage attributes

<i>Computation description:</i>	<p>A ‘first service’ is a service for:</p> <ul style="list-style-type: none"><li>• an issue/ problem that has not been previously managed /treated by the service for that client</li><li>• an existing issue/problem that has not been managed / treated by the service for that client for a (locally agreed) timeframe after which a new assessment is required (e.g. 12 months).</li></ul> <p>‘Clients requiring an interpreter’ means that the client (or carer, on their behalf), indicates that the client requires an interpreter at the time of making the appointment for the first service.</p> <p>This indicator is best calculated for a reference period.</p>
<i>Computation:</i>	100 x (numerator ÷ denominator)
<i>Numerator:</i>	Number of clients indicating that they required an interpreter who were provided with interpreter services at the first service, during the reference period.

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<i>Numerator criteria:</i>	<u>Inclusions</u> <ul style="list-style-type: none"><li>• Clients who have received their first service during the reference period.</li></ul> AND <ul style="list-style-type: none"><li>• Who indicated that they required an interpreter prior to the first service.</li></ul> AND <ul style="list-style-type: none"><li>• Who were provided with interpreter services at the first service.</li></ul>
<i>Denominator:</i>	Number of clients indicating that they required an interpreter at the first service prior to the delivery of the first service, during the reference period.
<i>Denominator criteria:</i>	<u>Inclusions</u> <ul style="list-style-type: none"><li>• Clients who have received their first service during the reference period.</li></ul> AND <ul style="list-style-type: none"><li>• Who indicated that they required an interpreter prior to the service.</li></ul>
<i>Comments:</i>	No further comments.
<b>References</b>	
<i>Reference documents:</i>	No further references.

## 14 Cultural and linguistic diversity awareness/sensitivity

### Identifying and definitional attributes

<i>Short name:</i>	Cultural and linguistic diversity awareness/sensitivity
<i>Description:</i>	The percentage of the service's workforce who have received cultural competency training.
<i>Dimension:</i>	Appropriateness
<i>Rationale:</i>	<i>"Culturally competent healthcare systems—those that provide culturally and linguistically appropriate services—have the potential to reduce racial and ethnic health disparities. When clients do not understand what their healthcare providers are telling them, and providers either do not speak the client's language or are insensitive to cultural differences, the quality of health care can be compromised."</i> [21] (p. 68)

### Collection and usage attributes

<i>Computation description:</i>	<p><i>'Cultural competence' is "the ability of healthcare providers and healthcare organizations to understand and respond effectively to the cultural and language needs brought by the patient to the healthcare encounter. Cultural competence requires organizations and their personnel to do the following: (1) value diversity; (2) assess themselves; (3) manage the dynamics of difference; (4) acquire and institutionalize cultural knowledge; and (5) adapt to diversity and the cultural contexts of individuals and communities served."</i> [22] (p. 9)</p> <p>Cultural competency training is training <i>"designed to (1) enhance self-awareness of attitudes toward people of different racial and ethnic groups; (2) improve care by increasing knowledge about the cultural beliefs and practices, attitudes toward health care, healthcare-seeking behaviors, and the burden of various diseases in different populations served; and (3) improve skills such as communication"</i> [21] (p. 74).</p> <p>This indicator is best calculated for a selected time point.</p>
<i>Computation:</i>	100 x (numerator ÷ denominator)
<i>Numerator:</i>	Number of staff with client contact who have received cultural competency training at a particular point in time.

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*Numerator criteria:*                      Inclusions

- Staff with client contact who have received cultural competency training at a particular point in time.

*Denominator:*                              Number of staff with client contact at a particular point in time.

*Denominator criteria:*                      Inclusions

- All staff of the service at a particular point in time who have any contact with clients (including, for example, administrative staff).

Exclusions

- Staff who do not have contact with clients.

*Comments:*                                      No further comments.

**References**

*Reference documents:*                      Anderson, LM, Scrimshaw, SC, Fullilove, MT, Fielding, JE & Normand, J 2003, 'Culturally competent healthcare systems: A systematic review', *American Journal of Preventive Medicine*, vol. 24, no. 3, Supplement, pp. 68-79.

The Joint Commission 2010, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*, The Joint Commission, Oakbrook Terrace, IL,  
<<http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf>>.

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## **Part 3: Acceptability/client participation indicators**

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## 15 Self-rated health

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### Identifying and definitional attributes

<i>Short name:</i>	Self-rated health
<i>Description:</i>	The percentage of regular clients who have completed a validated self-rated health status instrument that informs their health care.
<i>Dimension:</i>	Acceptability/client participation
<i>Rationale:</i>	<i>“Usefulness of self-rated health in predicting mortality and functional decline has been well documented in studies conducted in Western and Asian nations.” [23] (p. 2)</i>

### Collection and usage attributes

*Computation description:* A ‘self-rated health status instrument’ is an instrument that is used to measure self-perceived or subjective morbidity amongst clients. It should provide valuable information to the healthcare practitioner about the client’s perceived health status, and should be used to inform the client’s health care.

A ‘validated’ instrument is one that has been rigorously tested and approved for use for measuring self-perceived health status. It also means that the instrument is recognised within the practitioner’s profession as being suitable for this purpose, or that the instrument is recognised for use across professions.

The instrument may be completed by the client, or by the client’s carer/advocate if the client is unable to complete the instrument themselves.

‘Regular clients’ are clients defined as such by the primary health care service. The definition is generally based on a minimum number of visits over a specific period of time. As a guide, someone who has visited the primary health care service three or more times in the previous two years may be regarded as a regular client<sup>4</sup>.

This indicator is best calculated for a reference period.

*Computation:* 100 x (numerator ÷ denominator)

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<sup>4</sup> See data element concept ‘*Person—regular client indicator*’ [METeOR identifier 436653 <http://meteor.aihw.gov.au/content/index.phtml/itemId/181162>].

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*Numerator:* Number of regular clients who have completed a validated self-rated health status instrument, during the reference period.

*Numerator criteria:* Inclusions

- Regular clients.

AND

- Who have completed a validated self-rated health status instrument.

*Denominator:* Number of regular clients during the reference period.

*Denominator criteria:* Inclusions

- Regular clients.

*Comments:* Health care can be improved when clients and carers share with their healthcare practitioner issues that may impact on their compliance with treatment plans.

## **References**

*Reference documents:* Murata, C, Kondo, T, Tamakoshi, K, Yatsuya, H & Toyoshima, H 2006, 'Determinants of self-rated health: Could health status explain the association between self-rated health and mortality?', *Archives of Gerontology and Geriatrics*, vol. 43, no. 3, pp. 369-80.

National Safety and Quality Health Service Standard 2, from: Australian Commission on Safety and Quality in Health Care 2011, *National Safety and Quality Health Service Standards*, ACSQHC, Sydney, <<http://www.safetyandquality.gov.au/wp-content/uploads/2011/01/NSQHS-Standards-Sept2011.pdf>>.

## 16 Patient experience survey

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### Identifying and definitional attributes

<i>Short name:</i>	Patient experience survey
<i>Description:</i>	The percentage of regular clients who have been given a patient experience survey within the previous 12 months, (using a standard patient experience instrument, that informs the service's quality improvement).
<i>Dimension:</i>	Acceptability/client participation
<i>Rationale:</i>	Patient experience is closely related to and influences care effectiveness and safety.

