Consultation instructions: National Safety and Quality Health Service Standards user guide for health service organisations that provide care for children

Target audience and purpose

This resource is for all health service organisations that implement the NSQHS Standards (second edition).

Consultation dates

Consultation on this resource will run until 31 August 2017.

Consultation questions

You are invited to provide feedback on the whole resource, or alternatively, specific components of the resource that are important to you.

We are seeking feedback on the content of the NSQHS Standards (second edition) including the intent, key tasks and strategies for improvement. Please note that we are not seeking comments on the wording of the actions, as a final draft of these Standards has been submitted to health ministers for their approval.

Included below are some questions that may help guide your submission. You can answer all, some or none of the questions in your feedback.

1. **Language**: How could we improve the language, terminology and glossary used in the resource so that they are more appropriate and applicable to the context of your organisation?

2. **Usability**: How could we make the content in this resource more applicable and easier to use to implement the NSQHS Standards (second edition)? For example, changes to the length, layout, and level of detail of the content.

3. **Clarification**: Does any of the content in this resource require further clarification or rewording? Please provide suggestions for these changes.

4. **Gaps and duplication**: Are there any gaps in the content and how should they be addressed? Is there any unnecessarily duplicated content that could be removed?

5. **Additional functionality**: What additional functionality would be helpful in an interactive online resource or as separate resources? For example: links between actions; links to other resources; videos and animations; the ability to search and filter content based on topics and the user’s role; one-page factsheets; or infographics.

Submitting your feedback

When providing feedback, please reference the specific resource, Standard, item and/or action.

Our preferred method for receiving your feedback is by online survey at Survey link: https://www.surveymonkey.com/r/paedguide.
Alternatively, feedback can be provided by:

- Email: NSQHSstandards@safetyandquality.gov.au
- Mail:
  NSQHS Standards Resources
  GPO Box 5480
  SYDNEY   NSW   2001
- Fax: (02) 9126 3613

Please do not submit your feedback as tracked changes to a copy of the resource, due to difficulties in analysing feedback provided in this way.

**Our contact details**

If you have any questions in relation to this consultation process please contact the Commission on 1800 304 056 or NSQHSstandards@safetyandquality.gov.au.
National Safety and Quality Health Service Standards user guide for health service organisations that provide care for children

CONSULTATION DRAFT
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Introduction

The Australian Commission on Safety and Quality in Health Care (the Commission) leads and coordinates national improvements in the safety and quality of health care. Key functions of the Commission include developing national safety and quality Standards, developing clinical care Standards to improve the implementation of evidence-based health care, coordinating work in specific areas to improve outcomes for patients, and providing information, publications and resources about safety and quality.

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Commission in collaboration with states and territories, clinical experts, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality-assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met. Since 2013, assessment to the NSQHS Standards has been mandatory for all Australian hospitals and day procedure services.

In Australia, health service organisations that provide care to children vary widely. Services may be provided in dedicated children's hospitals and health services, or in general services and hospitals that provide care to all age groups including babies, children, adolescents, adults and geriatric patients. This guide has been developed to primarily support those health service organisations that provide care to children in general services. However, it also supports specialist children’s hospitals.

There are many physical, emotional, developmental and intellectual differences between children and adults. Because of this, children are among the most vulnerable groups in the healthcare setting and have very different healthcare needs to adults. Health service organisations who provide care for children are in a position to address the varied risks of harm faced by children compared to adults by providing access to quality health care that is in line with children’s evolving capabilities, maturity and independence.2

To support health service organisations provide safe and quality care for children, the Commission has collaborated with Children’s Healthcare Australasia to develop the National Safety and Quality Health Service Standards User Guide for Health Service Organisations that Provide Care for Children. Children’s Healthcare Australasia is the peak body for hospitals providing healthcare for children and young people in Australia and New Zealand.

This guide identifies criteria and actions in the NSQHS Standards (second edition) that need special consideration by services providing care to children, along with suggested approaches for services to implement.

The Clinical Governance and Partnering with Consumers Standards provide a robust clinical governance framework for health service organisations and set the overarching systems requirements for effective implementation of the remaining six Standards.
How to use this guide

In this guide, neonates, children, adolescents and young people are referred to collectively as ‘children’, unless otherwise stated. Children are any persons aged from birth to 18 years.

All of the NSQHS Standards apply to children; however, there are additional considerations required when caring for children.

The suggested approaches in this guide are not mandatory.

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

The guide is arranged by NSQHS Standard (2nd ed.) and each chapter contains:

- General information on the NSQHS Standard (2nd ed.)
- A rationale as to why the Standard needs special consideration by health service organisations that provide care to children
- A series of suggested approaches, organised by criteria from the NSQHS Standards (2nd ed.), for health service organisations that provide care to children to implement
- A list of actions from the NSQHS Standards (2nd ed.) that will support successful implementation of the suggested approaches.

This guide has been designed to be used by health service organisations that provide care for children alongside the guides:

- NSQHS Standards Guide for Multipurpose Services and Small Rural Hospitals
- NSQHS Standards Hospital Guide
- NSQHS Standards Guide for Day Procedure Services
- NSQHS Standards Guide for Governing Bodies
- NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health.
1. Clinical Governance Standard

The intention of the Clinical Governance Standard is to create a clinical governance framework that integrates corporate, clinical governance, and safety and quality systems to maintain and improve the reliability, safety and quality of health care, and improve health outcomes for patients.

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

Being a child-safe, child-friendly and child-aware health service organisation requires specific consideration of the broader healthcare setting and its suitability to provide care to children. In order to do this, health service organisations need to monitor and review the care provided to children to ensure thorough, effective clinical governance. In addition to this, the workforce requires specific knowledge, skills and expertise in areas of child growth and development, parenting support, and working in partnership with children and their families.

Effective governance among health service organisations that provide care to children ensures:

• The rights of children are promoted and protected
• Children and families are given opportunities to provide feedback on their experience of care to improve the quality of healthcare services
• The workforce has the relevant skills, knowledge and experience to provide child-focused health care
• The workforce has access to, and complies with, relevant paediatric clinical guidelines
• The environment is suited to and safe for children
• Environments in which children receive care are safe and meet their physical and psychosocial needs.
Criteria

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

- Governance, leadership and culture
- Patient safety and quality systems
- Clinical performance and effectiveness
- Safe environment for the delivery of health care.

There are additional suggested strategies that health service organisations that provide care for children should consider. These suggested strategies relate to all four criteria that make up this Standard.

Governance, leadership and culture

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

Management has an operational focus, whereas governance has a strategic focus. Managers run an organisation, whereas the governing body ensures the organisation is run well and in the right direction and monitors performance. It is the board’s responsibility to ensure good governance.5

The governing body and management together with clinicians, children, their families and the workforce are responsible for designing, monitoring, providing and improving care. They are also responsible for identifying and minimising the risks of harm for vulnerable groups of patients, including children.

Suggested approaches

Leadership and culture

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

Health service organisations delivering health services to children should embed strategies that support a child safety culture, through leadership on:

- A child safety policy or statement of commitment to child safety
- A Code of Conduct that establishes clear expectations for appropriate behaviour with children
- Screening, supervision, training and other human resource practices that reduce the risk of child abuse from the workforce.6

Policies and procedures

Policies, procedures and/or protocols for assessment, admission and the physical placement of children in cots, beds or on wards should consider mandating the processes for identifying vulnerable children, increasing their privacy and safety, and reducing the access of adults who may pose a risk to the child. This requires:
- Minimising exposure of children to persons not authorised to undertake their care – for example, ensuring the unit is secure and approving all visitors
- Physical screening to promote privacy – for example, screening of bench spaces used for nappy changes
- Promoting safe sleeping practices to prevent adverse events, including consideration of co-sleeping arrangements, the use of cots/beds that are appropriate to the size of the child (without ligatures or entrapment points) and implementing strategies for prevention of sudden unexpected death in infancy (SUDI).

The actions listed below will support the implementation of the suggested approaches. Only relevant elements of the actions are listed.

**Action 1.1**
The governing body:
- a. provides leadership to develop a culture of safety and quality improvement and satisfies itself that this culture exists within the organisation
- c. sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community
- e. ensures that roles and responsibilities are clearly defined for the governing body, executive management, clinicians and the workforce

**Action 1.3**
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality

**Action 1.5**
The health service organisation considers the safety and quality of health care for patients in its business decision making

**Action 1.7**
The health service organisation uses a risk management approach to:
- a. set out, review, and maintain the currency and effectiveness of policies, procedures and protocols

**Action 1.29**
The health service organisation maximises safety and quality of care:
- a. through the design of the environment
Patient safety and quality systems

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

The organisation’s approach to delivering and supporting clinical care systems should be described in policies, procedures and protocols, which will need to be endorsed by the governing body. Patient safety and quality systems should include the following topics:

- Developing policies, procedures and protocols
- Monitoring and reporting clinical system performance
- Managing clinical risk
- Adverse event reporting and management, including reporting on sentinel events and other significant events
- Managing complaints and compliments
- Managing open disclosure
- Engaging clinicians in planned, systematic audits of clinical services in accordance with agreed protocols and schedules.

Suggested approaches

Feedback and complaints

Feedback on a consumer’s experience of care is an essential part of the quality improvement system. However, for children, opinions and views about experiences of health care are often sought from carers and families rather than the child. While there are some circumstances where proxy feedback is necessary, such as for children under five years of age, health service organisations should consider ways for children to express their views that are appropriate to their developmental stage and age.

