AUSTRALIANCOMMISSIONON SAFETYANDQUALITYINHEALTHCARE

Consultation Paper on the

Draft

National Safety and Quality Health Service Standards

August 2010

Contents

1. Background

In April 2008, following extensive consultation by the Australian Commission on Safety and Quality in Health Care (the Commission), Australian Health Ministers endorsed in principle the model national accreditation scheme proposed by the Commission. Ministers also noted the Commission was to undertake the first phase of implementation.

The initial work has focused on:

- developing a preliminary set of National Safety and Quality Health Service Standards (the Standards), and

- detailed planning for national coordination of accreditation, involving a national body for this purpose.

To support this work, the Commission enlisted the support of technical expert working groups to identify key areas of safety and quality concerns for each topic and provide the technical content for each of the Standards.

2. The Consultation Process

The development of a complete set of Standards has occurred over the last 18 months and has involved extensive consultation. This has involved a seven-stage methodology:

1. selection of content areas in consultation with stakeholders against specified criteria

2. drafting of the Standards in conjunction with technical experts and key stakeholders

3. initial testing and validation of the Standards by the Commission's working groups and Commission standing committees, including the Inter Jurisdictional Committee

4. call for public written submissions

5. focus group meetings with consumers

6. meetings with industry groups and accrediting agencies

7. piloting the Standards in health services.

Each of the seven stages has been completed for the initial five Standards, which were released for consultation in November 2009. These Standards are:

- ***Governance for Safety and Quality in Health Service Organisations***, which provides the framework for Health Service Organisations as they implement safe systems

- ***Healthcare-Associated Infection***, which describes the standard expected to prevent infection of patients within the healthcare system and to manage infections effectively when they occur to minimise their consequences

- ***Medication Safety***, which describes the standard expected to ensure clinicians prescribe, dispense and administer appropriate and safe medication to informed patients

- ***Patient Identification and Procedure Matching,*** which specifies the expected processes for identification of patients and correctly matching their identity with the correct treatment

- ***Clinical Handover***, which describes the requirement for effective clinical communication whenever accountability and responsibility for a patient's care is transferred.

> The Commission is now seeking comment on the five new draft Standards (at Appendix 1 and highlighted with a page border) before piloting and final consideration by Health Ministers in early 2011.

The five new draft Standards are:

- ***Partnering for Consumer Engagement***, which creates a consumer-centred health system by including consumers in the design and delivery of quality health care

- ***Blood and Blood Product Safety***, which sets the standard to ensure that the patients who receive blood and blood products are safe

- **Prevention and Management of Pressure Ulcers***,* which specifies the expected standard to prevent patients developing pressure ulcers and best-practice management when pressure ulcers occur

- ***Recognising and Responding to Clinical Deterioration in Acute Health Care***, which describes the systems required by health services responding to patients when their clinical condition deteriorates

- ***Preventing Falls and Harm from Falls***, which describes the standards for reducing the incidence of patient falls in Health Service Organisations.

It is important to note that the ***Governance for Safety and Quality in Health Service Organisations*** Standard and the ***Partnering for Consumer Engagement*** Standard form the foundation on which each of the other Standards are to be applied.
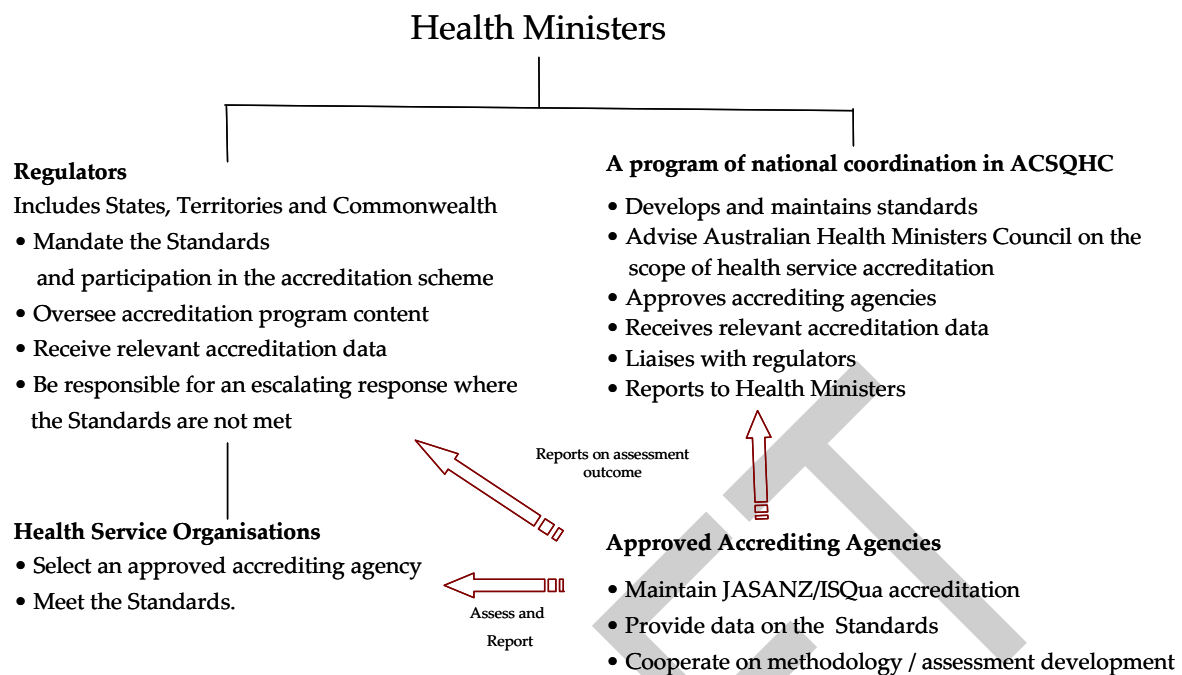
This consultation process aims to:

- refine the Standards and ensure they are meaningful for health services and practitioners implementing safety and quality systems, as well as accreditation agencies and surveyors using the Standards to assess whether they have been met

- ensure the Standards address consumer expectations for safe and high-quality services

- standardise and streamline processes where possible

- determine what documentation is needed by health services, practitioners and accrediting bodies to implement the Standards

- assist in setting the direction for future implementation activities.

3. Context

Current safety and quality accreditation of health services in Australia is seen as fragmented and is perceived by some Health Service Organisations as too complex and resource intensive. Further, accreditation outcomes lack the transparency expected by governments and consumers. For consumers, limited information is available publicly about the accreditation status of services. Information that is available is largely about process, such as period of accreditation, rather than the type of information that consumers seek, such as quality and safety of the service.

The model national accreditation scheme consists of five inter-related elements to support the application of the Standards and is summarised in Figure 1. The proposed roles of each of these elements are outlined broadly below.

1. *Health Ministers* endorse the Standards and receive information on the system's performance against the standards.

2. The *Regulators*, including States, Territories and the Commonwealth, would mandate the meeting of the Standards and participation in an assessment process by an Approved Accrediting Agency. As system managers, the Regulators would oversee the accreditation responsibilities of the health services in their jurisdiction. Where Standards were not met, the Regulator would commence a series of escalating responses that could ultimately result in sanctions or other actions being applied.

3. The *Health Service Organisations* would meet the Standards and select an approved accrediting agency to assess that the Standards had been met.

4. The *Approved Accrediting Agencies* would assess Health Service Organisations against the Standards and provide accreditation information to the Health Service Organisations, the Regulators and the national coordination program of the Commission.

5. A program of *national coordination within the Commission* would:
   - develop and maintain the Standards
   - define the scope of safety and quality accreditation for Health Service Organisations (initially to high-risk services)
   - approve accrediting agencies to assess against the Standards
   - receive accreditation data for the purpose of reporting on safety and quality matters, developing tools and resources and maintaining the Standards.
   - liaise with Regulators
   - report to Health Ministers.

Figure 1: A Model National Scheme for Safety and Quality Accreditation

Health Ministers

Regulators

Includes States, Territories and Commonwealth

• Mandate the Standards
   and participation in the accreditation scheme
• Oversee accreditation program content
• Receive relevant accreditation data
• Be responsible for an escalating response where
   the Standards are not met

A program of national coordination in ACSQHC

• Develops and maintains standards
• Advise Australian Health Ministers Council on the
   scope of health service accreditation
• Approves accrediting agencies
• Receives relevant accreditation data
• Liaises with regulators
• Reports to Health Ministers

Reports on assessment
outcome

Health Service Organisations

• Select an approved accrediting agency
• Meet the Standards.

Assess and
Report

Approved Accrediting Agencies

• Maintain JASANZ/ISQua accreditation
• Provide data on the Standards
• Cooperate on methodology / assessment development

The model national accreditation scheme proposes that all health services that pose high risk of harm to patients should participate in accreditation and be assessed against the Standards. **High-risk health services are those that undertake 'invasive' procedures into a body cavity or dissect skin while using anaesthesia or sedation.**

Most high-risk services are hospitals and procedure centres, many of which are currently accredited. These services would continue to participate in an accreditation program. Other high-risk Health Service Organisations would now also be required to participate in an accreditation program. Health Service Organisations with a lower risk of harm should utilise the Standards as part of their internal quality assurance mechanisms.

This would mean that accreditation against the Standards is required for:

- **public hospitals**
- **private hospitals**
- **day procedure** and **day hospitals**
- **practitioner rooms where high-risk activities can occur**, for example cosmetic surgery, endoscopy and dentistry.

4. Consultation Questions

It is intended that the introduction of the Standards will provide a standardised measure of the safety and quality of care that is applicable across all Health Service Organisations. The Standards will provide a guide to Health Service Organisations of the level of care expected to be provided to improve overall patient care in health settings in Australia.

The Commission is now seeking feedback on the five new draft Standards, in relation to the following questions:

1. Is the language and format of the Standards appropriate?

2. Are there gaps in the Standards that should be addressed?

3. Is there duplication that should be removed from the Standards?

4. General comment in relation to any one or all of the Standards.

5. Next Steps

Outcome of the consultation

The results of this consultation process will be used to refine the five new draft Standards and develop the tools and guidelines necessary for implementation.

Pilot of the five new draft Standards

A pilot study of the five new draft Standards will commence in early 2011. The pilot will involve representative organisations from a range of private and public health service providers where the Standards apply.

The Commission is currently identifying participants for the Pilot Study. If you would like to nominate your organisation to participate in the Pilot Study, please contact the Commission at mail@safetyandquality.gov.au

Ministers' approval process and timing

In November 2010, the Commission will submit to Health Ministers a package of reforms for accreditation that includes the Standards and their use in the Model National Accreditation Scheme.

If approved by Ministers, it is proposed that implementation would commence in July 2011.

6. Submissions

All submissions received will be published on the Commission's website, including the names and/or organisations making the submission. The Commission will consider requests to withhold part or all of the contents of any submission made. Any submission that includes personal information identifying specific individuals may be withheld from publication or de-identified before submissions are published.

Written submissions

Submissions can be sent by post, fax or email. All written submissions should be received by close of business on **Friday 8 October 2010** to be considered in the consultation process.

Submissions should include:

- name, organisation (if relevant) and contact details

- responses to questions posed

- general comments

- additional information, for example, any technical, economic or business information, or research-based evidence the Commission should be made aware of to support the views or comments.

Written submissions marked 'Consultation Paper on Standards' can be forwarded to:

> Consultation on National Safety and Quality Health Service Standards
> Australian Commission on Safety and Quality in Health Care
> GPO Box 5480
> SYDNEY NSW 2001
>
> or via email to: mail@safetyandquality.gov.au
>
> or fax to: 02 9263 3613

Questions relating to submissions should be directed to mail@safetyandquality.gov.au or made by calling the Commission on (02) 9263 3633.

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Introduction

This document presents the complete set of ten National Safety and Quality Health Service Standards (the Standards). Five of these standards were released for consultation in November 2009. Feedback from the 92 written submissions received and the four consumer focus groups held have been incorporated into the Standards. These five Standards were piloted in 27 health services throughout the country during early 2010 and the Standards were amended based on advice from these health services.

An additional five standards have been developed with the support of technical experts and key stakeholders. These Standards are now being released for consultation prior to piloting in health services.

Purpose of the Standards

Accreditation is a system to promote and support safe patient care and continuous quality improvement of services through a process of assessment and review. The intent of the Standards is two-fold. It is a ***quality assurance*** mechanism that will measure whether the relevant systems are in place to assure minimum standards of safety and quality are met; and ***quality improvement*** mechanism allowing services to identify aspirational or developmental criteria, for health services that have achieved the minimum requirements.