### Collection and usage attributes

<i>Computation description:</i>	<p>A 'patient experience survey' is a survey of the client's direct experience of specific aspects of treatment and/or care. The survey may be administered as a written survey (either as a paper form or online) to the client (or their carer), or as a face-to-face or telephone interview with the client (or their carer). Patient experience surveys used by the service should:</p> <ul style="list-style-type: none"><li>• include a standard set of questions that are asked of each client</li><li>• measure how well the service is meeting clients' needs</li><li>• be designed to draw attention to aspects of treatment/care where improvements can be made</li><li>• be documented</li><li>• be agreed to by members of the service</li><li>• be reviewed at defined intervals (e.g. annually).</li></ul> <p>'Regular clients' are clients defined as such by the primary health care service. The definition is generally based on a minimum number of visits over a specific period of time. As a guide, someone who has visited the primary health care service three or more times in the previous two years may be regarded as a regular client<sup>5</sup>.</p> <p>This indicator is best calculated for a reference period</p>
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<sup>5</sup> See data element concept '*Person—regular client indicator*' [METeOR identifier 436653 <http://meteor.aihw.gov.au/content/index.phtml/itemId/181162>].

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(specifically, a 12-month period).

*Computation:*

100 x (numerator ÷ denominator)

*Numerator:*

Number of regular clients who have been given a patient experience survey within the previous 12 months.

*Numerator criteria:*

Inclusions

- Regular clients.
- AND
- Who have been given a patient experience survey within the previous 12 months.

*Denominator:*

Number of regular clients in the last 12 months.

*Denominator criteria:*

Inclusions

- Regular clients in the last 12 months.

*Comments:*

No further comments.

**References**

*Reference documents:*

No further references.

## 17 Patient experience survey response rate

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### Identifying and definitional attributes

<i>Short name:</i>	Patient experience survey response rate
<i>Description:</i>	The percentage of regular clients who have responded to a patient experience survey within the previous 12 months (using a standard patient experience instrument, that informs the service's quality improvement).
<i>Dimension:</i>	Acceptability/client participation
<i>Rationale:</i>	Patient experience is closely related to and influences care effectiveness and safety.

### Collection and usage attributes

*Computation description:* A 'patient experience survey' is a survey of the client's direct experience of specific aspects of treatment and/or care. The survey may be administered as a written survey (either as a paper form or online) to the client (or their carer), or as a face-to-face or telephone interview with the client (or their carer). Patient experience surveys used by the service should:

- include a standard set of questions that are asked of each client
- measure how well the service is meeting clients' needs
- be designed to draw attention to aspects of treatment/care where improvements can be made
- be documented
- be agreed to by members of the service
- be reviewed at defined intervals (e.g. annually).

'Responded to a patient experience survey' means that the client (or carer, on the client's behalf) has:

- completed the service's paper survey or online patient experience form

OR

- participated in a face-to-face or telephone interview to answer the service's standard set of patient experience questions.

'Regular clients' are clients defined as such by the primary health care service. The definition is generally based on a minimum number of visits over a specific period of time. As a guide, someone who has visited the primary health care service three or more times in the previous two years may be regarded as a regular client<sup>6</sup>.

This indicator is best calculated for a reference period (specifically, a 12-month period).

*Computation:*

100 x (numerator ÷ denominator)

*Numerator:*

Number of regular clients who have responded to a patient experience survey within the previous 12 months.

*Numerator criteria:*

Inclusions

- Regular clients.
- AND
- Who have responded to a patient experience survey within the previous 12 months.

*Denominator:*

Number of regular clients who have been given a patient experience survey within the previous 12 months.

*Denominator criteria:*

Inclusions

- Regular clients.
- AND
- Who have been given a patient experience survey within the previous 12 months.

*Comments:*

No further comments.

**References**

*Reference documents:*

No further references.

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<sup>6</sup> See data element concept '*Person—regular client indicator*' [METeOR identifier 436653 <http://meteor.aihw.gov.au/content/index.phtml/itemId/181162>].

## 18 Satisfaction with patient experience

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### Identifying and definitional attributes

<i>Short name:</i>	Satisfaction with patient experience
<i>Description:</i>	The percentage of regular clients who are very satisfied with specified elements of their patient experience within the previous 12 months (using a standard patient experience instrument).
<i>Dimension:</i>	Acceptability/client participation
<i>Rationale:</i>	Patient experience is closely related to and influences care effectiveness and safety.

### Collection and usage attributes

*Computation description:* A 'patient experience survey' is a survey of the client's direct experience of specific aspects of treatment and/or care. The survey may be administered as a written survey (either as a paper form or online) to the client (or their carer), or as a face-to-face or telephone interview with the client (or their carer). Patient experience surveys used by the service should:

- include a standard set of questions that are asked of each client
- measure how well the service is meeting clients' needs
- be designed to draw attention to aspects of treatment/care where improvements can be made
- be documented
- be agreed to by members of the service
- be reviewed at defined intervals (e.g. annually).

'Very satisfied with specified elements of their patient experience' means that the client responds 'very satisfied' (or equivalent, e.g. if the instrument uses a numerical scale, such as a Likert scale, or other wording<sup>7</sup>) to most<sup>8</sup> dimensions of experience being measured by the survey.

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<sup>7</sup> In cases where a numerical rating scale or other wording other than 'very satisfied' is used by the instrument, the level equivalent to 'very satisfied' should be selected and agreed to by the service, and documented as such.

'Regular clients' are clients defined as such by the primary health care service. The definition is generally based on a minimum number of visits over a specific period of time. As a guide, someone who has visited the primary health care service three or more times in the previous two years may be regarded as a regular client<sup>9</sup>.

This indicator is best calculated for a reference period (specifically, a 12-month period).

*Computation:*

100 x (numerator ÷ denominator)

*Numerator:*

Number of regular clients who are very satisfied with specified elements of their patient experience within the previous 12 months.

*Numerator criteria:*

Inclusions

- Regular clients.
- AND
- Who are very satisfied with specified elements of their patient experience within the previous 12 months.

*Denominator:*

Number of regular clients who have responded to a patient experience survey within the previous 12 months.

*Denominator criteria:*

Inclusions

- Regular clients.
- AND
- Who have responded to a patient experience survey within the previous 12 months.

*Comments:*

No further comments.

## References

*Reference documents:*

No further references.

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<sup>8</sup> The number of dimensions constituting 'most' dimensions should also be locally agreed.

<sup>9</sup> See data element concept '*Person—regular client indicator*' [METeOR identifier 436653 <http://meteor.aihw.gov.au/content/index.phtml/itemId/181162>].