Data analysis

Data analysis should be used to determine safety and quality priorities. Of particular importance is the grouping of data during analysis to adequately recognise issues affecting children and then responding appropriately. Groupings should allow analysis of adverse event information and safety investigations, across a range of ages, developmental stages and service contexts.

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

- Reviewing their consumer feedback systems and considering whether there may be any barriers that prevent children from providing feedback; the use of focus groups to pilot test surveys may assist with this process
- Using paediatric-specific tools and/or technology that uses animations, pictures and visual scales for the collection of feedback from children
- Ensuring personnel assessing adverse event information are knowledgeable in the care of specific age and developmental groupings and are able to assess the information they receive
- Ensuring adverse events data are examined using principles that include consideration of the physical environment in relation to the size of the child and the developmental stage of the child
• Ensuring systems and processes are in place to examine events specific to the patient population and their needs.

The actions listed below will support the implementation of the suggested approaches. Only relevant elements of the actions are listed.

**Action 1.11**
The health service organisation has organisation-wide incident management and investigation systems and:

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

**Action 1.13**
The health service organisation:

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

**Action 1.20**
The health service organisation uses its training systems to:

c. provide access to training to meet its safety and quality training needs
Clinical performance and effectiveness

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

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

Suggested approaches

Working with children check
All members of the workforce, including any non-clinical staff, who provide care or services to children should comply with relevant jurisdictional ‘working with children check’ schemes. This may include:
- Participating in annual child protection training
- Undertaking criminal record or police background checks upon recruitment and on an ongoing basis
- Reviews of disciplinary, complaints or conditions history.

Roles and responsibilities for safety and quality
Health service organisations who operate in rural settings may consider the availability of on-site expertise in paediatrics. In circumstances where it is not available, the service may consider putting arrangements in place to adequately access paediatric-specific advice, guidance and ongoing education.

Clinicians should have access to education, training and orientation that outlines their roles and responsibilities for obtaining consent from children, including:
- Legal and ethical obligations for clinical decision-making and obtaining consent
- Age-appropriate strategies for engaging with children and providing information about the benefits and risks of care
- Obligations for confidentiality of clinical decisions as well as the circumstances that justify a breach in the process for referral to other clinicians for ongoing care on the basis of moral, religious or ethical grounds.

Evidenced-based guidelines and practice
The health service organisation should ensure clinicians have ready access, either electronically or in hard copy, to clinical guidelines that specifically address the needs of children.

Health service organisations should assess the effectiveness of clinical guidelines and support clinicians to use the best available evidence to provide safe, high-quality care. Good clinical governance promotes clinical practice that is effective and based on evidence.9

Effective quality management systems should identify the extent of variation from agreed clinical guidelines or pathways, and how such variation is managed. The Commission’s Clinical Care Standards support the delivery of appropriate care, reduce unwarranted variation in care, and promote shared decision-making between patients, carers and clinicians.

Credentiauling
Credentialing and defining the scope of clinical practice are essential processes to ensure that the workforce have the relevant knowledge, skills, experience and expertise to deliver safe,
high-quality care. Processes for credentialing and defining the scope of clinical practice should specifically examine and document clinicians authorised to care for children. Health service organisations will also need to ensure they monitor compliance with the scope of clinical practice, particularly in relation to services provided to children.

The following actions will support the implementation of the suggested approaches. Only relevant elements of the actions are listed.

**Action 1.20**
The health service organisation uses its training systems to:
- c. provide access to training to meet its safety and quality training needs

**Action 1.22**
The health service organisation has valid and reliable performance review processes that:
- b. identify needs for training and development in safety and quality

**Action 1.23**
The health service organisation has processes to:
- a. define the scope of clinical practice for clinicians, taking into account the clinical service capacity of the organisation and clinical services plan
- b. monitor clinicians’ practice to ensure that they are operating within their designated scope of practice

**Action 1.24**
The health service organisation:
- a. conducts processes to ensure that clinicians are credentialed, where relevant

**Action 1.27**
The health service organisation has processes that:
- a. provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision-support tools relevant to their clinical practice
- b. support clinicians to use the best available evidence, including relevant Clinical Care Standards developed by the Australian Commission on Safety and Quality in Health Care

**Action 2.4**
The health service organisation ensures that its informed consent processes comply with legislation and best practice
Safe environment for the delivery of health care

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

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

Providing clear directions and signage can help patients access the health services required, and the use of furnishings, artwork, light, colour and sound can improve patients’ comfort and experience of care.

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

Suggested approaches

Projects to design or redevelop care environments should take into account relevant feedback and the physical and psychosocial needs of children and their families. This may include:

- Accommodating children separately from adults to ensure that their unique needs are met and risks of harm are minimised
- Service-specific policies for employees, visitors and volunteers to ensure children are not exposed to risk
- Age-appropriate environments with bright colours and soft edges
- Minimal exposure to potentially distressing sights or sounds
- Dedicated communal play areas with toys and play equipment that are regularly cleaned, disinfected and checked for safety
- Consideration of children’s environmental safety needs throughout the healthcare facility including medical imaging, emergency departments and theatre suites
- Using equipment that is specifically designed to meet children’s needs, size and developmental age — for example, the height and placement of cots, toilets, sinks and soap dispensers
- Providing facilities to ensure that an approved family member can accompany the child throughout the patient journey, including rooming in/close support by family members to reduce fear and distress and to assist with patient identification
- Eliminating ligature, strangulation or entrapment risks for smaller bodies
- Implementing youth- and child-led audits on safety and quality environments.

When designing or redeveloping care environments, consideration should also be given to the feelings of fear children can experience when exposed to new environments and behaviours that are not common in their home setting. To mitigate this risk, it is suggested that, wherever possible, a separate space that implements the approaches outlined above is available for children, including in emergency departments, medical imaging departments and operating theatres.
The actions listed below will support the implementation of the suggested approaches. Only relevant elements of the actions are listed.

**Action 1.5**
The health service organisation considers the safety and quality of health care for patients in its business decision making.

**Action 1.15**
The health service organisation:
   - b. identifies groups of patients using its services who are at risk of harm

**Action 1.29**
The health service organisation maximises safety and quality of care:
   - a. through the design of the environment

**Action 3.11**
The health service organisation has processes to maintain a clean and hygienic environment – in line with the current edition of the *Australian guidelines for the prevention and control of infection in healthcare,* and jurisdictional requirements – that:
   - a. respond to environmental risks
Resources


Error! Hyperlink reference not valid.
2. Partnering with Consumers Standard

The intention of this Standard is to create an organisation in which there are mutually beneficial outcomes by having:

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

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

Partnering with children and their families requires a different approach from adult health settings due to the dependent nature and progression of developmental capabilities of children compared to adults.

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

Engaging children, their carers and families in the child’s care can present significant challenges for staff providing care across the hospital setting (for example, radiology, emergency department) due to the child’s:

- Level of maturity and capacity to understand
- Previous experiences of health care
- Personality and behavioural characteristics
- Cultural background
- Primary language and that of their family; this may affect the ability of family members to provide consent
- Illness, injury or condition
- Needs and wants versus those of their families.

Additional considerations include that all states and territories have different legislative provisions around consent based on age. Adolescents also have an evolving capacity to comprehend and be involved in decisions about their health care.
Criteria

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

• Clinical governance and quality improvement systems to support partnering with consumers
• Partnering with patients in their own care
• Health literacy
• Partnering with consumers in organisational design and governance.

There are additional suggested strategies that health service organisations that provide care for children should consider. These suggested strategies relate to the following three out of four criteria that make up this Standard:

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

Partnering with patients in their own care

Person-centred care is globally recognised as the gold standard approach to healthcare delivery. It is a diverse and evolving practice, encompassing concepts such as patient engagement and patient empowerment. Partnering with patients in their own care is an important pillar of person-centred care. It focuses on the relationship between a consumer and a clinician, and recognises that trust, mutual respect and sharing of knowledge are needed for optimal health outcomes.\(^{11}\)

Partnerships with patients comprise many different, interwoven practices – from communication and structured listening, through to shared decision-making, self-management support and care planning. There is growing acceptance that these practices can improve the safety and quality of health care, improve patient outcomes and experience, and improve the performance of health service organisations.\(^{12}\)

Suggested approaches

Policies and procedures

To partner with children in their own care, policies, procedures and/or protocols may define:

• Processes to establish and maintain the identity of the child
• Criteria for determining whether a child is competent and can provide consent
• Circumstances where it may be appropriate to obtain consent from a child
• The roles and responsibilities of clinicians when obtaining consent from children
• Requirements for documenting consent when obtained from a child
• Considerations around consent when the parents of a child are separated, or there are court orders in place
• Considerations when there is a dispute between the parents/caregiver and the child about treatment
• The circumstances in which it is the right of a mature child to refuse treatment.