Accreditation is awarded as an outcome of the process of independent assessment of a Health Service Organisation against standards. It can comprise self assessment, planned and *ad hoc* visits. However, an accreditation award does not guarantee the quality of healthcare outcomes achieved by the Health Service Organisation.

Background

In November 2006, Australian Health Ministers Conference (AHMC) requested that the Australian Commission on Safety and Quality in Health Care (the Commission) review national safety and quality accreditation standards. This followed the 2005 release of the *Review of Future Governance Arrangements for Safety and Quality in Health Care* [1]. In April 2008, following extensive consultation by the Commission, Australian Health Ministers endorsed the model national scheme for safety and quality accreditation proposed by the Commission. Ministers also noted the Commission was to undertake the first phase of implementation.

The initial work has focused on:

- developing a preliminary set of Standards
- detailed planning for national coordination of accreditation, involving a national body for this purpose.

National Safety and Quality Health Service Standards

Central to the package of accreditation reforms are the draft Standards. These Standards have been developed in collaboration with jurisdictions, experts and key stakeholders.

The Standards focus on areas that are essential to improving the safety and quality of care for patients. **The Standards provide a statement of controls that must be in place to assure, or provide the best possible chance that health services will deliver the expected level of safety and quality and patient outcomes.**

There are ten Standards in total. The first five standards are:

- ***Governance for Safety and Quality in Health Service Organisations***, which provides the framework for Health Service Organisations as they implement safe systems

- ***Healthcare-Associated Infection***, which describes the standard expected to prevent infection of patients within the healthcare system and to manage infections effectively when they occur, to minimise their consequences

- ***Medication Safety***, which describes the standard expected to ensure clinicians prescribe, dispense and administer appropriate and safe medication to informed patients

- ***Patient Identification and Procedure Matching***, which specifies the expected processes for identification of patients and correctly matching their identity with the correct treatment.

- ***Clinical Handover***, which describes the requirement for effective clinical communication whenever accountability and responsibility for a patient's care is transferred.

The five new draft Standards are:

- ***Partnering for Consumer Engagement***, which creates a consumer-centred health system by including consumers in the design and delivery of quality health care

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- ***Recognising and Responding to Clinical Deterioration in Acute Health Care***, which describes the systems required by health services responding to patients when their clinical condition deteriorates

- ***Preventing Falls and Harm from Falls***, which describes the standards for reducing the incidence of patient falls in Health Service Organisations.

The ***Governance for Safety and Quality in Health Service Organisations*** Standard and the ***Partnering for Consumer Engagement*** Standard provide the context for the implementation of each of the other Standards. The 'Governance' Standard provides the safety and quality framework by outlining the expected structures and processes of a safe organisation. It requires clear governance processes, routine risk management systems, monitoring of services and quality improvement programs to be in place throughout the organisation. The 'Partnering for Consumer Engagement' Standard provides the framework for a patient-focused service culture by involving consumers in the review, design and implementation of services. These Standards set the overarching requirements for effective implementation of the remaining eight Standards, which address clinically specific areas of patient care.

These Standards have been selected because they represent areas:

- that impact on a large number of patients

- where there is known gap between the current situation and best practice outcomes

- in which improvement strategies exist that are evidence based and achievable.

A broad range of key stakeholder groups with experience and expertise in the public and private healthcare systems have collaborated in the development of each Standard.

About the Draft Standards

Each of the draft Standards described in this document determines the framework that Health Service Organisations must implement to meet the requirements of the Standards. Each Standard contains:

- the **Standard,** which is a statement of intended actions and strategies

- a **Statement of intent,** which is an aspirational statement or desired outcome for the Standard

- a statement on the **Context** in which the Standard must be applied

- a list of key **Criteria**; each criterion has a number of **items** that describe the required activities for the Standard; the items contain the specific requirements for the Standard and the **Measure** by which these will be assessed.

In order to comply with each Standard, Health Service Organisations must ensure systems are in place to meet the stated objective. The systems require:

- effective planning, organisation, integration, regulation and administration of resources and procedures

- effective facilitation of the interface between risk management, governance, monitoring of operational processes and procedures and action on quality improvement

- appropriate training and orientation of staff, agreed protocols and guidelines, decision support and other resource material

- data collection, analysis and monitoring

- effective mechanisms for meaningful feedback to the organisation, the workforce and patients.

Core and Developmental Measures

The Standards provide a nationally consistent and uniform set of measures of safety and quality across health services. Not all items present an equal risk in all health services. Not all Standards are equally applicable across all health services. The Standards will be applied across a wide variety of services where the complexity, size, service delivery model and structure vary extensively. Application of the Standards in a meaningful way across these diverse health settings requires a degree of flexibility. To achieve this, it is intended that the measures against the items within a Standard would be designated as:

- core measures, which are critical for safety and quality

- developmental measures, which are aspirational targets

- not applicable measures, which are inappropriate in that service context and for which measurement would be meaningless.

Health Service Organisations must meet all core measures to meet the Standards and/or gain an accreditation award. Core measures are fundamental to safe practice and are therefore mandatory. Developmental measures flag areas where focused activities and/or investments are to be made by health services to improve patient safety and quality. Health services will not be required to meet all development measures in order to be awarded accreditation.

The Standard *Partnering for Consumer Engagement* requires effective and meaningful engagement of consumers in organisational planning. Increasingly, there is evidence to suggest that engaging consumers can result in improved safety, quality and efficiency. Since the tools and evidence for the most effective methods of consumer partnership and engagement are still emerging, health services would be expected to work towards achieving this Standard, but may not meet all of the requirements to meet the standard in the first cycle of accreditation.

The future

In November 2010, the Commission will submit to Health Ministers a package of reforms for accreditation that includes the Standards and their use in a model national accreditation scheme.

If approved by Ministers, implementation would commence in July 2011.

Roles for Safety and Quality in Health Care

This list outlines each participant's role in ensuring the effective delivery of healthcare services in relation to Safety and Quality in Health Service Organisations.

Specific roles that relate to the clinical issues covered in Standards 3–10 are described at the beginning of the relevant Standard.

Participant group	Role
Patient and carers	To exercise their healthcare rights.
	To engage actively in their health care and treatment decisions; provide accurate information about their health care when it is requested; seek to be informed about their treatment; and follow agreed treatment plans.
	To seek opportunities to form a partnership with the Health Service Organisation and participate in the decision-making processes for service planning, models of care and service measurement and evaluation.
	To provide feedback to Health Service Organisations.
Clinical workforce	To participate actively in organisational processes, safety systems, improvement initiatives, and related training according to the role/s for which they are accountable.
	To understand their broad responsibility for safety and quality in health care; follow safety and quality procedures; supervise and educate other staff; and participate in review and analysis performance procedures as an individual and/or as part of a team.
	To participate in safety and quality data collection and analysis, and in reviewing of evidence and guidelines.
	To partner with patients and their carer/families and support patients to exercise their healthcare rights in order to improve the experience of care for the individual patient.
	To work in partnership with consumers at every opportunity, including in the design and planning of organisational processes, safety systems, improvement initiatives and related training.
Non-clinical workforce	To participate actively in organisational processes, including the development and implementation of safety systems, improvement initiatives and related training.
	To participate actively in building partnerships with consumers involved in the design and planning of organisational processes, including the development and implementation of safety systems, improvement initiatives and related training.
	To notify the clinical workforce when concerns exist about a patient.

Participant group	Role
Health Service Organisation managers	To implement and maintain systems, materials, education and training that ensures safe, effective and reliable health care is delivered in partnership with patients, carers and consumers.
	To consider the advice of consumers through established partnerships when designing, implementing and maintaining systems.
	To facilitate compliance and manage performance across the organisation and within individual areas of responsibility for the governance of safety and quality systems.
	To model behaviours that optimise safety and high-quality care.
	To consider safety and quality implications in decision making processes.
Health service executive and owners	To clearly articulate organisational and individual accountabilities for safety and quality throughout the organisation.
	To implement planning and review of integrated governance systems that promotes patient safety and quality.
	To clearly support partnerships with consumers and their role in safety, models of care, program design and review of the organisation's performance.
	To model behaviours that optimise safe and high-quality care as part of the implementation of a safety culture in the organisation.
	To support patients to exercise their healthcare rights.
National coordinating body for accreditation *(potential roles are described here)*	To ensure the Standards target areas that impact on a large number of patients and/or the workforce where there is a known gap between current and best practice outcomes, and where there is evidence of an effective solution and the solution is feasible to implement.
	To ensure the requirements specified in the Governance for *Safety and Quality in Health Service Organisations* and *Partnering for Consumer Engagement* Standards are applied across all Standards.
	To ensure the Standards are measurable and are assessed consistently across all accredited organisations.
	To provide national guidelines and tools regarding compliance with the Standards that are useable, reliable and valid.
	To compile national data and analyse trends to support policy and decision making on governance and partnerships with consumers for safety and quality across all the Standards.
	To report on national safety and quality accreditation.

Participant group	Role
Approved Accrediting Agency	To assess compliance by Health Service Organisations with all Standards and provide data and reports required for national coordination of accreditation.
	To award accreditation and notify both the Regulators and the national coordinating body when an organisation's performance does not meet the Standards.
	To comply with eligibility requirements to assess health services against the Standards.
	To ensure the process of accreditation includes the assessment of Governance for Safety and Quality and Partnering for Consumer Engagement within an organisation and that the requirements of these Standards are applied broadly across the other eight Standards.
Regulators	To mandate the Standards and participate in the model national accreditation scheme
	To oversee the accreditation program content.
	To implement escalating responses where the Standards have not been met.

Terminology:

A definition of the specific meanings for terms used in the Standards is given below.

Accreditation: 'the granting of recognition for meeting designated standards for structure, process and outcomes, where the outcome is the status of an individual, group of people or population which is wholly attributable to an action, agent or circumstance', as defined by the Commission in a 2006 Discussion Paper on National Safety and Quality. [2]

In a more general sense, accreditation is a system to promote and support safe patient care and continuous quality improvement of services through a process of regular assessment and review.

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

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

Adverse drug reaction: see adverse medicines event

Adverse event: an incident that results in harm to a patient, where harm includes disease, injury, suffering, disability and death. [3].

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

Alcohol-based hand rub: an alcohol-containing preparation (liquid, gel or foam) designed for application to the hands to reduce the growth of micro-organisms. Such a preparation may contain one or more types of alcohol with excipients (binding agents), other active ingredients and humectants (moistening agents).

Antibiotic: a substance that kills or inhibits the growth of bacteria, fungi or parasites.

Antimicrobial: a chemical substance that inhibits or destroys bacteria, viruses and fungi, including yeasts or moulds.

Antimicrobial stewardship: a program implemented in a Health Service Organisation to reduce the risks associated with increasing microbial resistance and to extend the effectiveness of antimicrobial treatments which may incorporate a broad range of strategies including the monitoring and reviews of antimicrobial use.

Approved patient identifiers: items of information accepted for use in patient identification, including patient name (family and given names), date of birth, gender, address and/or medical record number. Clinicians and Health Service Organisations are responsible for specifying the approved data items for patient identification. Identifiers such as room or bed number are not to be used. The unique patient identifier to be introduced in Australia in 2010 will become a required identifier.

Bacteraemia: the presence of bacteria in the blood or the lymph system that may result in infection.

Blood: homologous and autologous whole blood, blood including red blood cells, platelets, fresh frozen plasma, cryoprecipitate and cryo-depleted plasma.

Blood products: plasma derivatives and recombinant products excluding medication products such as Rh (D) immunoglobulin.

Bloodstream infection: the presence of live pathogens in the blood, causing an infection.

Carers: people who provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness or who are frail. Carers include parents and guardians caring for children.

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

Clinical practice guidelines (CPGs): systematically developed statements that assist clinicians, consumers and health service decision makers to make appropriate health care decisions. CPGs provide statements of 'best practice' based on a thorough evaluation of the current evidence on the outcomes of treatment or other health care procedures. [4].

Clinical handover: the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.

Clinical workforce: the medical staff, allied health staff and nursing staff who provide patient care and students who provide patient care under supervision.

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

Community setting: a place outside a designated acute health service where health services are provided. These services may be self-administered or provided by health professionals or carers.