## 19 Client / carer complaints response

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### Identifying and definitional attributes

<i>Short name:</i>	Client / carer complaints response
<i>Description:</i>	The percentage of client and carer complaints responded to within the service's nominated timeframe from receipt of complaint.
<i>Dimension:</i>	Acceptability/client participation
<i>Rationale:</i>	<i>"Comments and complaints from consumers provide unique information about their needs and the quality of care they receive. Open discussion of consumers' concerns helps healthcare professionals to understand potential problems and how to improve their service to the public." [24] (p. 5)</i>

### Collection and usage attributes

<i>Computation description:</i>	<p>'Complaints' means any formal expression of dissatisfaction made to the service related to its services. These may be communicated to the service as a response to a patient experience survey, or other written correspondence, or conveyed verbally. The complaint may come directly from the client, their carer, or their legal representative.</p> <p>The 'service's nominated timeframe from receipt of complaint' means the timeframe that the service selects as being reasonable to respond to clients' or carers' complaints. The timeframe selected should be:</p> <ul style="list-style-type: none"><li>• informed by best practice</li><li>• agreed by members of the service</li><li>• documented</li><li>• reviewed at regular intervals to ensure that it continues to comply with best practice.</li></ul> <p>In some instances, the timeframe may be set by statutory/ legal requirements. In these cases, this timeframe should be adhered to if it is shorter than the timeframe established by the service.</p> <p>For this indicator to be correctly measured and reported, a register of customer complaints is required to be</p>
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maintained by the service. The register should contain the date of the receipt of the complaint, the details of the person making the complaint (to enable a response), and the date of the response.

This indicator is best calculated for a reference period.

*Computation:*

100 x (numerator ÷ denominator)

*Numerator:*

Number of client or carer complaints received during the reference period that have been responded to within the service's nominated timeframe from receipt of the complaint.

*Numerator criteria:*

Inclusions

- Client or carer complaints received during the reference period.
- AND
- That have been responded to within the service's nominated timeframe from receipt of the complaint.

Exclusions

- Client or carer complaints that have been responded to outside of the service's nominated timeframe.

*Denominator:*

Number of client or carer complaints received during the reference period.

*Denominator criteria:*

Inclusions

- Client or carer complaints received during the reference period.

*Comments:*

No further comments.

**References**

*Reference documents:*

No further references.

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## 20 Client partnership in quality improvement

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### Identifying and definitional attributes

<i>Short name:</i>	Client partnership in quality improvement
<i>Description:</i>	The percentage of clients who have been invited to contribute to quality improvement activities based on the results of the patient experience survey.
<i>Dimension:</i>	Acceptability/client participation
<i>Rationale:</i>	<i>“There is growing evidence about the importance of partnerships between health service organisations and health professionals, and patients, families, carers and consumers. Studies have demonstrated significant benefits from such partnerships in clinical quality and outcomes, the experience of care, and the business and operations of delivering care.” [9] (p. 23)</i>

### Collection and usage attributes

<i>Computation description:</i>	<p>‘Quality improvement activities’ in relation to the results of the patient experience survey can include the opportunity to interpret results of patient experience surveys (in an easily understood format), and to contribute to generating improvement actions based on this information.</p> <p>Invitations to contribute should be to clients, as well as their carers. If both client and carer contribute, this should be counted as a single contribution.</p> <p>This indicator may be calculated on the basis of a specific round of patient experience surveys, or if patient experience surveys are conducted continuously, then a reference period may be more appropriate.</p>
<i>Computation:</i>	100 x (numerator ÷ denominator)
<i>Numerator:</i>	Number of clients who have been invited to contribute to quality improvement activities during a particular round of patient experience surveys administered or during a specific reference period.
<i>Numerator criteria:</i>	<p><u>Inclusions</u></p> <ul style="list-style-type: none"><li>• Clients (and/or carers) who have been invited to contribute to quality improvement activities during a particular round of patient experience surveys administered or during a specific reference period.</li></ul>

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(Note that if client and carer are both invited to contribute, this should be counted as a single invitation.)

*Denominator:* Number of clients completing the patient experience survey at a particular round of patient experience surveys administered or during a specific reference period.

*Denominator criteria:* Inclusions

- Clients (or carers) completing the patient experience survey during a particular round of patient experience surveys administered or during a specific reference period.

*Comments:* No further comments.

**References**

*Reference documents:* Australian Commission on Safety and Quality in Health Care 2011, *National Safety and Quality Health Service Standards*, ACSQHC, Sydney.

## 21 Client / carer engagement in care

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### Identifying and definitional attributes

<i>Short name:</i>	Client / carer engagement in care
<i>Description:</i>	The percentage of clients (and/or their carers) who have discussed information about the purpose, treatment options, benefits, risks and costs of care, with a healthcare practitioner.
<i>Dimension:</i>	Acceptability/client participation
<i>Rationale:</i>	Client / carer engagement in care promotes clients as meaningful participants in the care process, including their own care, and can lead to improved outcomes.

### Collection and usage attributes

<i>Computation description:</i>	<p>'Who have discussed information about the purpose, treatment options, benefits, risks and costs of care, with a healthcare practitioner' means that the client (and/or carer) and healthcare practitioner have talked about the proposed intervention/treatment, including significant risks, costs, benefits and alternatives in a way that clients can understand. This may include for example, the use of an interpreter for clients from a non-English speaking background.</p> <p>This indicator is best calculated for a reference period.</p>
<i>Computation:</i>	$100 \times (\text{numerator} \div \text{denominator})$
<i>Numerator:</i>	Number of clients (or their carers, on the client's behalf where appropriate) with whom the healthcare practitioner has discussed information about the purpose, treatment options, benefits, risks and costs of care, during the reference period. (Note that if client and carer are both involved in the discussion, this should be counted once.)
<i>Numerator criteria:</i>	<p><u>Inclusions</u></p> <ul style="list-style-type: none"><li>• Clients of the service</li></ul> <p>AND</p> <ul style="list-style-type: none"><li>• Where the healthcare practitioner has discussed information about the purpose, treatment options, benefits, risks and costs of care with the client (and/or carer).</li></ul>

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*Denominator:* Number of clients of the service during the reference period.

*Denominator criteria:* Inclusions

- Clients of the service during the reference period.

*Comments:* No further comments.

**References**

*Reference documents:* No further references.

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## **Part 4: Effectiveness indicators**

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## 22 Client improvement / stabilisation

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### Identifying and definitional attributes

<i>Short name:</i>	Client improvement / stabilisation
<i>Description:</i>	The percentage of regular clients whose condition has improved, or stabilised (for conditions where improvement or stabilisation is expected).
<i>Dimension:</i>	Effectiveness
<i>Rationale:</i>	Ongoing care of clients should result in improvement or stabilisation of a client's condition, where this is expected.

### Collection and usage attributes

<i>Computation description:</i>	<p>A client's 'condition has improved, or stabilised' means that the client's condition has been assessed as such by the healthcare practitioner providing the care based on observable criteria. The improvement or stabilisation should also be documented in the client's record. Where a client's condition is not expected to improve or stabilise, this should be documented in the client's record.</p> <p>'Regular clients' are clients defined as such by the primary health care service. The definition is generally based on a minimum number of visits over a specific period of time. As a guide, someone who has visited the primary health care service three or more times in the previous two years may be regarded as a regular client<sup>10</sup>.</p> <p>This indicator is best calculated for a reference period.</p>
<i>Computation:</i>	$100 \times (\text{numerator} \div \text{denominator})$
<i>Numerator:</i>	Number of regular clients whose condition has improved or stabilised during the reference period.
<i>Numerator criteria:</i>	<p><u>Inclusions</u></p> <ul style="list-style-type: none"><li>• Regular clients during the reference period.</li></ul> <p>AND</p> <ul style="list-style-type: none"><li>• Whose condition has improved or stabilised.</li></ul>
<i>Denominator:</i>	Number of regular clients during the reference period.