Charter of Rights

The Charter on the Rights of Children and Young People in Healthcare Services in Australia was developed to specifically address the rights of children when receiving health care.\(^{13}\) This charter outlines 11 rights aimed at ensuring the care provided to children is appropriate and acceptable. The charter is based on three key principles:

• The primary consideration should be in the best interests of the child
• All children are to be listened to and taken seriously
• The family is recognised as the fundamental decision-making unit in a child’s life.\(^{13}\)

To improve the care provided to children, health service organisations may consider adopting the *Charter on the Rights of Children and Young People in Healthcare Services in Australia*. This would include:

• Allocating responsibility for implementation of the charter to a senior individual or committee
• Building the requirements of the charter into the organisation’s safety and quality systems and processes of care for children
• Displaying the charter in areas within the organisation frequented by children, such as paediatric wards or play rooms
• Providing accessible copies of the charter in formats that meet the needs of the community, particularly those with limited capacity to read and comprehend complex written text
• Orientation to the charter for new members of the workforce responsible for providing care to children
• Using the charter as the basis for discussions about care planning and treatment between clinicians and children, potentially using play-based techniques
• Adding specific questions relating to the charter to consumer experience surveys.

**Informed consent**

Engagement and participation of carers and families, legal guardians, consumer advocates or other support group representatives could be included in systems and processes for obtaining consent if:

• It is considered appropriate based on the age and developmental stage of the child
• It is consistent with the wishes of the child and their family.

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

• The processes to follow when obtaining consent
• Being inclusive of legislative requirements and the legal constraints on children providing consent at different ages within different jurisdictions
• The role of the parent/family to provide consent.

**Communication**

To support shared decision-making that includes children, policies, procedures and/or protocols for communicating and engaging with children, their carers and families should be based on child- and family-centred care principles that:

• Are appropriate to the child’s age and developmental stage
• Build trust between parents and/or carers, the patient and clinicians
• Promote active listening and discussion about care preferences
• Provide timely information about treatment options and the outcomes of any tests or procedures
• Include support from interpreters and other appropriate language services.

Health service organisations should consider supporting communication that:

• Enables, supports and accepts decision-making by the young person and their carers and families
• Includes systems and processes to gain consent and share information with schools and other service providers to meet the ongoing care needs of the child.

Suggested approaches to ensure that messages are communicated clearly include:

• The use of interpreter services wherever necessary
- Making sure that the child or young person and their family are aware of and exercise their choices, including the use of visual and other aids to communicate the message
- Ensuring that informed consent is obtained and that the consequences, including the long-term consequences, of treatment are explained.

The actions listed below will support the implementation of the suggested approaches. Only relevant elements of the actions are listed.

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| Action 2.6 | The health service organisation has processes for clinicians to partner with patients and/or their substitute decision maker to plan, communicate, set goals and make decisions about their current and future care |

| Action 2.7 | The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care |
Health literacy

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

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

Health literacy is important for:
- Consumers, because it affects their capacity to make informed decisions and take actions to manage their health
- Clinicians, because it affects the way they manage their communication and partnerships with consumers and deliver care
- Managers and policy makers, because the complexity of their systems can affect consumers’ ability to navigate health services and systems, partner with organisations and engage with their own care.

Suggested approaches

Health literacy

Children and their families should receive information about their health care that takes into account their level of health literacy. This information may relate to:
- Details about the benefits, risks and complications of different treatment options, including the administration and effects of different medicines
- Explanations of certain procedures or tests that they may undergo
- Infection prevention and control measures such as the use of gowns or masks, and/or handwashing techniques
- Advice or instructions for children, their carers and families about self-care and management of certain risk factors, such as the recognition of low blood sugar for a patient who has diabetes
- Information on the longer term effect of treatment and medicines, including information about side effects/consequences that may occur in the future
- Signage and way-finding within and between health services.

Health service organisations could use, identify or develop age-appropriate tools and resources to use when communicating and engaging with children, their carers and families in the child’s health care. Examples include:
- Use of play therapy to support children during procedures
- Use of play-based approaches when providing information to children, including breaking down communication into smaller elements and sharing those elements over time
- Use of a teddy or doll for medical play to explain medical procedures
- Instructional or demonstrative videos or the use of apps explaining planned treatments/procedures that might take place in hospital
- Fact sheets about preparing to stay in hospital, provided prior to admission
- A picture dictionary of medical terms with simple definitions of diseases, instruments and medicines
- Use of distraction rooms or professionals trained in distraction techniques
- Hospital play kits and activity books.
The actions listed below will support the implementation of the suggested approaches. Only relevant elements of the actions are listed.

**Action 2.8**
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the local communities

**Action 2.10**
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that:

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

b. information provided is easy to understand and use
Partnering with consumers in organisational design and governance

Partnering with consumers and the community is viewed as a fundamental element in discussions and decisions regarding the design, implementation and evaluation of health policies, programs and services.14,15

Specific methods of partnership range from informal, one-off events or feedback through social media, through to formal and ongoing participation on boards and committees. Consumers can be engaged as individuals or in small or large groups.14

Evidence on the benefits and sustainability of specific partnership approaches is lacking. It is important to consider the diversity of the local community as well as the organisation’s design and governance needs when selecting methods. The use of mixed methods is common and supports the concept that not all consumers will engage with health services in the same way.14

Suggested approaches

Consumer participation in design, evaluation and governance

Consumer partnerships should aim to be representative of the community served by the health service organisation, particularly those consumers who may be vulnerable or difficult-to-engage, such as children. It is important that there is appropriate engagement and consultation with children and their families on processes that affect them and the care they receive. However, age and developmental barriers may prevent children from participating formally in consumer partnership arrangements.

Health service organisations may consider having a governance structure that:

- Effectively engages children and their families using a toolkit or resource framework
- Has proportional representation of children to assist with the development, quality improvement and review of health services provided to children in all areas of the health service – for example, in emergency departments, mental health units and imaging units
- Includes mechanisms to ensure appropriate consultation with children and their families in the policies and processes that affect them; such partnerships may range from one-off events or feedback through social media, to ongoing participation on boards and committees – for example, child advisory groups, steering committees or representative councils
- Includes children, young people and their families during facilities planning.

Health service organisations could also review existing policies and practices for engaging with children by:

- Reviewing membership of committees or boards and their terms of reference to ensure children and young people are represented
- Identifying local community or advocacy groups representing children and engaging them in discussions about consumer engagement strategies.

If consumer participation from children is low, health service organisations could consider options to improve engagement of this group. Strategies to increase engagement include:

- Inviting children or their parents or carers to join existing steering committees or consumer advisory groups
- Engaging children, their carers and families to provide feedback informally through discussions in waiting areas, at the bedside during clinical handover or as part of discharge procedures
- Creating a new ‘critical friends’ group for paediatric-specific units or wards made up of past paediatric service users and their carers
• Using play-based techniques and event management to engage children in decision-making.

Consumer involvement in training
Health service organisations could consider incorporating the views of children into training and education programs by:
• Inviting consumers with previous experience of caring for children or parents of children to speak to the staff
• Displaying messages or artwork about a child’s experience of care, in training and education materials or in staff training facilities
• Sharing with staff the results of child-consumer feedback surveys, focus group sessions or interviews
• With their consent, filming children talking about what is important to them in health care, and using these videos to educate staff.

The following actions will support the implementation of the suggested approaches.

Action 2.9
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review

Action 2.11
The health service organisation:
  a. involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care
  b. has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the local communities

Action 2.12
The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation
Resources


Cook Children’s Medical Center. Making magic with medical supplies. www.cookchildrens.org/medical-center/recreation-retail/Pages/making-magic.aspx


The Royal Children’s Hospital Melbourne. Be positive (B+). Get ready for hospital. www.rch.org.au/be-positive

The Royal Children’s Hospital Melbourne, Children’s Bioethics Centre. Law, ethics and communication: a guide for giving information and obtaining informed consent for central venous access devices.
3. Preventing and Controlling Healthcare-associated Infection Standard

The intention of this Standard is to reduce the risk of patients acquiring preventable healthcare-associated infections, effectively manage infections if they occur, and limit the development of antimicrobial resistance through prudent use of antimicrobials as part of antimicrobial stewardship.

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

Maintaining infection control principles in health service organisations that provide care for children requires specific precautions to be observed, in addition to the routine and ongoing infection prevention and management processes, because:

- Children are at higher risk of spreading infectious material due to the nature of child play
- Children are more vulnerable than other populations to serious infection from certain foods
- Toys are reservoirs for microorganisms and provide a potential pathway for transmission of infections.
Criteria

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

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

There are additional suggested strategies that health service organisations that provide care for children should consider. These suggested strategies relate to the following one out of four criteria that make up this Standard:

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

Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

This criterion requires organisation-wide governance, leadership and commitment to prevent and control healthcare-associated infections, and support antimicrobial stewardship.

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

- Apply safety and quality systems to prevent and control healthcare-associated infections, and support antimicrobial stewardship
- Use quality improvement systems to monitor, review and improve the prevention and control of healthcare-associated infections, and to support antimicrobial stewardship
- Apply principles of partnering with consumers when designing and implementing systems to prevent and control healthcare-associated infections, and support antimicrobial stewardship.

This criterion relies on the systems established as part of the Clinical Governance Standard and Partnering with Consumers Standard to be effective.

Suggested approaches

Policies and procedures

Health service organisations should have separate provisions in policies and procedures relating to healthcare-associated infections and antimicrobial stewardship for adults and children. For example, policies may include advice on the process of cleaning toys and other instruments specific to children.

Surveillance

Health service organisations may consider separately identifying data for adults and children at the diagnostics-related groupings (DRG) level for healthcare-associated infections and antimicrobial stewardship.
The actions listed below will support the implementation of the suggested approaches. Only relevant elements of the actions are listed.