Competency based training (CBT): an approach to vocational education and training that places emphasis on what a person can do in the workplace as a result of completing a program of training that is conducted internally or externally to the organisation. [5]

Complementary healthcare products: vitamin, mineral, herbal, aromatherapy and homeopathic products, also known as 'traditional' or 'alternative' medicines.

Informed consent: a process of communication between a patient and their medical officer that results in the patient's authorisation or agreement to undergo a specific medical intervention [6]. This communication should ensure the consumer has an understanding of all the available options and the expected outcomes such as the success rates and/or side effects for each option..

Consumer representative: a person whose experience of health services is primarily as a consumer of services, and who takes part in decision-making processes on behalf of consumers. [7].

Consumer Medicines Information: brand-specific leaflets produced by a pharmaceutical company, in accordance with the Therapeutic Goods Regulations (*Therapeutic Goods Act 1989)*, [8], to inform consumers about prescription and pharmacist-only medicines. Available from a variety of sources, for example enclosed within in the medication package, supplied by a pharmacist as a leaflet or computer printout, provided by a doctor, nurse or hospital, provided by the pharmaceutical manufacturer or available via the internet.

Continuous improvement: a systematic, ongoing effort to raise an organisation's performance as measured against a set of Standards [47].

Decontamination: the combination of processes, including cleaning, disinfection and sterilisation, used to render a reusable item safe for further use on patients and handling by staff.

Disease surveillance: an epidemiological practice by which the spread of disease is monitored in order to establish patterns of progression. Disease surveillance is to predict, observe and minimise the harm caused by outbreak, epidemic and pandemic situations, as well as increase knowledge about factors contributing to the disease outbreak.

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

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

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

Fall: An event that results in a person coming to rest inadvertently on the ground or floor or other lower level. [9]

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

Hand antisepsis: reducing or inhibiting the growth of micro-organisms by the application of an antiseptic hand rub or by performing an antiseptic hand wash used for the recommended minimum contact time.

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

Healthcare associated infections: infections acquired in healthcare facilities (nosocomial infections) and infections that occur as a result of healthcare interventions (iatrogenic infections), and which may manifest after people leave the healthcare facility. [10]

Health consumers: patients and potential patients, carers and organisations representing consumers' interests. [48]

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

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

Health service record: information held about a patient or consumer that may be held in hard or soft copy and may include contact and demographic information, medical history, notes on treatment, observations, correspondence, investigations, test results, photographs, prescription records, medication charts, insurance information and legal and occupational health and safety reports.

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

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

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

Induction: see orientation.

Information on medicines: information on the name, indication, risks, benefits, contraindications and instructions for the use of medicines provided by a clinician, such as leaflets (e.g. *Consumer Medicines Information*), or accessed from trusted websites, journals and published literature.

Infection: the invasion and reproduction of pathogenic (disease-causing) organisms inside the body. This can cause tissue injury and progress to disease.

Infection control or **infection control measures:** actions to prevent the spread of pathogens between people in a healthcare setting. Examples of infection control measures include targeted healthcare associated infection (HAI) surveillance, infectious disease monitoring, hand hygiene and personal protective equipment.

Interventional procedures: any procedure used for diagnosis or treatment that penetrates the body and involves incision, puncture, entry into a body cavity.

Invasive devices: devices inserted through skin, mucosal barrier or internal cavity, including central lines, peripheral lines, urinary catheters, chest drains, peripherally inserted central catheters (PICC) and endotracheal tubes.

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

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

Medication history: an accurate recording of medications, comprising a list of all current medicines including all current prescription and non-prescription medicines, complementary healthcare products and medicines used intermittently; recent changes to the medication list; past history of adverse drug reaction including allergies; and other recreational drug use.

Medication incident: see adverse medicines event.

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

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

Monitoring plan: a written plan that documents the type and frequency of observations to be recorded as referred to in the *Recognising and Responding to Clinical Deterioration* Standard.

Near miss: an incident that did not cause harm, but had the potential to do so. [49]

Non-clinical workforce: the workforce engaged in a Health Service Organisation who are not providing direct clinical care but support the business of health service delivery through administration, management of hotel services, corporate records, management and support.

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

Open disclosure: the open discussion of incidents that resulted in harm to a 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 being taken to manage the event and prevent recurrence.

Orientation: a formal process of informing and training staff on entry into a position or organisation, covering the policies, processes and procedures applicable to that Health Service Organisation.

Patient: a person receiving health care. For the purpose of this document and ease of reading, only this term has been used. The term 'patient' is intended to also include consumers, clients and other people, however titled, receiving health care from a clinician.

Patient care mismatching events: events where a patient receives the incorrect procedure, therapy, medication, implant/device or diagnostic test. This may be as a result of

the wrong patient receiving the treatment (e.g. the wrong patient receiving an X-ray) or as a result of the correct patient receiving the wrong care (e.g. a surgical procedure performed on the wrong side or the provision of an incorrect meal resulting in an adverse event).

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

Patient information: formal **i**nformation provided by Health Service Organisations to patients to ensure they are informed prior to making decisions about their care.

Patient master index: a permanent listing or register of health information held by an organisation on patients who have received or are scheduled to receive services.

Patient records: see health service record.

Patient safety incident: an event or circumstance that resulted, or could have resulted, in avoidable harm to a patient. Patient safety incidents include adverse events and near misses.

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

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

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

Prescription medicine: a licensed medicine that is regulated by legislation to require a prescription authorised by an appropriately registered practitioner before it can be obtained. [50]

Pressure ulcer: a localised injury to the skin and/or underlying tissue, usually over a bony prominence and caused by unrelieved pressure, friction or shear. Pressure ulcers occur most commonly on the sacrum and heel but can develop anywhere on the body. Pressure injury is a synonymous term for pressure ulcer.

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

Quality improvement activities: activities directed through planning or as a result of negative data analysis that are a component of the Quality Management System. The methodology that is utilised should be consistent with a continuous improvement approach, for example Plan-Do-Study-Act.

Quality management system: the system established by the organisation to define quality policy and objectives (plans) and to achieve those objectives, including organisational structure, resource management, policy and procedures, review and improvement processes.

Quality in health care: a number of attributes that may include: appropriateness, effectiveness, efficiency, safety, access, consumer engagement, clinical performance and evaluation.

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

Recognition and response systems: formal systems to support staff to promptly and reliably recognise patients who are clinically deteriorating, and to respond appropriately to stabilise the patient.

Risk factor: an activity or factor that may increase the chance of developing a disease or causing harm.

Risk management: activities undertaken by an organisation to identify, control and minimise threats to the ongoing efficiency, effectiveness and success of its operations to deliver desired outcomes.

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

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

Training: the development of practical skills that should be related to the professional development needs of the individual and organisation and may be incorporated into professional development programs.

Treatment-limiting orders: orders, instructions or decisions that involve the reduction, withdrawal or withholding of life-sustaining treatment. These may include 'no cardiopulmonary resuscitation' (CPR), 'not for resuscitation' and 'do not resuscitate' orders.

Draft National Safety and Quality Health Service Standard 1
Governance for Safety and Quality in Health Service Organisations (SQ)

The SQ Standard:

Leaders of a Health Service Organisation actively participate in policy, protocol or procedure setting and management of clinical safety and quality performance. This includes communicating the importance of the patient experience and quality management to all staff.

The intention of this Standard is to:

Create integrated governance systems that maintain and improve the reliability and quality of patient care as well as improving patient outcomes.

Context:

This Standard provides the safety and quality governance framework. It is expected that this Standard will apply in conjunction with Standard 2, *Partnering for Consumer Engagement* to the implementation of all other Standards.

Criteria for the SQ Standard are:

A. **Governance and quality improvement system**
   There is an integrated system of governance that actively manages patient safety and quality risks.

B **Clinical practice**
   Care provided by the clinical workforce is guided by current best practice.

C. **Performance and skills management**
   The clinical workforce has the right qualifications, skills and approach to provide safe, high quality care.

D. **Incident management**
   Patient safety and quality incidents are recognised, reported, analysed and used to change how work is done.

E. **Patient engagement and rights**
   Patients' rights are respected and their engagement in their care is supported through widespread use of the *Australian Charter of Healthcare Rights.*

Explanatory Notes

Background

Despite most health care in Australia being associated with good clinical outcomes, patients still do not receive all the care that is recommended to them, and preventable adverse events continue to occur across the Australian healthcare system. [11].

Presently, the data available to measure the extent to which this problem is occurring are unavailable or too unreliable to establish a baseline from which improvements in safety and quality of care can be derived. [11] In addition, it is recognised that patient and stakeholder trust in the healthcare system is genuinely impacted when system failures occur. Confidence in the healthcare system is reportedly low, according to a 2007 population survey [11] This survey indicated that only 24% of respondents felt that the current healthcare system works well, 55% felt that fundamental changes were needed and 18% suggested a complete rebuild. [11].

Furthermore, economic projections for total health expenditure indicate that fiscal pressure on the system will only increase in the future. A predicted increase of $90.9 billion in total health expenditure is expected between 2009 and 2032–33 [11] .

Solutions to drive safe and appropriate health care

Sustained and continuous improvement to the Australian healthcare system has become the focus of a national reform agenda. Adoption of the overarching *Governance for Safety and Quality in Health Service Organisations (SQ)* Standard is essential to the effective implementation of the other clinically based Standards, such as medication safety and infection control.

A systematic approach to quality improvement identifies those accountable for action in Health Service Organisations; focusing on risk, quality and patient safety, to ensure that the necessary monitoring and actions are taken to improve services.

The SQ Standard is designed to improve the safety and quality of the care provided in all healthcare settings. The Standard would support:

- health service managers to develop and maintain robust management systems for safety and quality

- strategic and operational safety and quality plans

- current quality assurance and improvement activities and resources allocation for safety and quality

- decisions on commitments to patients, or designing goals for health service improvement

- engagement of and partnering with patients, consumers, clinicians, managers, researchers and policy-makers to contribute to safety and quality.

Criteria for the SQ Standard

A. Governance and quality improvement system
There is an integrated system of governance that actively manages patient safety and quality risks.

SQ:A will be achieved by:	SQ:A Measure
1. The Board, Chief Executive Officer or other higher level of government within a Health Service Organisation would take responsibility for patient safety and quality of care.	**1a.** Evidence that safety and quality indicators and other data are regularly reported to and monitored by the senior executive group.
	1b. Evidence of any required action being taken as a result of the data.
2. Implementing a governance system that sets out the policy, procedures or protocols for: • establishing and maintaining a clinical governance framework • identifying safety and quality risks • collecting and reviewing performance data • implementing prevention strategies based on data analysis • agreeing on escalation procedures for required actions • incident analysis • implementing performance management procedures • ensuing compliance with legislative requirements and relevant industry standards • communicating with and informing the clinical and non clinical workforce • regular clinical audits as required.	**2a.** Evidence that the impact on patient safety and quality of care is considered in all business decision making.
	2b. Evidence that the business changes necessary to support patient safety and quality of care improvement activities have been considered.
	2c Evidence that a process for escalation of patient safety and quality issues is incorporated into the organisation's structure and systems.
	2d Evidence of policies, protocols or procedures that incorporate the item requirements.
	2e Evidence that there is an organisation-wide management system to monitor compliance and review of policies, protocols or procedures to ensure effectiveness.
3. Assigning roles, responsibilities and accountabilities for: • the management of safety and quality nominated individuals in the workforce • each of the criteria and items in Standards 2–10.	**3a.** Evidence that the designated individuals understand and enact their roles and responsibilities.
	3b. Evidence that agency or locum workforce members have designed roles and responsibilities and that they are aware of these.

SQ:A will be achieved by:	SQ:A Measure
4. Implementing competency-based training for the clinical and relevant non-clinical workforce in their assigned safety and quality responsibilities in order to meet the intent of all draft Standards.	**4a.** Evidence that the workforce participate in orientation and ongoing training programs which meet the requirements of all Standards including safety and quality management and governance systems.
	4b. Evidence that annual mandatory training programs meet the requirements of all Standards.
	4c. Evidence that the locum and agency workforce receive induction and training.
5. Establishing an organisation-wide risk-management system that incorporates identification, assessment, rating, controls and monitoring for patient safety and quality.	**5a.** Evidence of an organisation-wide risk register that is used by the organisation to monitor risks, and supports reporting on action taken to minimise risks.
6. An established organisation-wide quality-management system that monitors the safety and quality of patient care and that results in changes to practice and the associated documentation.	**6a.** Evidence of an integrated approach to quality management that is based on the risk priorities and that quality-improvement techniques are used to improve patient safety and quality care.