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<sup>10</sup> See data element concept 'Person—regular client indicator' [METeOR identifier 436653 <http://meteor.aihw.gov.au/content/index.phtml/itemId/181162>].



*Denominator criteria:*

Inclusions

- Regular clients during the reference period.

Exclusions

- Regular clients with conditions where improvement or stabilisation of their condition is not expected.

*Comments:*

No further comments.

**References**

*Reference documents:*

No further references.

## 23 Self-rated client improvement / stabilisation

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### Identifying and definitional attributes

<i>Short name:</i>	Self-rated client improvement / stabilisation
<i>Description:</i>	The percentage of regular clients whose condition has improved, or stabilised (for conditions where improvement of stabilisation is expected) as measured through a validated self rated health status instrument that informs their individual care.
<i>Dimension:</i>	Effectiveness
<i>Rationale:</i>	Self-rated health assessment has been shown to be an independent predictor of the health care of clients, which has possible therapeutic implications for prevention and treatment.

### Collection and usage attributes

<i>Computation description:</i>	<p>A client's 'condition has improved, or stabilised' means that the client's condition has been assessed as such by the healthcare practitioner providing the care based on observable criteria. The improvement or stabilisation should also be documented in the client's record. Where a client's condition is not expected to improve or stabilise, this should be documented in the client's record.</p> <p>A 'self-rated health status instrument' is an instrument that is used to measure self-perceived or subjective morbidity amongst clients. It should provide valuable information to the healthcare practitioner about the client's perceived health status, and should be used to inform the client's health care.</p> <p>A 'validated' instrument is one that has been rigorously tested and approved for use for measuring self-perceived health status. It also means that the instrument is recognised within the practitioner's profession as being suitable for this purpose, or the instrument is recognised for use across professions.</p> <p>'Regular clients' are clients defined as such by the primary health care service. The definition is generally based on a minimum number of visits over a specific period of time. As a guide, someone who has visited the primary health care service three or more times in the previous two years may</p>
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be regarded as a regular client<sup>11</sup>.

This indicator is best calculated for a reference period.

*Computation:*

100 x (numerator ÷ denominator)

*Numerator:*

Number of regular clients during the reference period whose condition has improved or stabilised, as measured through a validated self rated health status instrument.

*Numerator criteria:*

Inclusions

- Regular clients during the reference period.
- AND
- Whose condition has improved or stabilised, as measured through a validated self rated health status instrument.

*Denominator:*

Number of regular clients during the reference period.

*Denominator criteria:*

Inclusions

- Regular clients during the reference period.

Exclusions

- Regular clients with conditions where improvement or stabilisation of their condition is not expected.

*Comments:*

No further comments.

## References

*Reference documents:*

No further references.

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<sup>11</sup> See data element concept 'Person—regular client indicator' [METeOR identifier 436653 <http://meteor.aihw.gov.au/content/index.phtml/itemId/181162>].

## 24 Goals of care attainment

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### Identifying and definitional attributes

<i>Short name:</i>	Goals of care attainment
<i>Description:</i>	The percentage of goals met in the timeframe stated for attainment of each goal, for clients with a care plan.
<i>Dimension:</i>	Effectiveness
<i>Rationale:</i>	<i>“The achievement of agreed objectives/goals of care is a measure of the success of the interventions.” [15] (p. 13).</i>

### Collection and usage attributes

<i>Computation description:</i>	<p>A ‘care plan’ is a documented plan of care for a specific client that contains client stated/agreed objectives/goals in addition to other key elements [15].</p> <p>‘Goals met in the timeframe stated for attainment of each goal’ means the number of goals agreed by the client and the healthcare practitioner as having being achieved <u>within</u> the timeframe documented in the care plan. Each goal should be fully met within this timeframe to be counted towards having being achieved.</p> <p>This indicator is best calculated for a reference period.</p>
<i>Computation:</i>	100 x (numerator ÷ denominator)
<i>Numerator:</i>	Sum of proportion of goals met within the timeframe stated for the attainment of each goal for each client with a care plan, during the reference period.

Calculated as:

$\Sigma$  (No. of goals within each client’s care plan that

were achieved at the time of the derivation of this indicator

÷

No. of goals within each client’s care plan that were planned to be achieved at the time of the derivation of this indicator).

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*Numerator criteria:*

Inclusions

- Clients with a care plan during the reference period.

AND

- All goals within each client's care plan that were planned to be achieved at the time point of the derivation of this indicator.

Exclusions

- Goals within each client's care plan that were not planned to be achieved at the point of the derivation of this indicator.

*Denominator:*

Number of clients with a care plan during the reference period, where at least one stated goal was planned to be achieved at the time point of the derivation of this indicator.

*Denominator criteria:*

Inclusions

- Clients with a care plan during the reference period.

AND

- Where at least one stated goal was planned to be achieved at the time point of the derivation of this indicator.

Exclusions

- Clients where none of the stated goals were planned to be achieved at the time point of the derivation of this indicator.

*Comments:*

No further comments.

**References**

*Reference documents:*

Victorian Healthcare Association 2008, *Clinical Indicators in Community Health*, Victorian Healthcare Association, Melbourne.

## 25 Goals of care partially attained

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### Identifying and definitional attributes

<i>Short name:</i>	Goals of care partially attained
<i>Description:</i>	The percentage of goals partially met in the timeframe stated for attainment of each goal, or appropriately renegotiated, for clients with a care plan.
<i>Dimension:</i>	Effectiveness
<i>Rationale:</i>	<i>“The achievement of agreed objectives/goals of care is a measure of the success of the interventions. If this indicator reveals a high number of partially met objectives/goals further information may be sought to determine why goals are only partially met to assist service improvement.” [15] (p. 13).</i>

### Collection and usage attributes

<i>Computation description:</i>	A ‘care plan’ is a documented plan of care for a specific client that contains client stated/agreed objectives/goals in addition to other key elements [15].
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‘Goals partially met in the timeframe stated for attainment of each goal’ means the number of goals agreed by the client and the healthcare practitioner as having been partly achieved within the timeframe documented in the care plan. The original goal may have been renegotiated between the client and the practitioner, and documented in the care plan, and therefore, may not have been met as originally stated. However, if the client and practitioner agree that the revised goal has been partially met, this should be counted as having been partially met for the purposes of this indicator.

This indicator is best calculated for a reference period.

<i>Computation:</i>	100 x (numerator ÷ denominator)
<i>Numerator:</i>	Sum of proportion of goals partially met in the timeframe stated for the attainment of each goal for each client with a care plan, during the reference period. Calculated as:

$\Sigma$  (No. of goals within each client’s care plan that

*were partially achieved at the time of the derivation of this indicator*

÷

*No. of goals within each client's care plan that were planned to be achieved at the time of the derivation of this indicator.)*

*Numerator criteria:*

Inclusions

- Clients with a care plan during the reference period.