**Action 3.1**
The workforce uses the safety and quality systems from the Clinical Governance Standard when:
- Implementing policies and procedures for healthcare-associated infections, and antimicrobial stewardship

**Action 3.4**
The health service organisation has a surveillance strategy for healthcare-associated infections and antimicrobial use that:
- Collects data on healthcare-associated infections and antimicrobial use relevant to the size and scope of the organisation

**Action 3.12**
The health service organisation has processes to evaluate and respond to infection risks for:
- New and existing equipment, devices and products used in the organisation
4. Medication Safety Standard

The purpose of this Standard is to ensure clinicians are competent to safely prescribe, dispense and administer appropriate medicines, and to monitor medicine use. In addition to this, the medication safety Standard aims to ensure consumers are informed about medicines and understand their individual medicine needs and risks.

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

Neonates, children and young people are more susceptible to harm from medicines due to:

- The absorption, distribution, metabolism and excretion of medicines in children at different ages
- Constant change in weight due to growth and changing activity levels
- Developmental factors.
Criteria

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

- Clinical governance and quality improvement to support medication management
- Documentation of patient information
- Continuity of medication management
- Medication management processes.

There are additional suggested strategies that health service organisations that provide care for children should consider. These suggested strategies relate to the following three out of four criteria that make up this Standard:

- Clinical governance and quality improvement to support medication management
- Continuity of medication management
- Medication management processes.

Clinical governance and quality improvement to support medication management

This criterion requires organisation-wide governance, leadership and commitment to support the safe and effective use of medicines.

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

- Apply safety and quality systems to support medication management
- Use quality improvement systems to monitor, review and improve medication management
- Apply principles of partnering with consumers when designing and implementing systems for medication management
- Define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians
- Train, educate and support clinicians to understand their roles and accountabilities in delivering safe and effective use of medicines.

This criterion relies on the systems established as part of the Clinical Governance Standard and Partnering with Consumers Standard to be effective.

Suggested approaches

Policies and procedures

Health service organisations that provide care to children could implement appropriate policies to ensure:

- The use of validated paediatric medication charts, such as the Paediatric National Inpatient Medication Chart\textsuperscript{17}
- Double-checking of paediatric medicines by administering staff
- Child-based protocols, drug approval processes and evaluation processes are in place for off-label medicines.

Evidence shows that incorrect recording of a child’s weight can contribute to incorrect dosing.\textsuperscript{18} Health service organisations that provide care to children may consider ensuring:

- A child’s weight is double-checked and documented upon admission
- A child’s height or length is documented upon admission
- Accurate current weight in kilograms is documented clearly on all medication charts for children
• Processes are in place to regularly weigh and track any variation in weight during an episode of care
• Estimated weights are not used except in life-saving situations
• Age-appropriate medical grade weighing scales are available in all areas that provide care to children and they are regularly calibrated.

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

Partnering with consumers
Medicine dosing errors at home are more likely to occur among carers and/or families with low levels of health literacy. It is estimated that approximately 40% of adults have the level of health literacy that enables them to meet the challenges of everyday life. Therefore, health service organisations may consider ensuring the person taking responsibility for care at home, whether adult or child, knows how to accurately and safely administer medicines. This can reduce the risk of an adverse medication event following discharge from the health service organisation.

The actions listed below will support the implementation of the suggested approaches. Only relevant elements of the actions are listed.

Action 4.1
Clinicians use the safety and quality systems from the Clinical Governance Standard when:
   a. implementing policies and procedures for medication management
   b. managing risks associated with medication management
   c. identifying training requirements for medication management

Action 4.2
The health service organisation applies the quality improvement system in the Clinical Governance Standard when:
   b. implementing strategies to improve medication management outcomes and associated processes

Action 4.3
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians

Action 4.4
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to:
   a. actively involve patients in their own care
   b. meet the patient’s information needs
Continuity of medication management

There are multiple points of vulnerability in the medication management pathway where communication and focused partnership with the patient and/or their carer can contribute to achieving the best treatment outcome, including:

- Medication review – health service organisations need to examine how medication review can be built into existing work practices including medication reconciliation
- Information for patients – patients and carers should be provided with sufficient information about medicine-related treatment options; this information needs to be in a form that is easy to understand by, and useful to, patients
- Medicines list – when patients are transferred between healthcare providers, health service organisations and units within organisations, communication of the patient’s medicines-related information must be complete and accurate to prevent opportunities for medication error.

Suggested approaches

Medicines information

Health service organisations should ensure high-quality medicines information is available to children and their families to help them better understand their role and responsibilities for medication management, and to assist with pharmacovigilance. Some suggested approaches include:

- Presenting information on medicines in graphic form; this has been shown to have a beneficial impact on the safe use of medicines among carers and/or families with low health literacy\(^\text{19}\)
- Inviting children, their carers and/or families to provide feedback on the medicines information made available by the health service organisation
- Health service organisations using this feedback to improve medicines information materials and distribution practices.

The following action will support the implementation of the suggested approaches.

Action 4.11

The health service organisation has processes to support clinicians to provide patients with information on their individual medicines needs and risks
**Medication management processes**

Many of the risks associated with each part of the medication management pathway can be avoided using systems and processes that are designed to improve safety, and that are based on evidence from initiatives that have demonstrated significant benefit. These initiatives focus on addressing the common contributing factors in medication errors, which include:\(^{22}\)

- Lack of knowledge of the medicine
- Lack of information about the patient
- Lack of concentration and memory lapses
- Transcription errors
- Failure in communication
- Lack of patient education
- Poor medicines distribution practices.

Included in this criterion is the management of high-risk medicines. High-risk medicines are those that, when misused or used in error, have a high risk of causing injury or harm.\(^{23}\) High-risk medicines will vary between hospitals and healthcare settings depending on the types of medicines used and the different patient groups treated.\(^ {24}\)

**Suggested approaches**

**Guidelines**

Health service organisations should ensure:

- Appropriate paediatric resuscitation medication dosing guidelines are readily available to clinical staff – for example, weight-based dosage guidelines
- Age-appropriate guidelines are available and used for the administration of injectable medicines for children and neonates
- Recommended children's/neonatal medicines information and dosing guidelines are available and used by all clinical staff who prescribe, dispense and administer medicine to children.

**Resources**

Health service organisations should ensure the availability of clinical decision-support tools for staff who prescribe and administer medicines to children and ensure the tools are current, consistent with best practice, and accessible at relevant points in the clinical workflow.

**Management of high-risk medicines**

It is important for health service organisations to review relevant literature, data and information on medication safety incidents to identify any high-risk medicines that require specific management guidelines for children.\(^{24,25}\)

Particular care needs to be taken with children to ensure that the correct dose of high-risk medications are administered. To further improve the management of high-risk medicines and address the safety needs of children, health service organisations could:

- Establish a list of high-risk medicines specific to children in the organisation
- Identify related policies, procedures and protocols for the administration of high-risk medicines to children – for example, syringes for administration of medication should have minimal dead space\(^ {26}\)
- Consider a double-check policy for paediatric medicines
- Develop a schedule to regularly review and update the policies, procedures and/or protocols
- Ensure prescribing guidelines and/or decision-support tools for the administration of high-risk medicines to children are readily available to the relevant clinical workforce.
The following actions will support the implementation of the suggested approaches.

**Action 4.13**
The health service organisation ensures that information and decision-support tools for medicines are available to clinicians

**Action 4.15**
The health service organisation:
- identifies high-risk medicines used within the organisation
- has a system to store, prescribe, dispense and administer high-risk medicines safely
Resources


Australian Commission on Safety and Quality in Health Care. Paediatric national inpatient medication charts. [website]

Australian Medicines Handbook. AMH children’s dosing companion (online). [website]

Children’s Hospitals Australasia. Standards for oral syringes and enteral feeding systems. [website]

Clinical Excellence Commission. Clinical incident management in the NSW public health system. Paediatrics. [website]

Clinical Excellence Commission. The Medication Safety Self Assessment® [website]

Health Direct. Children’s medicines. [website]

HNEkidshealth. Neonatal guidelines. Section 19 Medications. [website]


Medicines for Children. Practical and reliable advice about giving medicine to your child. [website]

Monash Children’s Hospital. Paediatric emergency medication book. [website]

NPS Medicinewise. How to give medicines to children. [website]

NPS MedicineWise Learning. National standard medication charts course. [website]

NSW Health. Standards for paediatric intravenous fluids: NSW Health (second edition) [guideline]. [website]

NSW Health. Safe administration of liquid medicines by routes other than injection [policy directive]. [website]


SA Health. Neonatal medication guidelines, [website]
SA Health. South Australian paediatric practice guidelines – Pain management and opioid safety


The Royal Children’s Hospital Melbourne. Medicines information.
www.rch.org.au/pharmacy/medicines-information

The Sydney Children’s Hospitals Network. High risk medicines register policy.
5. Comprehensive Care Standard

The intention of the Comprehensive Care Standard is to ensure that patients receive comprehensive care, that is, coordinated delivery of the total health care required or requested by a patient. This care is aligned with the patient’s expressed goals of care and their healthcare needs, considers the impact of the patient’s health issues on their life and wellbeing, and is clinically appropriate.