B. Clinical practice
Care provided by the clinical workforce is guided by current best practice.

SQ:B will be achieved by:	SQ:B Measure
1. Developing and/or applying clinical guidelines or pathways that are supported by the best available evidence.	**1a.** Evidence that agreed and documented clinical guidelines and/or pathways are available for the entire clinical workforce.
Item B2 applies to community based services for which Standard 9 *Recognising and Responding to Clinical Deterioration* is not applicable.	
2. Establishing a system for escalation of care when an unexpected change of health status occurs.	**2a.** Evidence of a system that informs staff of action to be taken.
3. Adopting processes to support the early identification, early intervention and appropriate management of patients at increased risk of harm from health care.	**3a.** Evidence that those patients at increased risk of harm are identified and early action to reduce that risk is taken.
4. An integrated health service record that identifies all aspects of the patient's care.	**4a** Evidence that accurate, integrated and readily-accessible health service records are available to the clinical workforce.
	4b. Evidence that the health service records have the capacity for a systematic audit process to assess the contents against the requirements of these Standards.

C. Performance and skills management

The clinical workforce has the right qualifications, skills and approach to provide safe, high quality care.

SQ:C will be achieved by:	SQ:C Measure
1. Implementing a system that determines the roles, responsibilities, accountabilities, regular review and set scope of practice for the clinical workforce.	**1a.** Evidence of a system to ensure that the clinical workforce has a defined scope of practice and mechanisms exist to monitor that they are working within that scope of practice.
	1b. Evidence of a system that considers scope of practice and organisational role delineation (or capability for community-based practices) for the introduction of a new clinical service, procedure or other technology.
	1c. Evidence of a valid and reliable peer review process for the clinical workforce. [12]
	1b. Evidence of supervision where it may be necessary for individuals to fulfil their designated role.
2. Implementing a performance development system for the clinical workforce that supports performance improvement within their scope of practice.	**2a.** Evidence that the clinical workforce participates in performance development processes that regularly review performance and supports change for individual improvement.
3. Ensuring that systems are in place for ongoing education and training, through learning and professional development programs.	**3a.** Evidence of access for the clinical and relevant non-clinical workforce to ongoing education and training for identified professional and personal development
4. Conducting a regular survey of the workforce to assess the level of engagement with and understanding of the organisations safety and quality systems.	**4a.** Evidence of the workforce participating in a regular survey with compilation of the results, analysis and feedback mechanisms that result in action as required.

D. Incident management

Patient safety and quality incidents are recognised, reported, analysed and used to change how work is done.

SQ:D will be achieved by:	SQ:D Measure
1. Implementing an incident management and investigation system that includes reporting, investigation and analysis of incidents, including near misses, and which results in corrective actions being taken.	**1a.** Evidence that processes are in place to support the workforce to recognise and report incidents and near misses and that the workforce has access to feedback on reported incidents.
	1b. Evidence of an effective system for reporting, analysing and taking action to reduce risks identified through the incident-management system.
2. Implementing a complaints management system that reflects partnership with patients and their	**2a.** Evidence that processes are in place to support the workforce to recognise and report complaints and they have access to feedback on reported complaints.

SQ:D will be achieved by:	SQ:D Measure
carers.	
	2b. Evidence of an effective system for reporting, analysing and responding to complaints and that action is taken to prevent reoccurrence.
3. Implementing an open disclosure process based on the national *Open Disclosure* Standard. [13]	**3a.** Evidence that an open disclosure program is in place, the clinical workforce are trained in open disclosure processes and that it is practiced in accordance with the national Standard**.**

E. Patient engagement and rights

Patients' rights are respected and their engagement in their care is supported through widespread use of the *Australian Charter of Healthcare Rights*.

SQ:E will be achieved by:	SQ:E Measure
1. Implementing the *Australian Charter of Healthcare Rights* [14] through organisational policies and practices.	**1a.** Evidence that information on patient rights and internal and external complaint mechanisms is provided and explained to patients and their carers and families.
	1b. Evidence that mechanisms are in place to support people at risk of not understanding their healthcare rights.
2. Implementing processes to enable partnership with patients in decision-making regarding their care, including informed consent to treatment.	**2a.** Evidence that patients are fully informed about their proposed treatment and have been a partner in the development of their planned treatment plan.
3. Implementing procedures that protect the confidentiality of patient records without compromising appropriate clinical workforce access to patient information.	**3a.** Evidence that clinical information is available at the point of care, and systems are in place to restrict its inappropriate access and dissemination.
4. Implementing well-designed, valid and reliable patient experience feedback mechanisms and using these to evaluate the health service performance.	**4a.** Evidence that data collected from patient feedback systems are used to measure and improve Health Service Organisation performance.

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Open Disclosure Standard: A National Standard for Open Communication in Public Private Hospitals, following an Adverse Event in Health Care. Australian Council for Safety and Quality in Health Care.

Standard for Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners. Australian Council for Safety and Quality in Health Care.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient satisfaction survey tools.

Draft National Safety and Quality Health Service Standard 2
Partnering for Consumer Engagement (CE)

The CE Standard:
Systems are in place to ensure that Health Service Organisations work in partnership with consumers to facilitate their input into policy and processes to improve safety and quality of care.

The intention of this Standard is to:
Create a health service that is responsive to consumer input and needs.

Context:
This Standard provides the framework for the active partnership with consumers by Health Service Organisations. It is expected that this Standard will apply in conjunction with Standard 1 *Governance for Safety and Quality in Health Service Organisations*, to the implementation of all other Standards.

Criteria for the CE Standard are:

A.   Consumer participation in service planning
Clinical leaders and senior managers ensure governance structures are in place to form partnerships with consumers.

B.   Models of care and program design
Mechanisms for consumers to actively participate in the Health Service Organisation processes are in place to improve patient experiences.

C.   Service measurement and evaluation
Consumers, healthcare professionals and service managers receive information on and contribute to the monitoring, measurement and evaluation of the Health Service Organisation's performance.

Explanatory Notes

There is a growing body of work that supports the claim that health systems are safer when consumers are involved in their design and delivery. *The National Health and Hospitals Reform Commission (NHHRC) Final Report* 2009, [15] for example, focused on the need to incorporate the views and experiences of both patients and consumers. It argued that, if people are educated and informed about health issues, they will become empowered to act as partners in their health care. 'Strengthened consumer engagement and voice' was cited as 'the first and most important principle guiding health reform' by the NHHRC, and linked to the need to increase public trust in the government's ability to deliver health services.

Emerging literature demonstrates that there are many benefits to patient-centred care, broadly categorised as care experience, clinical and operational care. Studies increasingly show that, when healthcare administrators and providers work in partnership with patients and families, the quality and safety of health care rises, costs decrease and provider and patient satisfaction increase The World Health Organisation (WHO) report '*People at the Centre of Health Care*' [16] states:

The essence of people-centred health care and health systems involves a balanced consideration of the values, needs, expectations, preferences, capacities, and health and well-being of all the constituents and stakeholders, and encompasses the ill and those who are well. (Page viii)

When potential health care users (the public) were asked what they expect health care to be, responses ranged from the basics of accessibility, affordability, safety and quality, to higher levels of expectations: responsiveness, flexibility and choice; health promotion; and transparency, accountability and the opportunity to influence health policy and participate in health services planning. (Page 12)

Beyond access, patients particularly wanted the following: clear, concise and intelligible information; effective treatments, administered by competent health professionals; emotional support, empathy and respect; continuity of care and smooth transitions; attention to physical and environmental needs; support for self-care; and involvement of family and other caregivers in the care experience'.

People-centred health care reaffirms these core values, articulated in the constitution of the World Health Organization and other international declarations:
- *health as a fundamental human right*
- *health as a central element in the process of development*
- *the end of all forms of discrimination*
- *the participation and inclusion of communities in health and development.*

These core values give rise to the seven essential principles of people centred health care, namely health care that is equitable, engages all stakeholders, promotes empowerment, provides effective care, is evidence-based and empathic, and is efficient and ethical. (Page viii)

Charmel & Frampton [17] state that increasing patient satisfaction through patient-centred approaches to health care increases employee satisfaction. This in turn assists with employee retention rates and an ability to continue practicing patient-centred care. According to Charmel & Frampton the link between patient satisfaction and employee satisfaction is reflected in the fundamental philosophy of patient-centred care. A defining tenet is the importance of staff feeling cared for themselves, so they can best care for their patients.

Other benefits associated with patient-centred care include: decreased length of stay; decreased emergency department return visits; fewer medication errors; improved liability claims experience (Charmel Frampton 2008); and improved clinical care (Jha, Orav, Zheng and Epstein 2008). [18]. These findings lead Charmel and Frampton to conclude that patient-centred care is not merely philosophical; rather it is sound business practice.

The Commission is working to promote patient-centred care through its programs and projects, including the Australian Charter of Healthcare Rights, Open Disclosure, Clinical Handover and Patient Engagement projects.

Criteria for the CE Standard*:*

A. Consumer participation in service planning
Clinical leaders and senior managers ensure governance structures are in place to form partnerships with consumers.

CE:A will be achieved by:	*Rationale*	Measure:
1. Establishing and reviewing governance structures to enable the partnership with consumers.	*A patient-centred approach to the development and implementation of health services contributes to meeting the expectations and needs of patients.*	**1a.** Evidence of consumer engagement in the organisation's governance systems.
2. Implementation of policies, procedures or protocols for partnering with consumers in: • strategic and operational planning • decision making about safety and quality initiatives • quality program activities.	*Consumer representatives require guidance to assist in utilising their knowledge and experience as users of the health service, and to assist in understanding the organisation's planned direction and the issues that impact on patient experience, including those that impact on safety and quality.*	**2a.** Evidence that mechanisms are in place to ensure consumer partnership in safety and quality decision making.
3. Facilitating access to relevant orientation and training for consumers engaging in partnership with the organisation.	*Consumer representatives who are adequately trained in organisational processes are able to contribute as an equal partner.*	**3a.** Evidence of consumers' participation in orientation and training.
4. Consumer consultation on the design and content of patient information distributed by the organisation.	*A consumer understands what patients and their carers 'need to know'.*	**4a.** Evidence of consumer involvement in the decision making about patient information distributed by the organisation.
		4b. Evidence that patients receive adequate information to make informed decisions regarding their treatment plan.

B. Models of care and program design

Consumers actively participate in the Health Service Organisation processes to improve the patient experience.

CE:B will be achieved by:	*Rationale*	Measure:
1. Consumers partnering with the organisation to design models of care to better meet patient needs and preferences.	*Consumers who are either patients or engage with patients understand their needs and priorities of care and can provide valuable insight for the Health Service Organisation.*	**1a.** Evidence of consumer participation in designing patient services.
2. Implementing training for clinical leaders and senior management on the value of, and ways to facilitate, consumer engagement and create and sustain partnerships.	*The workforce is adequately trained to engage and partner with consumer representatives.*	**2a.** Evidence of increasing participation of clinical leaders and senior managers in consumer engagement training over time.

C. Service measurement and evaluation

Consumers, health- care professionals and managers receive information on and contribute to the monitoring, measurement and evaluation of the Health Service Organisation's performance

CE:C will be achieved by:	*Rationale*	Measure:
1. Consumers receive information that informs them of the organisation's performance in a format that can be understood and interpreted independently.	*For consumers to partner with the organisation, the information that they receive needs to be informative and intuitive to interpret.*	**1a.** Evidence of information being provided to the consumers on the organisation's performance in matters relating to safety and quality.
2. Consumers participating in the analysis of performance information and data, and the development of action plans and their implementation.	*Performance priorities that are patient-centred require input from consumers.*	**2a.** Evidence of consumer participation in the analysis of performance data, planning and implementation of quality improvements.
3. Consumers participating in the evaluation of patient feedback data and subsequent action plans.	*The value of feedback cannot be under-estimated in its ability to provide a balanced information set to utilise in planning and change management processes.*	**3a.** Evidence of consumer participation in planning and implementation of quality activities relating to patient feedback data.

CE:C will be achieved by:	*Rationale*	Measure:
4. Reporting on patient feedback data, including complaints, to the highest level of governance.	*An understanding of the type and number of complaints informs the organisation of the service that requires review.*	**4a.** Evidence that patient feedback and related action plans are regularly reported to the highest level of governance in the organisation.