AND

- All goals within each client's care plan that were partially achieved at the time point of the derivation of this indicator.

Exclusions

- Goals within each client's care plan that were not planned to be achieved at the point of the derivation of this indicator.

*Denominator:*

Number of clients with a care plan during the reference period, where at least one stated goal was planned to be achieved at the time point of the derivation of this indicator.

*Denominator criteria:*

Inclusions

- Clients with a care plan during the reference period.

AND

- Where at least one stated goal was planned to be achieved at the time point of the derivation of this indicator.

Exclusions

- Clients where none of the stated goals were planned to be achieved at the time point of the derivation of this indicator.

*Comments:*

No further comments.

**References**

*Reference documents:*

Victorian Healthcare Association (VHA) 2008, *Clinical Indicators in Community Health*, VHA, Melbourne.

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## **Part 5: Coordination of care indicators**

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## 26 Referral process

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### Identifying and definitional attributes

<i>Short name:</i>	Referral process
<i>Description:</i>	The percentage of service referrals that are made in accordance with the service's policy for referral processes (for appropriateness and timeliness).
<i>Dimension:</i>	Coordination of care
<i>Rationale:</i>	<p>"A good referral system can help to ensure:</p> <ul style="list-style-type: none"><li>• <i>clients receive optimal care at the appropriate level and not unnecessarily costly</i></li><li>• <i>hospital facilities are used optimally and cost-effectively</i></li><li>• <i>clients who most need specialist services can accessing them in a timely way</i></li><li>• <i>primary health services are well utilized and their reputation is enhanced."</i></li></ul> <p>[25] (p. 1)</p>

### Collection and usage attributes

<i>Computation description:</i>	<p>A referral is "a process in which a health worker at one level of the health system, having insufficient resources (drugs, equipment, skills) to manage a clinical condition, seeks the assistance of [another health worker] ... to assist in, or take over the management of, the client's case. Key reasons for deciding to refer ... include:</p> <ul style="list-style-type: none"><li>• <i>to seek expert opinion regarding the client</i></li><li>• <i>to seek additional or different services for the client</i></li><li>• <i>to seek admission and management of the client</i></li><li>• <i>to seek use of diagnostic and therapeutic tools."</i></li></ul> <p>[25] (p. 2)</p>
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An appropriate referral is one where the client's symptoms, presenting problems, physical findings and/or results of diagnostic tests indicate that the client is expected to benefit from the service to which they are being referred. A timely referral is one that occurs at the point in the trajectory of care that minimises risks to the client and

maximises their outcomes.

The 'service's policy for referral processes' should be:

- agreed by members of the service
- documented
- appropriate to the conditions managed/ clients seen
- reviewed periodically to ensure that it aligns with best practice.

The policy may include:

- indications/criteria for priority referrals for specific conditions and/or client groups (e.g. clients with multiple or complex care needs)
- standardised referral forms and processes and/or standardised information to be included in referrals
- systems for dealing with sensitive client issues being referred (e.g. HIV status)
- provision of support to client for referrals (e.g. scheduling of appointments)
- involvement of clients in the referral process and systems to track client referrals (e.g. whether or not the client followed through with the referral/appointment).

This indicator may be calculated for all or a sample of service referrals during a reference period, or at a specific time point (e.g. an audit of records with a referral).

*Computation:*

100 x (numerator ÷ denominator)

*Numerator:*

Number of service referrals during the reference period/at a specific time point that are made in accordance with the service's policy for referral processes.

*Numerator criteria:*

Inclusions

- Service referrals that are made in accordance with the service's policy for referral processes.

*Denominator:*

Number of service referrals in the population or sample.

*Denominator criteria:*

Inclusions

- All service referrals in the population or sample.

*Comments:*

No further comments.

**References**

*Reference documents:*

No further references.

## 27 Referral content

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### Identifying and definitional attributes

<i>Short name:</i>	Referral content
<i>Description:</i>	The percentage of service referrals that contain appropriate identifying, clinical and contact information, and a current medication list (if relevant to the service).
<i>Dimension:</i>	Coordination of care
<i>Rationale:</i>	Service referrals containing appropriate and correct information are more likely to result in appropriate and timely care by the service receiving the client, and reduce risks and improve outcomes for the client.

### Collection and usage attributes

*Computation description:* A referral is “a process in which a health worker at one level of the health system, having insufficient resources (drugs, equipment, skills) to manage a clinical condition, seeks the assistance of [another health worker] ... to assist in, or take over the management of, the client’s case. Key reasons for deciding to refer ... include:

- to seek expert opinion regarding the client
- to seek additional or different services for the client
- to seek admission and management of the client
- to seek use of diagnostic and therapeutic tools.”

[25] (p. 2)

The content of referrals will be guided by the service’s policy for referral processes. This policy should be:

- agreed by members of the service
- documented
- appropriate to the conditions managed/ clients seen (therefore, may or may not include a current medications list)
- reviewed periodically to ensure that it aligns with best practice.

The policy should also include specific guidance on the appropriate identifying, clinical and contact information, and

a current medication list (if relevant to the service), for referrals. These may be specified in a standard referral form used by the service.

This indicator may be calculated for all or a sample of service referrals during a reference period, or at a specific time point (e.g. an audit of records with a referral).

*Computation:* 100 x (numerator ÷ denominator)

*Numerator:* Number of service referrals during the reference period or at a specific time point that contain appropriate identifying, clinical and contact information and a current medication list (if relevant to the service).

*Numerator criteria:* Inclusions

- Service referrals that contain appropriate identifying, clinical and contact information and a current medication list (if relevant to the service).

*Denominator:* Number of service referrals in the population or sample.

*Denominator criteria:* Inclusions

- All service referrals.

*Comments:* No further comments.

## **References**

*Reference documents:* No further references.

## 28 Allocation of a 'key contact' person/care coordinator

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### Identifying and definitional attributes

<i>Short name:</i>	Allocation of a 'key contact' person/care coordinator
<i>Description:</i>	The percentage of clients with multiple or complex needs who are allocated a 'key contact person' or care coordinator, according to locally agreed guidelines, and are given their contact details.
<i>Dimension:</i>	Coordination of care
<i>Rationale:</i>	"[Clients] with complex healthcare needs, their families, and their providers often should traverse numerous professional, geographical, information system, and organizational boundaries to ensure that necessary care activities are performed adequately." [26] (p. 13)

### Collection and usage attributes

<i>Computation description:</i>	'Multiple or complex needs' refers to the clients': <ul style="list-style-type: none"><li>• breadth of need (i.e. the client has multiple needs - more than one - that are interrelated or interconnected)</li><li>• depth of need (i.e. the client has profound, severe, serious or intense needs)</li><li>• complex needs (i.e. the client has multiple, interlocking needs that span health and social issues.</li></ul> [16] (p. ii) <p>A 'key contact person' or 'care coordinator' is a person appointed by the service for:</p> <p><i>"the deliberate organization of [client] care activities between two or more participants (including the [client]) involved in a [client]'s care to facilitate the appropriate delivery of healthcare services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required [client] care activities, and is often managed by the exchange of information among participants responsible for different aspects of care."</i> [26] (p. 41)</p> <p>Locally agreed guidelines will guide the extent to which, for example, the key contact person/care co-ordinator is</p>
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responsible for developing/monitoring the client's care plan, arranging and tracking appointments, educating the client and coordinating other aspects of their wellbeing. The local guidelines should include the provision, to the client, of the key contact person's/ care co-ordinator's contact details.