In addition, the purpose of this Standard is to ensure that risks of harm for patients during health care are prevented and managed. Clinicians identify patients at risk of specific harm during health care by applying the screening and assessment processes required in this Standard.

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

The provision of comprehensive care to children requires special consideration by health service organisations, particularly in relation to preventing pressure injuries and falls, as well as for those who require Advance Care Planning.

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

- Have an increased body temperature
- May have high/low body mass index and/or birth weight
- Are unable to verbalise their pain or discomfort
- May be incontinent
- May have immature skin
- May suffer from lifelong mobility-limiting conditions such as spina bifida, spinal cord injury or a neurological impairment
- May inadvertently cause friction and self-harm from active play
- May have medical devices that are firmly secured to reduce the risk of inadvertent or intentional removal due to the active nature of children.\(^{27, 28}\)

Reducing falls risks for children requires special consideration because of:

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

In regard to advance care planning, the needs of children are different to those of adults because of the need to:

- Incorporate the needs of the family and other care providers, such as schools and preschools, as well as the needs of the child
- Involve and coordinate clinicians and non-clinical support staff with specialised skills in child and family health care
- Understand and anticipate the different responses of children to symptoms and their treatments
- Deal with family/societal expectations that children will outlive their parents
- Address the uncertainty of prognoses for children and a tendency to focus on cure-oriented treatment\(^{29}\)
- Consider the legal capacity of children to make decisions about their care, understand their prognosis and express a view.
Criteria

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

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

The minimising patient harm criterion addresses the needs of people at risk from pressure injuries, falls, poor nutrition, cognitive impairment, unpredictable behaviour and restrictive practices.

There are additional suggested strategies that health service organisations that provide care for children should consider. These suggested strategies relate to all four criteria that make up this Standard.

Clinical governance and quality improvement to support comprehensive care

Taking an organisation-wide and systematic approach to the delivery of comprehensive care will help to ensure consistent experiences of comprehensive care for patients, and consistent expectations about how to deliver comprehensive care for clinicians and other members of the workforce.

This criterion requires organisation-wide governance, leadership and commitment to support delivery of comprehensive care and minimise patient harm.

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

- Integrate clinical governance and apply quality improvement systems
- Apply principles of partnering with consumers, health literacy and shared decision-making when developing and implementing organisational processes for comprehensive care and minimising patient harm
- Implement organisational systems and processes to support effective delivery of comprehensive care and minimise patient harm.

This criterion aligns closely with the Clinical Governance Standard and Partnering with Consumers Standard.

Suggested approaches

Training

Implementing quality improvement systems could include providing staff and families with access to training and education programs that cover:

- Specific identification, prevention and management strategies for pressure injuries and falls in children
- Advance Care Planning for children, including taking into account special circumstances such as activity level and participation in sport.

Risk management

Risk management strategies specific to children could include supporting clinicians to work in partnership with children, their carers and families to develop a pressure injury and falls risk management plan based on a patient’s risk.
The action listed below will support the implementation of the suggested approaches. Only relevant elements of the action are listed.

**Action 5.1**
Clinicians use the safety and quality systems from the Clinical Governance Standard when:
- b. managing risks associated with comprehensive care
- c. identifying training requirements to deliver comprehensive care
Developing the comprehensive care plan

Every patient receiving health care in Australia deserves comprehensive care. Some patient groups are particularly vulnerable and, for them, comprehensive care has a significant role in helping to prevent harm. Therefore, the groups of vulnerable patients that use an organisation’s health services must be considered to ensure that systems for comprehensive care address the needs of these groups.

Suggested approaches

Integrated screening tools

Health service organisations should consider the use of validated, age-appropriate risk screening and assessment tools when developing comprehensive care plans for children. For example:

- The Glamorgan Paediatric Pressure Ulcer Risk Assessment Scale
- The Braden Q Scale for predicting Pediatric Pressure Ulcer Risk
- The Humpty Dumpty Falls Scale, which has been adapted by the Clinical Excellence Commission
- The Little Schmidy Falls Risk Assessment Index.

Mental health

The needs of a child’s developmental stage must be carefully considered when deciding whether to allocate children to either the paediatric unit or an adult-oriented mental health facility.

Plan for discharge

Part of the comprehensive care planning process is planning for discharge from the health service organisation. Health service organisations that provide care to children should consider:

- Identifying any services, equipment and follow-up that may be needed to safely discharge the child home
- Developing processes to ensure that follow-up arrangements are made before the child leaves the health service organisation
- Developing processes to ensure that any required referrals are actioned in a timely way – for example, mandatory reporting of suspected child abuse and neglect to government authorities as per jurisdictional requirements.
The actions listed below will support the implementation of the suggested approaches. Only relevant elements of the actions are listed.

**Action 5.7**
The health service organisation has processes relevant to the patients using the service and the services provided:
   a. for integrated and timely screening and assessment
   b. that identify the risks of harm in the 'Minimising patient harm' criterion

**Action 5.10**
Clinicians use relevant screening processes:
   b. to identify cognitive, behavioural, mental and physical conditions, issues and risks of harm

**Action 5.11**
Clinicians comprehensively assess the conditions and risks identified through the screening process

**Action 5.13**
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that:
   a. addresses the significance and complexity of the patient’s health issues and risks of harm
   e. includes a plan for referral to follow-up services, if appropriate and where available
Delivering comprehensive care

The delivery of comprehensive care is based on partnership with patients, carers and families to identify, assess and manage patients’ clinical risks, and determine their preferences for care; and on communication and teamwork between members of the healthcare team.

Suggested approaches

Creating an environment where children feel safe

Services providing care to children need to work together with the child and their family to ensure that care is delivered in the most acceptable manner, to prevent the child feeling frightened and feeling future healthcare-associated anxiety. Parents and carers should be involved in the child’s care whenever possible, such as when procedures are performed and during bedside clinical handover, unless the child expresses a wish that they not be. The comprehensive care plan needs to incorporate elements that address this specifically for the individual child.

End-of-life care

Delivering advance care plans requires special considerations among health service organisations that provide care for children.35 Where palliative care services are provided to children, the health service organisation should consider having policies, procedures and/or protocols to:

- Develop advance care plans in consultation with children and their families; this should address the child’s and their family’s preferences for future care – for example, intervening during critical episodes such as airway obstruction
- Ensure clinicians understand their legal and ethical obligations, including determining the child or young person’s capacity to understand and be involved in clinical decisions about palliative care
- Implement advance care plans that have been developed in the community
- Document advance care plans in the child’s clinical record
- Inform clinicians as part of the care team of the existence of advance care plans
- Periodically review or amend advance care plans, when requested.

Where palliative care services for children are not available, the health service organisation may consider ensuring that processes are in place to refer children to appropriate services and that the organisation has the networks to gain timely advice.
The actions listed below will support the implementation of the suggested approaches. Only relevant elements of the actions are listed.

**Action 5.9**
Patients are supported to document advance care plans

**Action 5.15**
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National consensus statement: essential elements for safe and high-quality end-of-life care

**Action 5.16**
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice

**Action 5.17**
The health service organisation has processes to ensure that current advance care plans:
   a. can be received from patients
   b. are documented in the patient’s healthcare record

**Action 5.18**
The health service organisation provides access to supervision and support for the workforce providing end-of-life care

**Action 5.19**
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care

**Action 5.20**
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National consensus statement: essential elements for safe and high-quality end-of-life care
Minimising patient harm

The screening actions in the Comprehensive Care Standard aim to identify the patients who are at the greatest risk of harm while receiving health care. This criterion identifies specific risks that commonly cause harm to at-risk patients. Implementing targeted, best-practice strategies can prevent and minimise the risk of these specific harms.

Suggested approaches

Pressure injuries
In order to minimise the risk of harm from pressure injuries in children, health service organisations may consider:

- Having a policy/practice guideline around friction or pressure injury that is specific to children
- Identifying and following prevention strategies/practices
- Identifying patients who are at risk of friction/pressure injuries through an initial assessment and specify that they receive regular and repeat assessments; assessment tools validated for the intended population may be considered such as the Glamorgan Paediatric Pressure Ulcer Risk Assessment Scale or the modified Braden Q Scale
- Determining appropriate care pathways based on the risk assessment
- Ensuring information is made available to carers and families about the ongoing prevention and management of pressure injury; this is because many of the causative factors of childhood pressure injury are likely to be present on discharge (for example, spina bifida, low birth weight among neonates).

Falls
In order to minimise the risk of harm from falls in children, health service organisations may consider:

- Providing education and support to parents and carers to identify risks and help prevent falls, including on known falls risk factors such as co-sleeping, medication/sedation, blood pressure (adolescents), and reduced mobility during rehabilitation or recovery from injury/illness
- Ensuring falls prevention issues and requirements are visible to parents/carers in all areas where children are identified as being at risk of harm from falls
- Extending parent/carer education to include risks of harm from falls at home and in the community.

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

- Implementing processes to address allergies, including for complementary feeds
- Using paediatric-specific fluid balance and measurement charts
- Providing child-friendly foods that are both nutritious and visually attractive to children
- Strategies to prevent children from disconnecting intravenous or feeding tubes
- Preventing the accidental interchange between enteral and intravenous equipment.
The actions listed below will support the implementation of the suggested approaches. Only relevant elements of the actions are listed.

**Action 5.21**
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines.

**Action 5.22**
Clinicians providing care to patients at risk of developing or with a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency.