Draft National Safety and Quality Health Service Standard 3 Healthcare Associated Infections (HAI)

The HAI Standard

Clinical leaders and senior managers of a Health Service Organisation put in place systems for the prevention and management of healthcare associated infection and communicate these to all staff to achieve appropriate outcomes. Clinicians and other staff implement healthcare associated systems.

The intention of this Standard is to:

Prevent patients acquiring a healthcare associated infection and to effectively manage infections whenever they occur.

Context:

It is expected that this Standard will be applied in conjunction with the ***Governance for Safety and Quality in Health Service Organisations*** requirements and ***Partnering for Consumer Engagement*** as specified in Standards 1 and 2.

Criteria for the HAI Standard are:

A. Systems and governance for infection prevention, control and surveillance
Effective governance and management systems for healthcare associated infection are developed and maintained.

B. Infection prevention and control policies and protocols
Policies and protocols for the prevention and control of healthcare associated infection are developed and implemented.

C. Managing patients with infections
Patients presenting with an infection or who acquire an infection during their care are identified promptly and receive the necessary management and treatment.

D. Antimicrobial stewardship
Quality antimicrobial prescribing is a strategic goal and an objective of the clinical governance system.

E. Cleaning disinfection and sterilisation
Healthcare facilities, equipment, instruments and environments are clean.

F. Information for patients and consumers
Information on healthcare associated infection is provided to patients, the public and other service providers.

Explanatory Notes

Background

Each year, infections associated with health care occur in a large number of patients, making healthcare associated infections the most common complication affecting patients in hospitals. Some of these infections require stronger and more expensive medications (with the added risk of complications), and may result in life-long disabilities or even death. In addition to significant patient harm caused by healthcare associated infections, such infections increase patient utilisation of health services and greater demands on the clinical workforce (laboratory tests and other tools to diagnose the infection). There are prolonged hospital stays, which reduce the beds available for new admissions and which require more comprehensive quarantine/isolation procedures and facilities.

Infection agents evolve over time and continue to present new challenges for healthcare. Of major current concern is the transmission of antimicrobial resistant bacteria, such as *Methicillin-resistant Staphylococcus aureus* (MRSA) and *Vancomycin-resistant Enterococci* (VRE), and how they can be prevented in healthcare facilities. At least half of healthcare-associated infections are preventable. Australian and overseas studies have shown that mechanisms exist that can reduce the rate of infections from these agents.

In Australian healthcare facilities, large numbers of patients are treated in close proximity to each other. Here they often undergo invasive procedures, have medical devices fitted and receive broad-spectrum antibiotics or immunosuppressive therapies. These conditions provide ideal opportunities for the adaptation and spread of pathogenic microorganisms.

The Scale of the Problem

Annual figures of healthcare associated infections in Australia are as follows:
- 200,000 healthcare associated infections annually [19]
- 12,000 bloodstream infections associated with healthcare [20]
- 7000 *Staphylococcus aureus* bloodstream infections [20]
- 17–29% patients with healthcare associated infections die in hospital [20]
- 2 million extra bed days [20].

Solutions to Preventing Infection

Just as there is no single cause of infection, there is no single solution to the problems posed by healthcare associated infections. Successful infection control requires a range of strategies across all levels of the healthcare system and a collaborative approach for successful implementation.

Specific Roles for Healthcare Associated Infection

This list outlines each participant's specific role in ensuring the requirements of the HAI Standard are met. These roles are additional to the generic roles for safety and quality listed at the beginning of the Standards.

Participant group	Role
Patient and carers	To partner with the Health Service Organisation by engaging in processes that minimise the risk of spreading infections.
Clinical workforce	To participate in surveillance of healthcare associated infections by supporting data collection and analysis, review of evidence and guidelines.
	To understand their role in effective antibiotic stewardship.
Non-clinical workforce	To participate actively in and contribute to the governance of infection-control systems and supporting programs.
	To ensure a high level of personal hygiene is maintained and infection-control procedures are implemented at each healthcare transaction.
Health Service Organisation managers	To facilitate compliance and manage performance across the organisation and within individual areas of their responsibility for implementation of infection prevention and control systems.
Health service executive and owners	To clearly articulate organisational and individual accountabilities for infection prevention and control throughout the organisation.
National coordinating body for accreditation	To provide national guidelines regarding compliance with the HAI Standard and analyse trends to support policy and decision making on healthcare-associated infection.

Criteria for the HAI Standard

A. Systems and governance for infection prevention, control and surveillance
Effective governance and management systems for healthcare associated infections are developed and maintained.

HAI:A will be achieved by:	HAI:A Measure
1. Developing, implementing, and carrying out ongoing review of policies or protocols for infection prevention and control interventions that are relevant to the healthcare setting.	**1a.** Evidence of policies, protocols and procedures being implemented and monitored including: • standard infection-control precautions • transmission-based precautions • aseptic technique • outbreaks of communicable infection • isolation of patients • safe handling and disposal of sharps • prevention and management of occupational exposure to blood-borne viruses • environmental cleaning and disinfection • processing of reusable medical devices • single-use devices • antimicrobial prescribing • surveillance and reporting of data where relevant • reporting of communicable/notifiable diseases • provision of risk assessment guidelines to staff.
2. Undertaking a regular comprehensive risk assessment of healthcare associated infections that includes reporting, investigating and analysing healthcare-associated infection incidents.	**2a.** Evidence that there are mechanisms to regularly assess the healthcare-associated infection risks, actions taken based on the risks and monitoring the results of those actions.
3. Undertaking quality improvement activities for healthcare associated infections and implementing changes to practice with documentation and monitoring to improve system effectiveness.	**3a.** Evidence of quality improvement techniques to reduce and prevent healthcare associated infections.

B. Infection prevention and control protocols

Policies and protocols for the prevention and control of healthcare associated infection are developed and implemented.

HAI:B will be achieved by:	HAI:B Measure
1. Developing, implementing and auditing a hand hygiene program consistent with the current national hand hygiene initiative.	**1a.** Evidence of staff compliance with the Australian *Guidelines for the Prevention and Control of Infections in Health Care (National Health and Medical Research Council (NHMRC) 2010).*[10]
	1b. Evidence that auditing of hand hygiene compliance rates is regularly reported to the highest level of governance in the organisation.
2. Developing, implementing and monitoring a risk-based workforce immunisation program in accordance with the current *NHMRC Australian Immunisation Handbook[21].*	**2a.** Evidence that a staff immunisation program is in place and is in accordance with the current *NHMRC Australian Immunisation Handbook.*[21]
3. Promoting collaboration with Occupational Health and Safety (OHS) programs to decrease the risk of infection to healthcare workers.	**3a.** Evidence of infection prevention and control related to OHS policies, protocols or procedures being implemented to address factors including: - communicable disease status - healthcare worker immunisation is in accordance with the current *NHMRC Australian Immunisation Handbook* [21] - post-exposure management and prophylaxis - work restrictions - personal protective equipment (PPE).
4. Developing and implementing a system for use and management of infection prevention for invasive devices based on the current *Australian Guidelines for the Prevention and Control of Infections in Health Care (NHMRC 2010).* [10]	**4a.** Evidence that the system for the use and management of invasive devices, incorporating infection prevention, is monitored for compliance.
5. Implementing mandatory protocols, education and competency-based training for the invasive device procedures routinely used within the organisation.	**5a.** Evidence that education and competency-based training is in place for all staff who perform procedures with invasive devices.
6. Developing and implementing protocols, education and competency-based training for aseptic technique procedures.	**6a.** Evidence that the clinical workforce is trained in aseptic protocols, techniques and procedures.
	6b. Evidenced by auditing that aseptic technique compliance is conducted regularly and action taken to address any issues identified.

C. Managing patients with infections

Patients presenting with an infection or who acquire an infection during their care, are identified promptly and receive the necessary management and treatment.

HAI:C will be achieved by:	HAI:C Measure
1. Implementing systems for using standard precaution procedures and transmission based precautions that are consistent with the current *Australian Guidelines for the Prevention and Control of Infections in Health Care (NHMRC 2010)*. [10]	**1a.** Evidence that compliance with standard precautions is being monitored and action taken when required.
	1b. Evidence that compliance with transmission-based precautions is monitored and action taken when required.
2. Undertaking planning based on local risk assessment so patient segregation facilities are available when necessary.	**2a.** Evidence that risk analysis has specifically considered the need for transmission-based precautions including: • accommodation based on the means of transmission • environmental controls through air flow • transportation • cleaning procedures • equipment requirements.
	2b. Evidence of systems to manage the workforce and visitor access to isolation and treatment areas.
3. Developing and implementing protocols relating to admission, receipt and transfer of patients with an infection.	**3a:** Evidence of mechanisms for checking for pre-existing communicable disease on presentation for care.
	3b. Evidence of a process for communicating a patient's infectious status whenever responsibility for care is transferred between service providers or facilities.

D. Antimicrobial stewardship

Quality antimicrobial prescribing is a strategic goal and an objective of the clinical governance system.

HAI:D will be achieved by:	HAI:D Measure
1. Developing, implementing and regularly reviewing the effectiveness of the antimicrobial management system.	**1a.** Evidence of an antimicrobial management system.
	1b. Evidence of ready access for the clinical workforce to the Therapeutic Guidelines: Antibiotic.
	1c. Evidence of monitoring of antimicrobial usage and recurrent infections associated with resistance.

E. Cleaning, disinfection and sterilisation
Healthcare facilities, equipment, instruments and environment are clean.

HAI:E will be achieved by:	HAI:E Measure
1. Developing, implementing and reviewing the effectiveness of a system to create and maintain a clean environment.	**1a.** Evidence of policies for infection prevention and control that are implemented and regularly reviewed relating to: • maintenance of building facilities • cleaning services • decontamination of infected sites • laundry linen • waste management • workforce dress code.
	1b. Evidence of risk analysis and action taken to create and maintain a clean environment.
	1c. Evidence of an established cleaning schedule and regular cleaning audits.
2. Reprocessing and sterilisation of reusable medical devices and other devices is in accordance with relevant national standards and manufacturers' instructions.	**2a.** Evidence of compliance with the current national standards for reprocessing and sterilising of reusable medical devices.
3. Implementing systems to enable the identification of patients on whom the reusable medical devices have been used.	**3a.** Evidence of a traceability system that identifies patients who have a procedure using sterile reusable medical instruments and devices.
4. Ensuring staff who decontaminate reusable medical devices undertake competency-based training in these practices.	**4a.** Evidence of the measurement of the proportion of the workforce decontaminating reusable medical devices trained in a competency-based program.

F.   Information for patients and consumers
Information on healthcare associated infection is provided to patients, the public and other service providers.

HAI:F will be achieved by:	HAI:F Measure
1. Ensuring access to consumer-specific information on the reduction of healthcare-associated infections is available at the point of care.	**1a.** Evidence that information on the reduction of infection risks associated with the health services is available to consumers.
	1b. Evidence that Health Service Organisations audit the usefulness of the infection reduction information provided.

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Reducing Harm to Patients from Healthcare Associated Infection: An Australian Infection Prevention and Control Model for Acute Hospitals.

Draft National Safety and Quality Health Service Standard 4
Medication Safety (MS)

The MS Standard

Clinical leaders and senior managers of a Health Service Organisation put in place systems to reduce the occurrence of medication incidents and improve the safety and quality of medicines use. Clinicians and other staff implement medication safety systems.

The intention of this Standard is to:

Ensure competent clinicians safely prescribe, dispense and administer appropriate medicines to informed patients and carers.

Context:

It is expected that this Standard will be applied in conjunction with the *Governance for Safety and Quality in Health Service Organisations* requirements and *Partnering for Consumer Engagement* as specified in Standards 1 and 2.

Criteria for the MS Standard are:

A. Systems and governance for medication safety
   Health Service Organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing and monitoring of the effects of medicines.

B. Documentation of patient information
   The clinical workforce accurately records a patient's medication history and it is available throughout the episode of care.

C. Provision of medicines information to patients
   The clinical workforce informs patients about the options, risks and their responsibilities for an agreed medicines treatment plan.

D. Medication management processes
   The clinical workforce is supported to prescribe, dispense, administer and store medicines safely.

E. Continuity of medication management
   The clinician provides a complete list of a patient's medicines to the receiving clinician and patient when handing over care or changing medicines.

Explanatory Notes

The Scale of the Problem

Medicines are the most common treatment used in health care. Because they are so commonly used, medicines are associated with a higher incidence of errors and adverse events than other healthcare interventions. Many of these events are costly and potentially avoidable.