This indicator may be calculated for all or a sample of clients with multiple or complex needs during a reference period, or at a specific time point (e.g. an audit of records of clients with multiple or complex needs).

*Computation:*

100 x (numerator ÷ denominator)

*Numerator:*

Number of clients with multiple or complex needs in the population or sample who are allocated a 'key contact person' or care coordinator, according to locally agreed guidelines, and are given their contact details.

*Numerator criteria:*

Inclusions

- Clients with multiple or complex needs.
- AND
- Who are allocated a 'key contact person' or care coordinator, according to locally agreed guidelines, and are given their contact details.

*Denominator:*

Number of clients with multiple or complex needs in the sample or population.

*Denominator criteria:*

Inclusions

- Clients with multiple or complex needs.

*Comments:*

No further comments.

**References**

*Reference documents:*

McDonald, K, Sundaram, V, Bravata, D, Lewis, R, Lin, N, Kraft, S, McKinnon, M, Paguntalan, H & Owens, D 2007, *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies*, Technical Review 9, vol. 7: Care Coordination, Agency for Healthcare Research and Quality, Rockville, MD.

## 29 Timely communication to healthcare practitioners

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### Identifying and definitional attributes

<i>Short name:</i>	Timely communication to healthcare practitioners
<i>Description:</i>	The percentage of clients where timely reporting of care assessments or outcomes was communicated to all relevant healthcare practitioners involved in the client's care.
<i>Dimension:</i>	Coordination of care
<i>Rationale:</i>	Timely communication of information to other healthcare practitioners involved in the client's care can improve clients' safety, quality of care and outcomes, and the client and carer's experience of the care provided.

### Collection and usage attributes

<i>Computation description:</i>	<p>Timely communication is a component of effective communication. 'Timely reporting' should be locally agreed, as appropriate for the specific program and/or client group.</p> <p>This indicator may be calculated in relation to a reference period, or at a specific time point (e.g. an audit). Also, the indicator may be derived for the population of clients with more than one healthcare practitioner involved in their care, or for a sample of these. If a sample is undertaken, random sampling is preferable to eliminate bias of records selected.</p>
<i>Computation:</i>	$100 \times (\text{numerator} \div \text{denominator})$
<i>Numerator:</i>	Number of clients in the population or sample where timely reporting of care assessments or outcomes was communicated to all relevant healthcare practitioners involved in the client's care.
<i>Numerator criteria:</i>	<p><u>Inclusions</u></p> <ul style="list-style-type: none"><li>• Clients in the sample/population with more than one healthcare practitioner involved in their care, where timely reporting of care assessments or outcomes was communicated to all relevant healthcare practitioners involved in the client's care.</li></ul>
<i>Denominator:</i>	Number of clients in the population or sample with more



than one healthcare practitioner involved in their care.

*Denominator criteria:*

Inclusions

- All clients in the sample/population with more than one healthcare practitioner involved in their care.

*Comments:*

No further comments.

**References**

*Reference documents:*

Victorian Quality Council 2010, Promoting effective communication among healthcare professionals to improve patient safety and quality of care, Victorian Government Department of Health, Melbourne.

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## **Part 6: Continuity of care indicators**

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## 30 Timely review and follow-up of diagnostic results

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### Identifying and definitional attributes

<i>Short name:</i>	Timely review and follow-up of diagnostic results
<i>Description:</i>	The percentage of clients whose diagnostic results were reviewed by a healthcare practitioner and acted on in a timely manner in accordance with agreed guidelines.
<i>Dimension:</i>	Continuity of care
<i>Rationale:</i>	Timely review and follow-up of diagnostic results has downstream implications on care and, ultimately, client outcomes.

### Collection and usage attributes

<i>Computation description:</i>	<p>For diagnostic test results to be adequately reviewed by a healthcare practitioner, services should have in place systems to track all tests ordered and to notify clients of results.</p> <p>'Acted on in a timely manner' is locally determined, as appropriate for the specific program and/or client group.</p> <p>'Agreed guidelines' should be:</p> <ul style="list-style-type: none"><li>• agreed by members of the service</li><li>• documented</li><li>• appropriate to the conditions managed/ clients seen</li><li>• reviewed periodically to ensure that it aligns with best practice.</li></ul> <p>This indicator is best derived in relation to a reference period. It may be derived for a sample of clients rather than for all clients. If a sample is undertaken, random sampling is preferable to eliminate bias of records selected.</p>
<i>Computation:</i>	$100 \times (\text{numerator} \div \text{denominator})$
<i>Numerator:</i>	Number of clients in the population or sample whose diagnostic results were reviewed by a healthcare practitioner during the reference period and acted on in a timely manner in accordance with agreed guidelines.

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*Numerator criteria:*

Inclusions

- Clients in the sample/population whose diagnostic results were reviewed by a healthcare practitioner and acted on in a timely manner in accordance with agreed guidelines.

*Denominator:*

All clients in the population or sample.

*Denominator criteria:*

Inclusions

- All clients in the sample/population.

*Comments:*

No further comments.

**References**

*Reference documents:*

No further references.

## 31 Medication reconciliation

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### Identifying and definitional attributes

<i>Short name:</i>	Medication reconciliation
<i>Description:</i>	The percentage of clients whose medication list has been reconciled against the service's patient health record.
<i>Dimension:</i>	Continuity of care
<i>Rationale:</i>	<p>"[Clients] are most at risk for medication errors when transitioning across different levels or between different providers of care. The process of medication reconciliation was established to reduce adverse medication events that may occur as a result of this transition." [27]</p> <p>"Though most often discussed in the hospital context, medication reconciliation can be equally important in ambulatory care, as many patients receive prescriptions from more than one outpatient provider." [28]</p>

### Collection and usage attributes

<i>Computation description:</i>	<p>Medication reconciliation is a formal process of obtaining and verifying a complete and accurate list of each client's current medicines; matching the medicines the client should be prescribed to those they are actually prescribed. Where there are discrepancies, these are discussed with the prescriber and reasons for changes to therapy are documented. When care is transferred, a current and accurate list of medicines, including reasons for change, is provided to the person taking over the client's care. Points of transition relevant to primary care that require special attention are:</p> <ul style="list-style-type: none"><li>• admission to hospital or discharge from the hospital to home or to another residential facility</li><li>• admission via an emergency department or discharge from the emergency department to home or to another residential facility.</li></ul> <p>Medication reconciliation is aimed at reducing adverse drug events associated with medication discrepancies.</p> <p>'Medication list has been reconciled against the service's patient health record' means that initially, a healthcare practitioner has identified an accurate list of all</p>
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medications the client is currently taking, including:

- name
- dosage
- frequency
- route
- information about previous adverse medicine events and allergies
- action / indication (as reported by the client).