**Action 5.23**
The health service organisation providing services to patients at risk of pressure injuries ensures that:
   a. patients, carers and families are provided with information about preventing pressure injuries.

**Action 5.24**
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for:
   a. falls prevention
   b. minimising harm from falls.

**Action 5.25**
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls.

**Action 5.26**
Clinicians providing care to patients at risk of falls provide patients, families and carers with information about reducing falls risks and falls prevention strategies.

**Action 5.27**
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice.

**Action 5.28**
The workforce uses the systems for preparation and distribution of food and fluids to:
   a. meet patients’ nutritional needs and requirements
   b. monitor the nutritional care of patients at risk.
Resources


Braden Q Scale for assessment of pressure ulcer risk related to immobility in your paediatric population. www.marthaaqcurley.com/braden-q.html


NSW Paediatric Palliative Care Programme. 

Palliative Care Australia. Health care professional’s role in palliative care. 
http://palliativecare.org.au/im-a-health-professional

The Royal Children’s Hospital Melbourne. Falls – high risk management plan. 
www.rch.org.au/uploadedFiles/Main/Content/rchcpg/Falls_-High_risk_management_plan_2202.pdf

The Royal Children’s Hospital Melbourne. Pressure injury prevention. 
www.rch.org.au/kidsinfo/fact_sheets/Pressure_injury_prevention

The Royal Children’s Hospital Melbourne. Reference guide: Little Schmidy Falls Risk Assessment. 
www.rch.org.au/uploadedFiles/Main/Content/rchcpg/Little_Schmidy_Falls_Risk_Assessment.pdf

Western Australian Department of Health. Pressure injury prevention and management clinical guideline (includes the Glamorgan Paediatric Pressure Injury Risk Assessment Scale). 
6. Communicating for Safety Standard

The intention of this Standard is to ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for patients.

Communication is a key safety and quality issue. Health care involves a team of people – clinicians, nurses and other health professionals, patients, carers and families. It is important that communication between these groups supports the delivery of continuous and safe care.

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

The process of establishing the identity of children can be complex, as many cannot identify themselves independently or report discrepancies during identification checking procedures. Further complicating this matter is the different anatomy of children which means that identification bands can easily fall off or be removed. In addition, children may not be able to confirm the procedure or treatment that is intended.

There is a small but significant risk of error whenever breastmilk is expressed and stored in a health service organisation. There are several factors present in healthcare environments that increase the risk of administration error of expressed breastmilk, including the separation of women and their babies, babies of multiple births and relocating infants to different bed spaces.
Criteria

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

- Clinical governance and quality improvement to support effective communication
- Correct identification and procedure matching
- Communication at clinical handover
- Communication of critical information
- Documentation of information.

There are additional suggested strategies that health service organisations that provide care for children should consider. These suggested strategies relate to the following three out of five criteria that make up this Standard:

- Clinical governance and quality improvement to support effective communication
- Correct identification and procedure matching
- Communication at clinical handover

Clinical governance and quality improvement to support effective communication

For systems and processes to work effectively and consistently across a health service organisation, they need to be embedded in the overall governance of the organisation.

This criterion requires organisation-wide governance, leadership and commitment to support effective clinical communication with patients, families and carers; between clinicians and multidisciplinary teams; and across organisations. To meet this criterion, health service organisations are required to:

- Integrate clinical governance and apply quality improvement systems
- Apply principles of partnering with consumers, health literacy and shared decision-making when developing and implementing organisational clinical communication processes
- Implement organisational systems and processes to support effective clinical communication during high-risk situations.

Organisations will need to understand their priorities, identify their risks in relation to clinical communications, and consider how to best address these within their given resources, workforce and organisational structures.

This criterion aligns closely with the Clinical Governance Standard and Partnering with Consumers Standard.

Suggested approaches

Policies and procedures

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

- Identification bands cannot be worn
- Identification bands are lost or accidently removed
- Children do not have the capacity to identify themselves
Mothers and babies are separated.*

The following actions will support the implementation of the suggested approaches:

**Action 6.1**
Clinicians use the safety and quality systems from the Clinical Governance Standard when:
Implementing policies and procedures to support effective clinical communication

**Action 6.5**
The health service organisation:

- defines approved identifiers for patients according to best-practice guidelines
- requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and whenever clinical handover, transfer or discharge documentation is generated

* The separation of mothers and babies should only occur when clinically indicated.
Correct identification and procedure matching

Correctly identifying and implementing processes to match patients to their intended care is critical to ensuring patient safety. Risks to patient safety occur when there is a mismatch between a patient and components of their care. This includes diagnostic, therapeutic and supportive care.

Patient identification is performed frequently in all care settings, and can be seen as a relatively unimportant or routine task. The development of safety routines for common tasks (such as patient identification) provides a powerful defence against simple mistakes that may cause harm. Routines allow the workforce to focus their attention on activities that require more cognitive processing and judgement, such as providing clinical care. The design and implementation of routines should consider human factors such as human capabilities, limitations and characteristics.

Suggested approaches

Identification bands

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

- Ensure the correct ongoing identification of each child
- Restore the identification band as soon as possible
- Restrict all procedures or treatment for children until the band can be replaced and the child’s identity confirmed.

Breastmilk

The system for collection, storage and use of expressed breastmilk should include highly reliable processes for correct identification of mother and baby, including:

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

Complementary feeds

The use of complement or formula feeds should be given careful consideration, and should include:

- Obtaining and documenting consent before the administration of complementary feeds
- Establishing the presence of allergies as well as interactions between formula and any medicines being administered
- Training of relevant members of the workforce on local policies, processes and consent requirements for the management of complementary feeds, expressed breastmilk and identity confirmation.
The actions listed below will support the implementation of the suggested approaches. Only relevant elements of the actions are listed.

**Action 2.4**
The health service organisation ensures that its informed consent processes comply with legislation and best practice

**Action 6.5**
The health service organisation:
- defines approved identifiers for patients according to best-practice guidelines
- requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and whenever clinical handover, transfer or discharge documentation is generated

**Action 6.6**
The health service organisation:
- specifies the processes to correctly match patients to their care
Communication at clinical handover

Structured clinical handover has been shown to reduce communication errors between health service organisations, and to improve patient safety and care, because critical information is more likely to be accurately transferred and acted on.\(^{39, 40}\) This is particularly important at transitions of care, where communication errors are more likely and there is an increased risk of information being miscommunicated or lost. Ineffective communication at clinical handover is also associated with clinicians spending extensive time attempting to retrieve relevant and correct information.\(^{41}\) This can result in inappropriate care, and the possibility of misuse or poor use of resources.\(^{42, 43}\)

Although standardisation improves the efficiency and effectiveness of clinical handover, there needs to be some flexibility due to variability in the situations in which handover occurs, the methods of handover, the place in which handover occurs and who is involved in the process. A flexible standardised approach will provide the structure for handover and allow for flexibility to fit the service context and work practices.

Suggested approaches

Partnering with consumers

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

- Assess the level of capability of the family to provide ongoing care and provide information in a way that ensures it is understood
- Educate families and carers to detect deterioration, administer medicines and access relevant primary/community services
- Provide relevant information for families and carers to pass onto schools and childcare services.

Transitions of care

To ensure transitions of care are safe and effective, health service organisations may consider having specific systems in place, particularly when transitions are from:

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

For example, when young people transition to adult health services, support will be required by individual patients and their family to manage the transition.
The actions listed below will support the implementation of the suggested approaches. Only relevant elements of the actions are listed.

**Action 2.10**
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that:
- a. information is provided in a way that meets the needs of patients, carers, families and consumers
- b. information provided is easy to understand and use

**Action 6.7**
The health service organisation, in collaboration with clinicians, defines the minimum information content to be communicated at clinical handover, based on best-practice guidelines; risks relevant to the service context and the particular needs of patients, carers and families; and clinicians who are involved in the clinical handover.

**Action 6.8**
Clinicians use structured clinical handover processes that include:
- d. being aware of the patient’s goals and preferences
- e. supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient
- f. ensuring that clinical handover results in the transfer of responsibility and accountability for care

**Action 8.7**
The health service organisation has processes for patients, carers or families to directly escalate care.
Resources

Agency for Clinical Innovation. Key principles for transition of young people from paediatric to adult health care.  

Australian College of Midwives. Baby Friendly Health Initiative (BFHI) Information Pack for maternity facilities.  

Clinical Excellence Commission. In safe hands.  

The Royal Children’s Hospital Melbourne. Transition Support Service. What is adolescent transition?  
www.rch.org.au/transition

The Sydney Children's Hospitals Network. Trapeze – a supported leap into adult health.  
www.trapeze.org.au

7. Blood Management Standard

This Standard aims to improve outcomes for patients by using management strategies that boost and conserve their own blood, as well as ensuring that any blood and blood products that the patient receives are safe and appropriate.

A patient’s blood is a valuable and unique resource that should be conserved and managed well. Patient blood management is the means by which a patient’s own blood is optimised and conserved.

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

The administration and use of blood and blood products to children presents additional risks because of the size, developmental age, communication skills and cognitive ability of children. The Australian and New Zealand Society of Blood Transfusion recommends that health service organisations using blood and blood products to care for children tailor policies, procedures and/or protocols to the specific needs of this group.
Relevant criteria

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

- Clinical governance and quality improvement to support blood management
- Prescribing and clinical use of blood and blood products
- Managing the availability and safety of blood and blood products.