It is estimated that the rate of medicine-related hospital admissions in Australia is around 2–3%, with as many as 30% of unplanned geriatric admissions being associated with an adverse medicines event. [22] Approximately 50% of these admissions are considered potentially avoidable (a range of 32–77%). [22] Around 190,000 medication-related admissions are thought to occur each year in Australia. [23]

Common causes of medication error in the acute care setting include slips and lapses, difficulties in accessing patient and medical information at point of care, and communication lapses at transition of care. [24] Over half of all hospital errors are reported to occur at the interface of care. Patients having medicines omitted from their discharge summary are at least two to three times more likely to be readmitted to hospital. [25] It is estimated that between 2% and 5% of drug charts contain prescribing errors, while administration errors occur at a rate of 5% to 18%. [26]

In the community, as many as 10.4% of patients report experiencing an adverse drug event within the previous 6 months of presentation to their general practitioner, and 23.2% of these were considered preventable. [27] In high-risk patients, up to 25% report experiencing an adverse drug event in the previous 3 months. [28] Risk factors for medication error and adverse events in the community are patient age (older patients being at most risk), serious health conditions, multiple medicines, use of high-risk medicines and transfer of care from community to hospital. [29]

With over 1.5 million Australians estimated to experience an adverse event from medicines each year [30], resulting in at least 400,000 visits to general practitioners and 140,000 hospital admissions, the cost to individual patients and the healthcare system is significant. In 2009, medicine-related hospital admissions in Australia were estimated to cost $660 million. [23] The impact on patients' quality of life is much more difficult to quantify.

Solutions to Prevent Adverse Medicine Events

Many solutions to prevent medication error are found in standardisation and systemisation. Standardisation of processes, improved communication, use of technology and access to patient information and clinical decision support at the point of care are recognised solutions for reducing common causes of medication error.

Specific Roles for Medication Safety

This list outlines each participant's specific role in ensuring the requirements of the MS Standard are met. These roles are additional to the generic roles for safety and quality listed at the beginning of the Standards.

Participant group	Role
Patient and carers	To provide accurate information about their medical conditions and the medicines they are taking, including non-prescription and complementary medicines.
	To maintain an up to date list of all medicines they are currently taking.
	To be informed about their medicines, including the associated risks.
	To raise issues that may impact on compliance with an agreed medication plan.
The clinical workforce	To prescribe, supply and administer medicines safely and appropriately in partnership with the patient and/or carer.
	To participate in surveillance of medication-related adverse events by supporting data collection and analysis.
Non-clinical workforce	To participate actively in and contribute to the implementation of medications management and supporting programs.
	To ensure information relevant to a patient's medicines management is communicated to the clinical workforce.
Health Service Organisation managers	To implement and maintain systems, materials and training that ensures safe and effective medication management systems are in place and preventable medication errors and harm are avoided.
	To facilitate compliance and manage performance across the organisation and within individual areas of responsibility for the governance of a medication system.
Health service executive and owners	To clearly articulate organisational and individual accountabilities for safety and quality throughout the organisation for the safe and quality use of medicines.
	To implement planning and review of integrated governance systems that promotes patient safety and quality use of medicines.

Criteria for the MS Standard

A. Systems and governance for medications safety

Health Service Organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing and monitoring of the effects of medicines

MS:A will be achieved by:	MS:A Measure
1. Ensuring the policies, protocols or procedures are consistent with the national guidelines and facilitate safe and appropriate use of medicines. [26]	**1a.** Evidence that policies, procedures or protocols are based on national and professional guidelines. [25]
2. Undertaking a regular, comprehensive assessment of medication-use systems to identify risks to patient safety and implementing system changes to address the identified risks.	**2a.** Evidence of regular risk assessment of medication management systems and action taken in response to identified risks.
3. Undertaking quality improvement activities to enhance the safety of medicines use	**3a.** Evidence of quality improvement activities to address safety risks and measure the performance of the medication management system.

B. Documentation of patient information

The clinical workforce accurately records a patient's medication history and it is available throughout the episode of care.

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MS:B will be achieved by:	MS:B Measure
1. The clinical workforce taking an accurate medication history on initial presentation of a patient to a Health Service Organisation, or as early as possible in the episode of care, which is then available at the point of care.	**1a.** Evidence that a comprehensive medication history is documented and available at the point of care.
2. The clinical workforce documenting patients' previous adverse medicine event/s on initial presentation and updating this when an adverse reaction to a medicine occurs during the episode of care.	**2a.** The proportion of patients whose health service record clearly documents the presence or absence of medication allergies.
	2b. Evidence that a patient's adverse reaction to a medicine is reviewed and the action taken is documented.
3. The clinical workforce reviews the patient's current medication orders against their medication history and reconciles any discrepancies.	**3a.** The proportion of patients whose current medications are documented and reconciled at admission/transfer of care between healthcare settings.

C. Provision of medicines information to patients
The clinical workforce informs patients about the options, risks and their responsibilities for an agreed medicines treatment plan.

MS:C will be achieved by:	MS:C Measure
1. The clinical workforce informing patients and carers about medication treatment options, benefits and associated risks.	**1a.** Evidence is recorded that patients were provided with information associated with treatment options and the agreed treatment plan.
2. Current medicines information being available to patients in a format that can be understood whenever new medicines are prescribed or dispensed.	**2a.** Evidence that patient-specific medicines information is readily available to the clinical workforce and provided to patients.
	2b. Patient feedback information on the provision of medicines information is collected, analysed and actioned.

D. Medication management processes
The clinical workforce is supported to prescribe, dispense, administer and store medicines safely.

MS:D will be achieved by:	MS:D Measure
1. Ensuring that patients' current clinical information is available to the clinical workforce when making clinical decisions related to medicines use.	**1a.** Evidence that the clinical workforce has access to patients' current clinical information at the point of care.
2. Ensuring that current and accurate medicines information and decision support tools are readily available to the clinical workforce when making clinical decisions related to medicines use.	**2a.** Evidence that the clinical workforce has access to medicines information and decision support tools at the point of care.
3. Developing and disseminating prescribing, dispensing and administering authorities for medications to all the relevant workforce.	**3a.** Evidence a system exists where the workforce can verify medication authorities and the system is monitored for compliance.
4. Establishing defined processes for verifying patient identification when prescribing, dispensing and administering medicine.	**4a.** Evidence that a system is in place for the identification of compliance and actioning deviations.

5. Ensuring that medicines are distributed and stored securely, safely and in accordance with the manufacturer's directions, legislation, jurisdictional orders and operational directives.	**5a.** Evidence that the risks of non-compliance accompanying secure storage and safe distribution requirements are identified and actions taken to address non-compliance.
	5b. Evidence of a system for monitoring storage of temperature-sensitive medicines.
	5c. Evidence of a system for disposal of unused, unwanted or expired medications according to legislated and jurisdictional requirements.
6. Identifying high-risk medicines in the organisation and ensuring they are stored, prescribed, dispensed and administered safely.	**6a.** Evidence that the risks of compliance with high-risk medicine requirements are addressed.

E.   Continuity of medication management
The clinician provides a complete list of a patient's medicines to the receiving clinician and patient when handing over care or changing medicines.

MS:E will be achieved by:	**MS:E Measure**
1. Ensuring clinical handovers between healthcare settings include a current comprehensive list of medicines, and the reason/s for change, is provided to the receiving clinician and the patient.	**1a.** Evidence of a system that generates and distributes a current and comprehensive list of medicines, which is provided to the patient and receiving clinician.
	1b. Evidence of a system that generates the comprehensive list and which includes explanations of changes to medicines.

Bibliography for the Medication Safety Standard

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Patient Identification and Procedure Matching. Safety and Quality Healthcare Standard

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Quality Care Pharmacy Program Standards. Pharmacy Guild.
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Draft National Safety and Quality Health Service Standard 5
Patient Identification and Procedure Matching (PI)

The PI Standard

Clinical leaders and senior managers of a Health Service Organisation establish systems to ensure patient identification and matching patient identification with the intended clinical interventions. Clinicians and other staff use the patient identification and procedure matching systems.

The intention of this Standard is to:

Correctly identify all patients whenever care is provided.

Context:

It is expected that this Standard will be applied in conjunction with the *Governance for Safety and Quality in Health Service Organisations* requirements and *Partnering for Consumer Engagement* as specified in Standards 1 and 2.

Criteria for the PI Standard are:

A. Identifying individual patients
At least three approved patient identifiers are used when providing care, therapy or services.

B. Transfer of care
A patient's identity is confirmed using three approved patient identifiers when transferring responsibility for care.

C. Matching patients and their care
Health Service Organisations have explicit processes to correctly match patients with their intended care.

D. Assessing risks of mismatching patients and their care
Health Service Organisations implement risk assessment mechanisms for patient matching.

Explanatory Notes

The Scale of the Problem

Evidence from Australia and overseas indicate that errors involving a mismatch between patients and their surgical care account for 13–48% [19,30] of reported events, depending on reporting requirements. When non-surgical mismatching events are included in reporting systems, this rate rises. In a US study of patient-identification adverse events, 81% involved procedures other than invasive procedures and surgery. [31] It is known that patient mismatching also occurs in non-clinical areas of care delivery, such as the provision of meals for inpatients.

Mismatches between patients and their care are not confined to the inpatient environment; similar errors occur in the community and office practice settings. While there is limited systematic information of mismatches in these settings, examples that have been reported include errors such as filing results or correspondence into the file of a different person with the same name, and prescribing a sedative inappropriately because the patient had two records with two different surnames and different medication lists. [32,33]

In community and office practice settings, an established relationship between the patient and clinician sometimes reduces the risk of mismatching. However, with the growth of multi-clinician general practice clinics and team-based community care, this relationship cannot be relied upon as the sole defence against mismatch adverse events.

Solutions to Prevent Patient Mismatching

Human factors science demonstrates that the development of safety routines for common tasks (such as patient identification) provides a powerful barrier to the eventual expression of errors. This allows staff to focus their attention on those activities that require more cognitive processing and judgement, such as the provision of clinical care.

Patient identification is an activity that is performed frequently and should be based on a standard set of questions and tasks, supported by unambiguous documentation. To prevent a mismatch between a patient and their health record or treatment orders, every patient and each aspect of their care would ideally be differentiated in a way that makes each unique. In practice, achieving this can be difficult and may not always be feasible.

Use of Patient Identifiers to Prevent Mismatching

Patient name is the primary means of identification, followed by the progressive introduction of other specific identifiers, such as address, date or place of birth, to refine the accuracy of patient identification as the circumstances require.

Typically, patients in Australia receiving community-based or office-based health care identify themselves in person at the point of care and may need to confirm their identity by something that they are (e.g. a recognised patient), something they have (e.g. a photo identification, an insurance card or a confirming family member) and/or something they know (e.g. their name, address, doctor's name and appointment time). As this involves direct face-to-face contact, any confusion can usually be rectified on the spot, provided sufficient information is elicited.

In hospital-based care, the process of identification and matching occurs more commonly away from the care giver and must be maintained through a number of 'handovers' from one staff member to another. This can involve interaction with electronic systems, often without the patient present. The problem with personal identifiers such as name and address is that they are usually not unique to the individual, can change over time, and may be entered into different data systems in different formats. Hospital-assigned health record numbers are usually unique only to a given institution, and patient records are sometimes duplicated within the one organisation. [34]

Australia does not yet have a universal, unique identifier for individuals accessing the healthcare system. Because of this, it is often necessary to establish the identity of patients using other identifiers. Statistical matching can be required to do this because of the time-consuming nature of manual matching and the size of health record indices. Statistical matching 'attempts to string together enough information about an individual to substitute for a unique personal identifier'. [34]

Statistical matching has recognised false-positive and false-negative errors and the rate of these risks is reduced as more attributes are used in the process. Studies using both large and small databases of health records from the US have demonstrated that the risk of false positive matching falls from a two-in-three chance using last name only to a one-in-3500 chance when first and last names, zipcode and date of birth are used. [34]

To ensure the manual and electronic systems have the best chance of correctly matching a patient with their record, while not imposing impractical demands on information gathering, the Standard requires the use of at least three approved patient identifiers each time identification is made. Approved patient identifiers are those items of information accepted for use in patient identification and include patient name (family and given names), date of birth, gender, address and/or health record number. [35] Healthcare providers and organisations must specify the data items approved for patient identification. Identifiers such as room or bed number are not to be used.