The practitioner then reconciles this list against the list in the service's patient health record. Discrepancies should be discussed with the prescriber, and once resolved, the list may be used to:

- inform treatment/interventions provided by the service
- inform the need for any new prescriptions/changes to existing prescriptions
- communicate with the client's other care givers
- initiate a medication review (if issues are encountered).

This indicator may be calculated in relation to a reference period, or at a specific time point (e.g. an audit). Also, the indicator may be derived for all clients, or for a sample. If a sample is undertaken, random sampling is preferable to eliminate bias of records selected.

*Computation:*

100 x (numerator ÷ denominator)

*Numerator:*

Number of clients in the population or sample whose medication list has been reconciled against the service's patient health record.

*Numerator criteria:*

Inclusions

- Clients in the sample/population whose medication list has been reconciled against the service's patient health record.

*Denominator:*

All clients in the population or sample.

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*Denominator criteria:*

Inclusions

- All clients in the sample/population.

*Comments:*

Medication reconciliation will require pharmacist involvement.

**References**

*Reference documents:*

Australian Commission on Safety and Quality in Health Care 2011, *Medication reconciliation*, ACSQHC, Sydney, viewed 2 August 2012, <<http://www.safetyandquality.gov.au/our-work/medication-safety/medication-reconciliation/>>.

Burridge, N 2007, 'SHPA Standards of Practice for the Provision of Medication Reconciliation', *Journal of Pharmacy Practice and Research*, vol. 37, no. 3, pp. 231-3.

Mueller, SK, Cunningham Sponsler, K, Kripalani, S & Schnipper, J 2012, 'Hospital-Based Medication Reconciliation Practices: A Systematic Review', *Archives of Internal Medicine*, vol. 172, no. 14, pp. 1057-69.

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## **Part 7: Safety indicators**

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## 32 Adverse drug reactions and medication allergies

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### Identifying and definitional attributes

<i>Short name:</i>	Adverse drug reactions and medication allergies
<i>Description:</i>	The percentage of clients whose known adverse drug reactions and medication allergies are documented in the service's patient health record.
<i>Dimension:</i>	Safety
<i>Rationale:</i>	<i>"The purpose of [adverse medicine events and allergies] documentation is to avoid further harm to patients who have previously experienced an [adverse drug reaction and/or medication allergy] to that (or a similar) medication...Prevention of such errors depends on current and complete information being available at the time of prescribing, dispensing and administration."</i> [29] (p. 1)

### Collection and usage attributes

<i>Computation description:</i>	<p>An 'adverse drug reaction' is a "response to a drug which is noxious and unintended and which occurs at doses normally used in man for prophylaxis, diagnosis, or therapy of disease or for the modification of physiologic function" [30] (p. 1).</p> <p>A 'medication allergy' is "an adverse drug reaction mediated by an immune response (e.g. rash, hives)" [30] (p. 1).</p> <p>The service's patient health record may be paper-based or electronic. In both instances, all healthcare practitioners treating the client at that service must have access to this record in the course of their care for the client, and be able to clearly see:</p> <ul style="list-style-type: none"><li>• Where there are known reactions and/or allergies. The specific drugs/substances causing the reactions and/or allergies should be stated where known.</li><li>• Where there are no reactions and/or allergies. If a client has no known reactions and/or allergies, this should be clearly documented in their record.</li></ul> <p>This indicator may be calculated in relation to a reference period, or at a specific time point (e.g. an audit). Also, the indicator is best derived for a sample of clients rather than the whole population. If a sample is undertaken, random sampling is preferable to eliminate bias of records selected.</p>
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<i>Computation:</i>	100 x (numerator ÷ denominator)
<i>Numerator:</i>	Number of patient records in the sample where known adverse drug reactions and medication allergies are documented.
<i>Numerator criteria:</i>	<u>Inclusions</u> <ul style="list-style-type: none"><li>• All patient records in the sample where clients with known adverse drug reactions and medication allergies have had their specific reactions and/or allergies documented.</li></ul> OR <ul style="list-style-type: none"><li>• Where a client does not have a known adverse drug reaction or medication allergy, that 'No reactions/allergies' is clearly documented against the appropriate place in that client's record.</li></ul>
<i>Denominator:</i>	Number of patient records in the sample.
<i>Denominator criteria:</i>	<u>Inclusions</u> <ul style="list-style-type: none"><li>• Total patient records sampled.</li></ul>
<i>Comments:</i>	No further comments.

**References**

<i>Reference documents:</i>	NSW Therapeutic Advisory Group Inc 2007, <i>Indicators for Quality Use of Medicines in Australian Hospitals</i> , Sydney, < <a href="http://www.ciap.health.nsw.gov.au/nswtag/documents/publications/QUMIndicators/3.2.pdf">http://www.ciap.health.nsw.gov.au/nswtag/documents/publications/QUMIndicators/3.2.pdf</a> >.
	VA Center for Medication Safety & VHA Pharmacy Benefits Management Strategic Healthcare Group and the Medical Advisory Panel 2006, <i>Adverse Drug Events, Adverse Drug Reactions and Medication Errors Frequently Asked Questions</i> , VA Center for Medication Safety, Melbourne, < <a href="http://www.pbm.va.gov/vamedsafe/Adverse%20Drug%20Reaction.pdf">http://www.pbm.va.gov/vamedsafe/Adverse%20Drug%20Reaction.pdf</a> >.

## 33 Patient safety incidents investigations

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### Identifying and definitional attributes

<i>Short name:</i>	Patient safety incidents investigations
<i>Description:</i>	The percentage of the service's documented patient safety incidents (i.e. near misses or errors, and adverse events that result in harm) where an investigation has been completed in accordance with local policy.
<i>Dimension:</i>	Safety
<i>Rationale:</i>	<i>"Patient safety incidents can be associated with all aspects of primary health care services, including the administration of a practice, the delivery of treatment, communicating with patients and other services, and the knowledge and skills of the practitioner."</i> ([31] (p. 11). Investigation of patient safety incidents <i>"can help provide learn about problems of care delivery, prompt system improvements and reduce future harmful incidents"</i> [32] (p. 1).

### Collection and usage attributes

<i>Computation description:</i>	<p>A patient safety incident is <i>"an event or circumstance which could have resulted, or did result, in unnecessary harm to a patient"</i> [33] (p. 19).</p> <p>An 'investigation has been completed' means that the incident was reviewed in accordance with local policy. Such a review may involve, but should not be limited to, the following:</p> <ul style="list-style-type: none"><li>• assessment of the level of severity of the incident (e.g. based on the consequence or outcome of the incident, such as whether or not there was harm to a client) and determination of the likelihood of recurrence of the incident</li><li>• analysis of the cause of the incident</li><li>• identification of actions to reduce, manage or control any future harm, or probability of harm, including system improvements</li><li>• communication back to the client and/or other person raising the risk about the outcomes of the investigation.</li></ul>
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The local policy guiding the investigations should:

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- be documented
- assign appropriate levels of responsibility for investigation and action of all patient safety incidents
- be communicated to or have provision for training of all staff involved in investigations.

This indicator is best calculated in relation to a reference period.

*Computation:* 100 x (numerator ÷ denominator)

*Numerator:* Number of documented patient safety incidents during the reference period where an investigation has been completed in accordance with local policy.