There are additional suggested strategies that health service organisations that provide care for children should consider. These suggested strategies relate to the following one out of three criteria that make up this Standard:

- Clinical governance and quality improvement to support blood management.

Clinical governance and quality improvement to support blood management

This criterion requires organisation-wide governance, leadership and commitment to support blood management.

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

- Apply safety and quality systems to support timely and appropriate blood management
- Use quality improvement systems to monitor, review and improve blood management
- Apply principles of partnering with consumers when designing and implementing blood management systems.

This criterion aligns closely with the Clinical Governance Standard and Partnering with Consumers Standard.

Safety and quality governance arrangements for blood and blood products may be embedded within, or managed as an adjunct to, broader safety and quality governance arrangements. Regardless of the approach, safety and quality governance arrangements for blood and blood products are required.

Suggested approaches

Consent

To ensure the issues of consent by children are addressed, health service organisations could consider:

- Ensuring that information on consent is provided in formats that are easy for children, their carers and/or families to understand
- Ensuring that the length of time that the consent remains valid is specified, particularly for children who may be chronically ill
- Taking action in the event that children and/or their carers refuse the use of blood or blood products – for example, Jehovah’s witnesses
- Taking action in circumstances where consent cannot be obtained.44

In addition, the health service organisation could audit patient clinical records to identify levels of compliance with transfusion consent policies, procedures and/or protocols and areas for improvement.
Evidence-based guidelines and practice

Health service organisations should ensure that patient blood management strategies are based on best practice guidelines and current evidence, including consideration of:

- A restrictive transfusion strategy
- Preoperative iron therapy for children at risk of iron deficiency
- Reducing the need for red blood cell transfusion and exchange transfusion.45

The actions listed below will support the implementation of the suggested approaches. Only relevant elements of the actions are listed.

**Action 2.4**
The health service organisation ensures that its informed consent processes comply with legislation and best practice.

**Action 7.1**
Clinicians use the safety and quality systems from the Clinical Governance Standard when:
   a. implementing policies and procedures for blood management

**Action 7.3**
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to:
   b. share decision making

**Action 7.4**
Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by:
   a. optimising patients’ own red cell mass, haemoglobin and iron stores
   b. identifying and managing patients with, or at risk of, bleeding
   c. determining the clinical need for blood and blood products, and related risks
Resources


8. Recognising and Responding to Acute Deterioration Standard

The intention of this Standard is to ensure that a person’s acute deterioration is recognised promptly and appropriate action is taken. Acute deterioration includes physiological changes, as well as acute changes in cognition and mental state.

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

There are several physiological differences between children and adults. For example, a young child’s airway is shaped in a way that can make intubation more difficult, they have a relatively higher metabolic and oxygen consumption rate, their circulating blood volume is higher and stroke volume is small and relatively fixed.46

As we age, our vital signs mature and the way that our bodies cope with acute illness or injury changes. The following factors affect recognition of and response to acute deterioration in children:

- Children’s physiological response to critical illnesses and treatments differs from that of adults
- During the progress of an acute illness children may look relatively well before deteriorating very suddenly
- Deterioration can occur rapidly, even in instances where children present with relatively minor illnesses.47

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

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

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

There are additional suggested strategies that health service organisations that provide care for children should consider. These suggested strategies relate to the following two out of three criteria that make up this Standard:

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

Clinical governance and quality improvement to support recognition and response systems

This criterion requires organisation-wide governance, leadership and commitment to support recognising and responding to acute deterioration in physiological and/or mental state.

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

- Apply safety and quality systems to support timely and appropriate recognition of and response to acute physiological and mental deterioration
- Use quality improvement systems to monitor, review and improve recognition and response systems
- Apply principles of partnering with consumers when designing and implementing systems to recognise and respond to acute physiological and mental deterioration.

This criterion aligns closely with the Clinical Governance Standard and Partnering with Consumers Standard.

Suggested approaches

Health service organisations that provide care to children rely on safety and quality systems and clinical governance frameworks that ensure safe and appropriate recognition of and response to acute deterioration. Ideally, these systems should take into account the differing parameters required to recognise and respond to deterioration in various age groups so that risks, trends and changes over time can be monitored.

Suggested approaches to do this include designing a system that:

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

The training of clinicians responsible for providing care to children may include:
- The clinical assessment of the specified demographic
- The use, measurement and recording of vital signs using approved age-appropriate observation charts and equipment
- Basic and advanced paediatric/neonatal life support, where appropriate, or the ability to call such staff if required.

The actions listed below will support the implementation of the suggested approaches. Only relevant elements of the actions are listed.

**Action 8.1**
Clinicians use the safety and quality systems from the Clinical Governance Standard when:
- a. implementing policies and procedures for recognising and responding to acute deterioration
- b. managing risks associated with recognising and responding to acute deterioration
- c. identifying training requirements for recognising and responding to acute deterioration

**Action 8.2**
The health service organisation applies the quality improvement system in the Clinical Governance Standard when:
- c. reporting on effectiveness and outcomes of recognition and response systems
Detecting and recognising acute deterioration, and escalating care

Monitoring and tracking changes in vital signs and other observations over time plays a significant role in detecting acute deterioration. Recognition systems include identifying the requirements for escalating care. These may be documented on vital sign observation charts, in policies and guidelines, and in escalation protocols. Escalation protocols provide details of the criteria, parameters and thresholds that indicate acute deterioration, the action to be taken when deterioration is detected, the process of calling for help and the expected responses.

It is vital to the effectiveness of recognition and response systems that escalation protocols are developed with local knowledge of the individual clinical area or health service organisation. Criteria for escalation that are appropriate for a large tertiary metropolitan hospital will not necessarily be appropriate for a small rural hospital. The availability of resources and clinical expertise also mean that response actions vary considerably from one organisation to another. Different protocols may be needed in different locations within a health service organisation, such as in specialist mental health services, the emergency department or standalone outpatient areas.

Suggested approaches

Policies and procedures
To ensure appropriate detection and recognition of acute deterioration in children, health service organisations may consider specifying the following in their policies, procedures and/or systems:

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

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

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

Partnering with consumers
To ensure effective consumer and carer escalation systems are in place, health service organisations may consider:

• Having a set of agreed triggers for families and carers to escalate care
• Clearly identifying methods for activating the system
• Identifying clinicians responsible for responding to family or carer concerns
• Describing the responding clinicians’ roles and responsibilities
• Implementing measures and processes for evaluating the effectiveness of the system
• Evaluating the effectiveness of family and carer activation.

To support family and carer involvement in escalation of care, families and carers should be empowered and educated to use the escalation system. This may include:
• Education and orientation provided on admission
• Use of printed brochures or posters placed in prominent locations
• Broadcasting information about the system on television and audio services throughout the health service organisation
• Auditing the effectiveness of communication strategies to empower carers and families to trigger the escalation process.

Implementing these suggested approaches will be supported by, or rely on, the following actions:

**Action 8.3**
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to:
  a. actively involve patients in their own care
  b. meet the patient’s information needs
  c. share decision making

**Action 8.4**
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to:
  a. document individualised vital sign monitoring plans
  b. monitor patients as required by their individualised monitoring plan
  c. graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient

**Action 8.6**
The health service organisation has protocols that specify criteria for escalating care, including:
  a. agreed vital sign parameters and other indicators of physiological deterioration
  b. worry or concern in members of the workforce, patients, carers and families about acute deterioration

**Action 8.7**
The health service organisation has processes for patients, carers or families to directly escalate care

**Action 8.8**
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance

**Action 8.9**
The workforce uses the recognition and response systems to escalate care
Resources


Advanced Paediatric Life Support Australia. www.apls.org.au


Monash Children’s Hospital, State Government of Victoria and The Royal Children’s Hospital Melbourne. ViCTOR: Victorian Children’s Tool for Observation and Response. www.victor.org.au