Resources

A number of protocols have been developed that apply to specific therapeutic areas, including radiology (including CT Scan & Medical Resonance Imaging scanning), interventional radiology, nuclear medicine, radiation therapy simulation and treatment and oral surgery. The principles and processes in these specific protocols can also be applied to other therapeutic areas for which specific protocols do not yet exist.

The Australian Standard 5017–2006 *Health Care Client Identification* provides the basis for establishing policy, protocol and/or procedures for the design of patient identification bands and other associated identification mechanisms where the use of bands is inappropriate.

Specific Roles for Patient Identification and Procedure Matching

This list outlines each participant's specific role in ensuring the requirements of the PI Standard are met. These roles are additional to the generic roles for safety and quality listed at the beginning of the Standards.

Participant group	Role
Patient and carers	To provide accurate information and participate in the patient identification and matching process.
Clinical workforce	To correctly identify the patient, and their care, at each healthcare transaction.
	To participate in organisational processes for patient identification and procedure matching.
Non-clinical workforce	To correctly identify the patient at each transaction.

Criteria for the PI Standard

A. Identifying individual patients

At least three approved patient identifiers are used when providing care, therapy or services.

PI:A will be achieved by:	PI:A Measure
1. Developing, implementing and regularly reviewing the effectiveness of a patient identification matching system including the associated policies, protocols or procedures that: • define approved patient identifiers • require at least three approved patient identifiers on registration or admission • require at least three approved patient identifiers when care, therapy or other services are provided.	**1a.** Evidence that a patient identification matching system is operating throughout the Health Service Organisation. **1b.** Evidence that patient identification processes are provided to the workforce during orientation and ongoing training.
Items 2 and 3 relate to Health Service Organisations that use patient identification bands	
2. Ensuring that patient identification bands meet the Australian Specifications for Patient Identification Bands; • ensuring patients for whom a patient identification band is appropriate are wearing one; • ensuring patients for whom a patient identification band is not appropriate have some other identification mechanism that is consistent with the Australian specifications for patient identification bands.	**2a.** The proportion of all inpatients who are wearing an identification band that meets the *Australian Specifications for Patient Identification Bands*. **2b.** The proportion of the audited inpatients with identification bands that accurately match the patients' identity.
3. Ensuring that the patient master index and health record contains the three approved patient identifiers.	**3a.** The proportion of patients admitted for care for whom at least three approved patient identifiers are recorded in the health record and/or the patient master index. **3b.** The proportion of ambulatory patients on a daily patient list (or equivalent documentation) whose entry contains the three approved patient identifiers. **NB:** *This measure applies where an institutional based service is being provided outside the organisation where access to the full health record is not available.*

Item 4 relates to Health Service Organisations that DO NOT use patient identification bands	
4. Implementing a device or mechanism that includes three points of patient identification.	**4a.** Evidence that the identification mechanism or device uses three points of patient identification.

B. Transfer of care

A patient's identity is confirmed using three approved patient identifiers when transferring responsibility for care.

PI:B will be achieved by:	PI:B Measure
1. Developing, implementing and regularly reviewing the effectiveness of a patient identification and matching system at patient handover, transfer and discharge.	**1a.** Evidence of implementation of patient identification as part of an organisation's structured clinical handover processes.
2. Ensuring that all clinical handover, transfer and discharge documentation contains the three Health Service Organisation-approved patient identifiers for each patient.	**2a.** The proportion of clinical handover, transfer and discharge documentation that includes three approved patient identifiers.

C. Matching patients and their care

Health Service Organisations have explicit processes to correctly match patients with their intended care.

PI:C will be achieved by:	PI:C Measure
1. Ensuring a documented process to match patients to their intended procedure, treatment or investigation exists and is consistent with the Commission's patient procedure matching protocol or other relevant protocols. [36]	**1a.** Evidence of the availability of a process to match patients to their intended procedure, treatment or investigation is included in the organisation's procedures manuals or equivalent distribution process.
2. Ensuring that all interventional procedures comply with the organisation's patient and procedure-matching requirements.	**2a.** The proportion of interventional procedures with the completed patient-matching process documented.

D. Assessing risks of mismatching patients and their care

Health Service Organisations implement risk assessment mechanisms for patient matching.

PI:D will be achieved by:	PI: D Measure
1. Implementing a robust organisation-wide system of reporting, investigation and change	**1a.** Evidence that a system and process for the reporting, investigation and analysis of patient care mismatching

PI:D will be achieved by:	PI: D Measure
management to respond to any patient care mismatching events.	events is implemented.
2. Implementing changes to reduce the risk of future patient care mismatching events.	**2a.** Evidence that quality improvement activities are undertaken and changes to practice are implemented and monitored.

Bibliography for Patient Identification and Procedure Matching

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Draft National Safety and Quality Health Service Standard 6 Clinical Handover (CH)

The CH Standard

Clinical leaders and senior managers of a Health Service Organisation put in place documented systems for effective and structured clinical handover. Clinicians and other staff implement clinical handover systems.

The intention of this Standard is to:

Ensure there is timely, relevant and structured clinical handover that contributes to safe patient care.

Context:

It is expected that this Standard will be applied in conjunction with the *Governance for Safety and Quality in Health Service Organisations* requirements and *Partnering for Consumer Engagement* as specified in Standards 1 and 2.

Criteria for the CH Standard are:

A. Governance and leadership for effective clinical handover

Health Service Organisations implement effective clinical handover.

B. Effective clinical handover processes

Health Service Organisations have in place documented and structured clinical handover processes.

C. Patient and carers involvement in clinical handover

Health Service Organisations establish mechanisms to include patients and carers in clinical handover processes.

Explanatory Notes

According to the Australian Medical Association, clinical handover refers to 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. [53, 54]

This CH Standard draws on significant work and new evidence developed as a result of the Commission's clinical handover program. Tools, guidelines and resources for clinical handover improvement that have been developed by the program can also be used to assist with implementation of the CH Standard.

The Scale of the Problem

Patient care is complex. One element of this complexity is the number of contacts and transitions undertaken by patients. Approximately 7,068,000 clinical handovers occur annually in Australian hospitals and about 26,200,000 clinical handovers are carried out in community care settings [19]. Clinical handovers can occur at shift change, when clinicians take breaks, when patients are transferred inter- and intra-hospital and during admission, referral or discharge, for example. Clinical handover can be varied including face-to-face, via telephone, written, in a common staff area, aided by electronic handover tools or in the presence or absence of the patient and carer. Some of the complexity is demonstrated in the *Matrix of Clinical Situations and Handover Options* (Figure 1). [55]

Figure 1. Key Principles for Clinical Handover.

Source: Implementation Toolkit: Standard Key Principles for Clinical Handover, NSW Department of Health 2009.

WHY – implement standard key principles?		Provide the best patient care by improving the transfer of clinical information, responsibility and accountability.						
WHAT – clinical information is handed over?		Locally defined minimum data set that meets the key principles, ensuring the most important clinical information is handed over **						
WHO – should attend handover?		Key participants in the handover process are identified and available to attend the clinical handover of their patients.						
WHEN - Should handover occur?		Escalation of deteriorating patient	Patient transfers to another ward	Shift to shift change over	Patient transfers for a test or appointment	Patient transfers to another facility	Multi-disciplinary team handover	Patient transfers to /from the community
HOW – should handover be delivered?	Face to face + checklist	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓
	In the patient's presence (bedside handover)	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓
	Face to face verbal only	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓
	Checklist	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓
	In a common staff area	•••	•••	✓✓✓	•••	•••	✓✓✓	•••
	Telephone handover	✓✓✓	✓✓✓	•••	✓✓✓	✓✓✓	✓✓✓	✓✓✓
	Mobile electronic tools	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓
	Detailed transfer letter	✗✗✗	•••	✗✗✗	•••	✓✓✓	•••	✓✓✓
	Tape recording	✗✗✗	✗✗✗	✗✗✗	✗✗✗	✗✗✗	✗✗✗	✗✗✗

LEGEND	
✓✓✓	Recommended Options
•••	Not Recommended
✗✗✗	Should Never Occur

Current handover processes are highly variable and may be unreliable, causing clinical handover to be a high risk area for patient safety. Breakdown in the transfer of information or

in communication has been identified as one of the most important contributing factors in serious adverse events and is a major preventable cause of patient harm. [54] Poor clinical handover also leads to wasted resources. Additional consequences can include: unnecessary delays in diagnosis, treatment and care; repeated tests, missed or delayed communication of test results; incorrect treatment or medication errors and increased risk of medico-legal action. [38]

Solutions to minimise the risks at clinical handover

Achieving sustainable improvement in the processes of health care and in patient outcomes can be difficult and will require standardised processes, minimum data sets and committed resources. Clinical handover solutions must be fit for purpose and appropriate to the clinical context in which handover occurs. The successful improvement of clinical handover processes requires the inclusion of staff who participate in clinical handover practice. It also requires the implementation of a robust change management framework to support staff. New processes imposed on clinicians often fail because they do not fit easily into current practice. Engaging and obtaining the views of the clinical workforce during redesign can reduce this risk.

Clinical handover is a group practice and a group responsibility. To ensure patient safety, the improvement activities need to include all staff. When a standard process for clinical handover is used, the safety of patient care will improve as critical information is more likely to be transferred and acted upon. [39 - 42]

Specific Roles in Clinical Handover

This list outlines each participant's specific role in ensuring the requirements of the CH Standard are met. These roles are additional to the generic roles for safety and quality listed at the beginning of the Standards.

Participant group	Role
Patient and carers	To be a partner in clinical handover when it relates to their care.
Clinical workforce	To participate actively in organisational clinical handover processes.
	To review and continuously improve structured clinical handover communication.
	To make sure relevant information as well as the responsibility and accountability for patient care is transferred effectively and in partnership with the patient and their carer.
Non-clinical workforce	To actively participate in agreed clinical handover processes when participating in patient care.
Health Service Organisation managers	To implement and monitor processes for clinical handover to ensure timely, relevant and structured clinical handover communications.
	To facilitate compliance and manage performance across and within the organisation's areas of responsibility for effective clinical handover systems.
Health service executive and owners	To clearly articulate organisational and individual accountabilities for clinical handover.

Criteria for the CH Standard

A. Governance and leadership for effective clinical handover
Organisations implement effective clinical handover.

CH:A will be achieved by:	CH:A Measure
1. Developing and implementing an organisational system including a policy on clinical handover that is relevant to the healthcare settings and specialities, and includes the use of agreed tools and guides.	**1a.** Evidence of clinical handover policies, protocols or procedures being implemented and/or used.
2. Regular monitoring and evaluation of the agreed structured clinical handover processes, including: • development of implementation measurements • regular review of locally used processes based on current best practice in collaboration with clinicians, patients and carers • review of results at an appropriate level of governance to inform of any required changes.	**2a.** Evidence of an evaluation plan for clinical handover, which includes a strategy for process monitoring. **2b.** Evidence of local processes for clinical handover that are reviewed and action taken based on the results.
3. Undertaking quality improvement activities to address the actions as identified through the evaluation of clinical handover.	**3a.** Evidence of quality improvement activities based on the results of the evaluation of clinical handover processes.

B. Effective clinical handover process
Health Service Organisations have in place documented and structured clinical handover processes.

CH:B will be achieved by:	CH:B Measure
1. Ensuring there are documented and structured processes for clinical handover that incorporates the following: • preparation • organisation • environmental awareness • transferred responsibility and accountability.	**1a.** Evidence that a documented and structured process for clinical handover is in use.

C. Patient and carers involvement in clinical handover

Health Service Organisations establish mechanisms to include patients and carers in clinical handover processes.

CH:C will be achieved by:	CH:C Measure
1. Developing and implementing mechanisms to include patients and carers in the clinical handover process that is relevant to patient care and the healthcare setting.	**1a**. Evidence of mechanisms to demonstrate patient and, where relevant, carer involvement in clinical handover.

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Draft National Safety and Quality Health Service Standard 7
Blood and Blood Product Safety (BBP)

The BBP Safety Standard:
Clinical leaders and senior managers of a Health Service Organisation put in place systems to ensure the supply and use of blood and blood products is safe, efficient and effective. Clinicians and other staff implement the blood and blood-product safety systems.

The intention of this standard is to:
Ensure that the patients who receive blood and blood products are safe.

Context:
It is expected that this Standard will be applied in conjunction with the *Governance for Safety and Quality in Health Service Organisations* requirements and *Partnering for Consumer Engagement* as specified in Standards 1 and 2.