*Numerator criteria:* Inclusions

- All documented patient safety incidents during the reference period.
- AND
- Where an investigation has been completed in accordance with local policy.

*Denominator:* Number of documented patient safety incidents during the reference period.

*Denominator criteria:* Inclusions

- All documented patient safety incidents during the reference period.

*Comments:* No further comments.

**References**

*Reference documents:* No further references.

## 34 Patient safety incidents follow-up

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### Identifying and definitional attributes

<i>Short name:</i>	Patient safety incidents follow-up
<i>Description:</i>	The percentage of the service's documented patient safety incidents (i.e. near misses or errors, and adverse events that result in harm) where action is taken to reduce risks identified through the investigation.
<i>Dimension:</i>	Safety
<i>Rationale:</i>	<i>"Patient safety incidents can be associated with all aspects of primary health care services, including the administration of a practice, the delivery of treatment, communicating with patients and other services, and the knowledge and skills of the practitioner."</i> [31] (p. 11).

### Collection and usage attributes

<i>Computation description:</i>	<p>A patient safety incident is <i>"an event or circumstance which could have resulted, or did result, in unnecessary harm to a patient"</i> [33] (p. 19).</p> <p>'Action is taken to reduce risks identified through the investigation' means that the incident was reviewed and actions identified and taken to prevent a recurrence of the incident. Actions should be:</p> <ul style="list-style-type: none"><li>• documented</li><li>• aimed at reducing, managing or controlling any future harm, or probability of harm.</li></ul> <p>They can involve making improvements to specific processes of care or to systems (i.e. service-wide improvements).</p> <p>This indicator is best calculated in relation to a reference period.</p>
<i>Computation:</i>	$100 \times (\text{numerator} \div \text{denominator})$
<i>Numerator:</i>	Number of documented patient safety incidents during the reference period where an investigation has been completed in accordance with local policy and where action is taken to reduce risks identified through the investigation.
<i>Numerator criteria:</i>	<u>Inclusions</u> <ul style="list-style-type: none"><li>• All documented patient safety incidents during the</li></ul>

reference period.

AND

- Where an investigation has been completed in accordance with local policy.

AND

- Where action is taken to reduce risks identified through the investigation.

*Denominator:* Number of documented patient safety incidents during the reference period.

*Denominator criteria:* Inclusions

- All documented patient safety incidents during the reference period.

*Comments:* No further comments.

## **References**

*Reference documents:* No further references.

## 35 Infection prevention and control

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### Identifying and definitional attributes

<i>Short name:</i>	Infection prevention and control
<i>Description:</i>	The percentage of the service's workforce who have received infection prevention and control training within the previous 12 months.
<i>Dimension:</i>	Safety
<i>Rationale:</i>	<i>"Effective infection prevention and control is central to providing high quality health care for patients and a safe working environment for those that work in healthcare settings." [34] (p. 7)</i>

### Collection and usage attributes

<i>Computation description:</i>	<p><i>'Infection prevention and control training' is "specific education and training for all healthcare workers and students about infection prevention and control principles, policies and procedures that are relevant to the facility. The aim is to inform and educate healthcare workers about the infectious hazards they will face during their employment, and their role in minimising the spread of infection to others." [34] (p. 216).</i></p> <p><i>"At a minimum, all staff (both clinical and non clinical) should be educated about:</i></p> <ul style="list-style-type: none"><li><i>• modes of transmission of infectious agents</i></li><li><i>• risk identification, assessment and management strategies including transmission-based precautions</i></li><li><i>• orientation to the physical work environment with a focus on its risks for infection</i></li><li><i>• safe work procedures</i></li><li><i>• correct use of standard precautions</i></li><li><i>• correct choice and use of personal protective equipment (PPE), including procedures for putting on and removing PPE and fit checking of respirators</i></li><li><i>• appropriate attire (shoes/hair/nails/jewellery)</i></li><li><i>• hand hygiene practices</i></li><li><i>• levels of cleaning required for clinical areas and</i></li></ul>
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*equipment*

- *how to deal with spills (chemical and biological)*
- *safe handling and disposal of sharps*
- *reporting requirements of incidents such as sharps injuries and exposures*
- *waste management*
- *antibiotic policy and practice.”*

*This information should be provided in the context of healthcare workers' roles in the organisation or service, and with a focus on respecting and maintaining patient confidentiality at all times. It should be provided as part of staff orientation, with periodic updates and refresher courses as required for specific jobs.*

*Healthcare workers may also require job or task-specific education and training, such as:*

- *instrument cleaning and sterilisation competency testing*
- *insertion and management of central and peripheral lines*
- *risks and prevention of multi-resistant organism (MRO) transmission.*

[34] (p. 216-217)

This indicator is best calculated in relation to a reference period (specifically, a 12-month period).

*Computation:* 100 x (numerator ÷ denominator)

*Numerator:* Number of staff who have received infection prevention and control training in the last 12 months.

*Numerator criteria:* Inclusions

- Staff who have received infection prevention and control training in the last 12 months.

*Denominator:* Number of staff in the last 12 months.

*Denominator criteria:* Inclusions

- Total number of staff (clinical and non clinical) in the last 12 months.

*Comments:* The denominator is a count of all staff (clinical and non



clinical), who were at the service during the last 12 months.  
It is not a count of fulltime equivalents (FTEs).

## References

*Reference documents:*

National Health and Medical Research Council 2010,  
*Australian Guidelines for the Prevention and Control of  
Infection in Healthcare*, Commonwealth of Australia,  
Canberra.

# Glossary

## Acceptability

The care/service provided meets the expectations of the client, community, providers and paying organisations, recognising that there may be conflicting or competing interests among stakeholders, and that the needs of the clients/patients are paramount. [35]

## Accessibility

Clients/patients can obtain care/service at the right place and the right time, based on respective needs. [35]

## Appropriateness

The care/service provided is relevant to the clients/patients' needs and based on established standards. [35]

## Coordination of care

Coordinated use of other levels of health care. [10]

## Continuity of care

Uninterrupted, coordinated care/service across programs, practitioners, organisations and levels of care/service over time. [35]

## Dimensions of quality

Notion popularised by the US Institute of Medicine in *Crossing the quality chasm* [36]. The usual six dimensions of quality are safety, effectiveness, appropriateness, consumer participation (or acceptability), access and efficiency. [37]

## Effectiveness

The care/service, intervention or action achieves the desired results. [35]

## Practice-level indicators of safety and quality for primary health care

Measures or markers of quality of care that should be generated and reviewed routinely by primary healthcare providers at the service unit, practice or local level.

## Quality indicators

Succinct measures or markers of quality of care.

## Safety

Potential risks of an intervention, or the environment, are avoided or minimised. [35]

## References

1. Australian Commission on Safety and Quality in Health Care, *Practice-level indicators of safety and quality for primary health care: Consultation paper*, 2011, ACSQHC: Sydney.
2. Australian Commission on Safety and Quality in Health Care, *Practice-level indicators of safety and quality for primary health care: Synthesis of submissions on the consultation paper and recommended national indicator set*, 2012, ACSQHC: Sydney.
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