# Glossary

Where appropriate, glossary definitions from external sources have been adapted to fit the context of the NSQHS Standards.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>acute deterioration</td>
<td>Physiological, psychological or cognitive changes that may indicate a worsening of the patient’s health status; this may occur across a period of hours to days.</td>
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<tr>
<td>advance care plan</td>
<td>A plan that states preferences about health and personal care, and preferred health outcomes. An advance care planning discussion will often result in an advance care plan. Plans should be made on the person’s behalf and prepared from the person’s perspective to guide decisions about care.</td>
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<tr>
<td>adverse event</td>
<td>An incident that results, or could have resulted, in harm to a patient or consumer.</td>
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<tr>
<td>antimicrobial</td>
<td>A chemical substance that inhibits or destroys bacteria, viruses or fungi and can be safely administered to humans and animals.</td>
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<tr>
<td>antimicrobial resistance</td>
<td>Failure of an antimicrobial to inhibit a microorganism at the antimicrobial concentrations usually achieved over time with standard dosing regimens.</td>
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<tr>
<td>antimicrobial stewardship</td>
<td>An ongoing effort by a health service organisation to reduce the risks associated with increasing antimicrobial resistance and to extend the effectiveness of antimicrobial treatments. It may incorporate a broad range of strategies, including monitoring and review of antimicrobial use.</td>
</tr>
<tr>
<td>blood management</td>
<td>A process that improves outcomes for patients by improving their medical and surgical management in ways that boost and conserve their own blood, and ensure that any blood and blood products they receive are appropriate and safe.</td>
</tr>
<tr>
<td>carer</td>
<td>A person who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail and aged. An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are paid, a volunteer for an organisation, or caring as part of a training or education program.</td>
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<tr>
<td>child/children</td>
<td>A person aged from birth to 18 years of age.</td>
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<tr>
<td>Clinical Care Standards</td>
<td>Nationally relevant standards developed by the Commission and agreed by health ministers that identify and define the care people should expect to be offered or receive for specific conditions.</td>
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<tr>
<td>clinical communication</td>
<td>The exchange of information about a person’s care that occurs between treating clinicians, patients, families and carers, and members of a multidisciplinary team. Communication can take a number of different forms, including via face-to-face meetings, telephone, written notes or other documentation, and electronic means.</td>
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<tr>
<td>clinical governance</td>
<td>A system through which organisations and individuals are accountable to the community for continually improving the quality of services provided to consumers, and safeguarding high standards of care, ensuring that they are person centred, safe and effective.</td>
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<td>Term</td>
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<tr>
<td>clinical handover</td>
<td>The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.</td>
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<tr>
<td>clinician</td>
<td>A healthcare provider, trained as a clinician, including registered and nonregistered practitioners. Clinicians may provide care within a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They may include nurses, midwives, medical practitioners, allied health practitioners, technicians, scientists and other clinicians who provide health care, and students who provide health care under supervision.</td>
</tr>
<tr>
<td>comprehensive care plan</td>
<td>A document describing agreed goals of care, and outlining planned medical, nursing and allied health activities for a patient. Comprehensive care plans reflect shared decisions made with patients, families and carers about the tests, interventions, treatments and other activities needed to achieve the goals of care. The content of comprehensive care plans will vary depending on the setting and the service that is being provided, and may be called different things in different health service organisations. For example, a care or clinical pathway for a specific intervention may be considered a comprehensive care plan.</td>
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<tr>
<td>consumer</td>
<td>A person who has used, or may potentially use, health services or is a carer for a patient using health services. A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision-making processes.</td>
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<tr>
<td>corporate governance</td>
<td>Encompasses the establishment of systems and processes that shape, enable and oversee the management of an organisation. It is the activity undertaken by governing bodies (often boards) of formulating strategy, setting policy, delegating responsibility, supervising management, and ensuring appropriate risk management and accountability arrangements are in place throughout the organisation.</td>
</tr>
<tr>
<td>credentialing</td>
<td>The formal process used by a health service organisation to verify the qualifications, experience, professional standing, competencies and other relevant professional attributes of clinicians, so that the organisation can form a view about the clinician’s competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments.</td>
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<tr>
<td>diversity</td>
<td>The varying social, economic and geographic circumstances of consumers who use, or may use, the services of a health service organisation, as well as their cultural backgrounds, religions, beliefs, practices, languages spoken and sexualities (currently referred to as lesbian, gay, bisexual, transgender and intersex, or LGBTI).</td>
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<tr>
<td>end of life</td>
<td>The period when a patient is living with, and impaired by, a fatal condition, even if the trajectory is ambiguous or unknown. This period may be years in the case of patients with chronic or malignant disease, or very brief in the case of patients who suffer acute and unexpected illnesses or events, such as sepsis, stroke or trauma.</td>
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<tr>
<td>environment</td>
<td>The physical surroundings where health care is delivered, including the building, fixtures, fittings, and services such as air and water supply. Environment can also include other patients, consumers, visitors and the workforce.</td>
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<tr>
<td>Term</td>
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<tr>
<td>family</td>
<td>Those who are closest to the patient in knowledge, care and affection. This may include parents, siblings, grandparents, aunts, uncles, cousins and friends.</td>
</tr>
<tr>
<td>governance</td>
<td>The set of relationships and responsibilities established by a health service organisation between its executive, workforce and stakeholders (including patients and consumers). Governance incorporates the processes, customs, policy directives, laws and conventions affecting the way an organisation is directed, administered or controlled. Governance arrangements provide the structure for setting the corporate objectives (social, fiscal, legal, human resources) of the organisation and the means to achieve the objectives. They also specify the mechanisms for monitoring performance. Effective governance provides a clear statement of individual accountabilities within the organisation to help align the roles, interests and actions of different participants in the organisation to achieve the organisation’s objectives. In the NSQHS Standards, governance includes both corporate and clinical governance.</td>
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<tr>
<td>governing body</td>
<td>A board, chief executive officer, organisation owner, partnership or other highest level of governance (individual or group of individuals) that has ultimate responsibility for strategic and operational decisions affecting safety and quality in a health service organisation.</td>
</tr>
<tr>
<td>healthcare-associated infections</td>
<td>Infections that are acquired in healthcare facilities (nosocomial infections) or that occur as a result of healthcare interventions (iatrogenic infections). Healthcare-associated infections may manifest after people leave the healthcare facility.</td>
</tr>
<tr>
<td>health literacy</td>
<td>The Commission separates health literacy into two components – individual health literacy and the health literacy environment:</td>
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<tr>
<td></td>
<td>• Individual health literacy is the skills, knowledge, motivation and capacity of a consumer to access, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action</td>
</tr>
<tr>
<td></td>
<td>• The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the health system, and affect the ways in which consumers access, understand, appraise and apply health-related information and services.</td>
</tr>
<tr>
<td>informed consent</td>
<td>A process of communication between a patient and clinician about options for treatment, care processes or potential outcomes. This communication results in the patient’s authorisation or agreement to undergo a specific intervention or participate in planned care. The communication should ensure that the patient has an understanding of the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.</td>
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<tr>
<td>medication management</td>
<td>Practices used to manage the provision of medicines. Medication management has also been described as a cycle, pathway or system, which is complex and involves a number of different clinicians. The patient is the central focus. The system includes manufacturing, compounding, procuring, dispensing, prescribing, storing, administering, supplying and monitoring the effects of medicines. It also includes decision-making, and rules, guidelines, support tools, policies and procedures that are in place to direct the use of medicines.</td>
</tr>
<tr>
<td>open disclosure</td>
<td>An open discussion with a patient and carer about an incident that resulted in harm to the patient while receiving health care. The criteria of open disclosure are an expression of regret, and a factual explanation of what happened, the potential consequences, and the steps taken to manage the event and prevent recurrence.</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>partnership</td>
<td>A situation that develops when patients and consumers are treated with dignity and respect, when information is shared with them, and when participation and collaboration in healthcare processes are encouraged and supported to the extent that patients and consumers choose. Partnerships can exist in different ways in a health service organisation, including at the level of individual interactions; at the level of a service, department or program; and at the level of the organisation. They can also exist with consumers and groups in the community. Generally, partnerships at all levels are necessary to ensure that the health service organisation is responsive to patient and consumer input and needs, although the nature of the activities for these different types of partnership will vary depending on the context of the health service organisation.</td>
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<tr>
<td>patient</td>
<td>A person who is receiving care in a health service organisation.</td>
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<tr>
<td>person-centred care</td>
<td>An approach to the planning, delivery and evaluation of health care that is founded in mutually beneficial partnerships among clinicians and patients. Person-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of person-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of family and carers, and access to care. Also known as patient-centred care or consumer-centred care.</td>
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<tr>
<td>risk</td>
<td>The chance of something happening that will have a negative impact. Risk is expressed as a combination of the likelihood of an event occurring and the consequences of the event.</td>
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<tr>
<td>risk management</td>
<td>The design and implementation of a program to identify and avoid or minimise risks to patients, employees, volunteers, visitors and the organisation.</td>
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<tr>
<td>scope of clinical practice</td>
<td>The extent of an individual clinician’s approved clinical practice within a particular organisation, based on the clinician’s skills, knowledge, performance and professional suitability, and the needs and service capability of the organisation.</td>
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<tr>
<td>shared decision making</td>
<td>A consultation process in which a clinician and a patient jointly participate in making a health decision, having discussed the options and their benefits and harms, and having considered the patient’s values, preferences and circumstances.</td>
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<tr>
<td>substitute decision-maker</td>
<td>A person appointed or identified by law to make health, medical, residential and other personal (but not financial or legal) decisions on behalf of a patient whose decision-making capacity is impaired. A substitute decision-maker may be appointed by the patient, appointed for (on behalf of) the person, or identified as the default decision-maker by legislation, which varies by jurisdiction.</td>
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<td>system</td>
<td>The resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish a stated objective. The system:</td>
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<td>• Brings together risk management, governance, and operational processes and procedures, including education, training and orientation</td>
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<td>• Deploys an active implementation plan; feedback mechanisms include agreed protocols and guidelines, decision-support tools and other resource material</td>
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<td>• Employs a range of incentives and sanctions to influence behaviours and encourage compliance with policy, protocol, regulation and procedures.</td>
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<td>The workforce is both a resource in the system and involved in all elements of systems development, implementation, monitoring, improvement and evaluation.</td>
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<tr>
<td>Term</td>
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<tr>
<td>workforce</td>
<td>All people working in a health service organisation, including clinicians (see above) and any other employed or contracted, locum, agency, student, volunteer or peer workers. The workforce can be members of the health service organisation or medical company representatives providing technical support who have assigned roles and responsibilities for care of, administration of, support of, or involvement with patients in the health service organisation.</td>
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References