Criteria for the BBP Standard are:

A. Governance and systems for blood and blood product management.
Health services have in place systems that are safe and minimise waste at all stages of blood and blood products provision, storage, distribution and use.

B. Documentation of patient information
The clinical workforce accurately records the blood and blood product use of each patient including transfusion history and indications for treatment.

C. Information for patients
The clinical workforce informs patients and carers about the options and risks for any treatment plan that may include the use of blood and blood products.

D. Blood and blood product management
Health services have systems in place to obtain, store, prescribe, transport and administer blood appropriately, efficiently and safely.

Explanatory Notes

The scope of this Standard is from the clinical decision to prescribe blood or blood products, including supply by the health service, to the administration or disposal of the blood or its products.

The definition intended for the application of this Standard is:

- **Blood:** homologous and autologous whole blood, blood including red cells, platelets, fresh frozen plasma, cryoprecipitate and cryo-depleted plasma.

- **Blood products**: plasma derivatives and recombinant products excluding medication products such as Rh (D) immunoglobulin.

Blood products have historically been used in the medical environment as a life-saving option. More recently, the risks associated with the use of blood and blood products have not only been better understood, but have also escalated. Increased demand and the evidence of adverse events have resulted in the need for better practice in the management of a finite resource.

A range of factors have influenced the use of blood and blood products in recent years. These include:
- recognition of the potential contamination of blood through donor illness or medication use
- changing treatment options
- changing environments for the administration of blood and blood products including from home
- understanding of the role of blood components rather than whole blood
- increasing requirements for blood in surgical interventions including organ transplant
- increasing options for treatment of trauma patients
- improving risk management resulting from the analysis of incident data
- increasing costs associated with the collection, administration and use of blood and blood products
- growth of the patient safety and quality agenda
- recognition and acceptance of consumer choices.

Research into the prescribing and administration of blood has resulted in the publication of guidelines for the clinical workforce. There has, however, been a scarcity of monitoring processes to review safety and quality for patients requiring blood and blood products.

As stated in the February 2005 report '*Towards Better, Safer Blood Transfusion for the Australian Council for Safety and Quality in Health Care*': [50]

There is a failure in governance of the transfusion process. No one agency or group manages the overall transfusion safety chain. Instead different groups focus oversight on one or more components of this chain. Some critical processes effectively have no review or management. These structures and processes have produced predictable consequences in terms of transfusion outcomes in Australia. We will not improve on our current levels of transfusion performance unless we improve these governance arrangements.

The 2003 report to the Institute for Clinical Excellence on '*The Blood Transfusion Improvement Collaborative*' demonstrated that "education and promulgation of guidelines reduced the spread of the mean of pre-transfusion haemoglobin, however introducing restrictive thresholds through vetting requests had a greater position influence on reducing the mean haemoglobin pre transfusion". [51]

Solutions to Prevent Adverse Blood Use Events

National and international research demonstrates that the dual approach of implementing governance structures and clinical guidelines is the most effective methodology in ensuring the safe and quality use of blood and blood products. The inclusion of a BBP Standard that contains these components will assist in managing this valuable and finite resource.

Specific Roles in Blood and Blood Product Safety

This list outlines each participant's specific role in ensuring the requirements of the BBP Standard are met. These roles are additional to the generic roles for safety and quality listed at the beginning of the Standards.

Participant group	Role
Patients and carers	To provide accurate information about the patient's medical history in relation to blood products.
	To raise issues that may impact on compliance with a treatment plan including those related to the home administration of blood products.
	To participate in training prior to self or carer administration of blood and blood products in a community setting.
Clinical workforce	To prescribe and administer blood products safely and appropriately, according to the roles for which they are accountable, following discussion with the patient and/or carer.
	To understand their broad responsibility for blood product management and legislation and guidelines on the use of blood products.

Criteria for the BBP Standard:

A. Governance and systems for blood and blood product management
Health services have in place systems that are safe and minimise waste at all stages of blood and blood-product provision, storage, distribution and use.

BBP:A will be achieved by:	*Rationale*	Measure
1. Ensuring the policies, protocols or procedures are based on available nationally approved guidelines, and include: • prescribing and administration • management of the risk of harm • adequate provision • correct storage • correct transport • appropriate use.	*A blood and blood product system provides a framework for the safe use of blood and blood products. System review by appropriate committees and individuals ensures the system is monitored for efficacy.* *The system that is supported by documented approved and current policies, protocols or procedures that are accessible will guide the clinical workforce to provide safe care.*	**1a.** Evidence of policies, protocols or procedures based on best-practice guidelines. **1b.** Evidence that any blood or blood-product wastage or inappropriate use is recorded and monitored with action taken as required.
2. Undertaking a regular, comprehensive assessment of blood and blood product systems to identify risks to patient safety and implementing system changes to address the identified risks.	*Proactive risk assessment of the system based on recent guidelines of blood and blood product usage will assist in preventing adverse events.*	**2a.** Evidence of planned actions and their implementation as a result of the risk assessment.
3. Undertaking quality improvement activities to address safety risks and ensure the appropriate use of blood products.	*Improvement activities assist in maintaining current best practice effective system/s that help to reduce adverse events.*	**3a.** Evidence of quality improvement activities to ensure the safe and appropriate use of blood and blood products. **3b**. Evidence of participation in the legislated and jurisdictional accreditation processes associated with the management of blood and blood products for the relevant services.

B. Documentation of patient information
The clinical workforce accurately records the blood and blood product use of each patient including transfusion history and indications for treatment.

BBP:B will be achieved by:	*Rationale*	Measure
1. The clinical workforce taking the specific history of blood use and relevant medical conditions before prescribing blood or blood products.	*An accurate patient history provides a basis for clinical decision making to prevent harm.*	**1a.** Evidence of documentation within the health service record of blood and blood product use, including: • indications for prescribing • products transfused • effectiveness or outcome of use.
2. The clinical workforce documenting any known blood related patient adverse events on initial presentation and updating this when a blood or blood product adverse event occurs.	*Communication issues have the highest frequency of occurrence in the investigation of adverse events.*	**2a.** Evidence of documentation of outcomes associated with the provision of blood and blood products and any required action during an episode of care.

C. Information for patients
The clinical workforce informs patients and carers about the options and risks for any treatment plan that may include the use of blood and blood products.

BBP:C will be achieved by:	*Rationale*	Measure
1. Information being provided to patients about blood and blood product use and possible alternatives in a format that can be understood by patients and carers.	*Patients who are in pain or a stressful environment do not have good memory recall.* *The information provided needs to be written and in the appropriate language without health jargon.*	**1a.** Evidence that patient information relating to blood and blood products, including alternatives, is available to the clinical workforce in the required format that is appropriate to the needs of the patient.
		1b. Evidence that a patient feedback/survey includes assessment of satisfaction with the information relating to the use of blood and blood products and that this assessment is collated, analysed and actioned.

BBP:C will be achieved by:	*Rationale*	Measure
2. An informed consent process for all blood and blood product administration.	*Patient rights and responsibilities provide for the patient to be informed and to participate in decision making when a treatment plan is being developed. The exception is in an emergency situation where a carer is not available.* *A jurisdictional requirement is for all patients to undergo a consent process relating to the use of blood and blood products when actual or planned use is a component of the treatment plan.*	**2a.** Evidence that the use of blood and blood products has been discussed by a clinician with the patient or carer and the outcome of the discussion is recorded.
		2b. The proportion of patients who receive blood or blood products during an episode of care where there is documented consent.
		2c. Evidence that the consent process complies with the organisation policy that is based on legislated and jurisdictional requirements.

D. Blood and blood product management

Health services have systems in place to obtain, store, prescribe, transport and administer blood appropriately, efficiently and safely.

BBP:D will be achieved by:	*Rationale*	Measure
1. Ensuring that current approved guidelines and decision support tools are readily available to the clinical workforce when making prescribing decisions about blood and blood products.	*The clinical workforce requires current information to enable informed decision/s relating to patient care to increase patient safety.*	**1a.** Evidence that the clinical workforce has access to and uses accurate current best practice guidelines.
		1b. Evidence of monitoring to ensure the use of blood and blood products meets the current guidelines.
2. Ensuring that a system for prescribing and supplying of blood and blood products is in place.	*The clinical workforce that is directed through a structured process has increased compliance with working in their scope of practice.*	**2a.** Evidence that the prescribing and supply system is monitored for compliance.
3. Ensuring the transport and storage arrangements within the organisation meet the current guidelines and, where available, standards.	*The viability of blood and blood products is dependent on correct storage through the 'vein to vein' journey.'*	**3a.** Evidence of monitoring and reporting of wastage associated with transport and storage.

BBP:D will be achieved by:	*Rationale*	Measure
4. Ensuring the clinical workforce responsible for administration of blood and blood products, including the monitoring of the patient during transfusion, are competent to do so.	*The administration rate and type of blood product prescribed is dependent on the correct monitoring of the process of administration including the patient's reaction.*	**4a.** Evidence of a competency-based program for all permanent and temporary clinical workforce that ensures current best practice of the administration of blood and blood products.

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Draft National Safety and Quality Healthcare Service Standard 8
Prevention and Management of Pressure Ulcers (PU)

The PU Standard:
Clinical leaders and senior managers of the Health Service Organisation put in place evidence based systems to prevent pressure ulcers and manage them when they occur. Clinicians and other staff implement the prevention and management systems.

The intention of this Standard is to:
Prevent patients developing pressure ulcers and manage pressure ulcers when they occur in accordance with best practice guidelines.

Context:
It is expected that this Standard will be applied in conjunction with the *Governance for Safety and Quality in Health Service Organisations* requirements and *Partnering for Consumer Engagement* as specified in Standards 1 and 2.

Criteria for the PU Standard are:

A.   Governance and systems for the prevention and management of pressure ulcers
Clinical workforce leaders and senior managers ensure governance structures are in place to support the systems for the prevention and management of pressure ulcers.

B.   Screening for existing pressure ulcers
Patients on admission, on a regular basis as clinically indicated and prior to discharge, are screened for existing pressure ulcers.

C.   Prevention of pressure ulcers
Patients on admission and when clinically indicated are screened for risk factors associated with the development of pressure ulcers and the required pressure ulcer prevention strategies are implemented and monitored.

D.   Management of pressure ulcers
Patients who have pressure ulcers are managed according to best-practice guidelines.

E.   Information for patients
Patients and carers are informed of the risks, prevention strategies and management of pressure ulcers.

Explanatory Notes

Research demonstrates pressure ulcers as a major contributor to the care needs of patients within the health industry. Prevalence surveys conducted by Wounds West in Western Australia in 2007, 2008 and 2009 demonstrated pressure ulcers to be the second largest group of wounds in public hospitals and the majority of these were hospital acquired. [42] In the majority of cases pressure ulcers are preventable if the prevention strategies consider all the risk factors, including nutrition status, skin integrity, mobility, age and the level of oxygenation of the blood supply to pressure point ulcers.

International and national research has been extensive and has resulted in the development of evidence-based clinical practice guidelines that guide cost effective outcomes.

In the December 2009 issue of '*Queensland Health Patient Safety Matters*', Dr. John Wakefield, Senior Director of the Patient Safety Centre in Queensland Health, stated: [43]

> At first look it would be easy to dismiss the reduction of pressure ulcer prevalence in Queensland Health hospitals and residential care facilities, from 18.4 to 15.2% between 2003 and 2008. However, let's take a minute to examine what this means in terms of patient suffering and direct costs.
> ….. this 3.2% reduction equates to 20,000 patients per year, who have been spared this preventable, painful and serious complication. Around three quarters of patients developed their pressure ulcer/s in hospital. With the additional average length of stay … of 4.3 days, this equates to an estimated saving of over 65,000 occupied bed days per annum across Queensland Health – the equivalent of a 180 bed hospital being freed up for a whole year. There is indeed a powerful business case for investment in strategies [to prevent pressure ulcers].
> The return on investment in dollars alone may be as high as 100:1, but it is hard to place a price on the reduction of human suffering on such a scale.

Research indicates both national and international experts are unified in their approach to the prevention and management of pressure ulcers.

It is also of note that patients who are managed in residential aged-care facilities and community-based services are also prone to pressure ulcers if they have contributing risk factors. Pressure ulcer management is a major reason for an increased health burden.

National and international bodies are currently discussing the correct terminology relating to the name of a pressure induced wound or potential wound. This Standard retains the term pressure ulcer as this is the current terminology and the most widely utilised. The alternate term 'pressure injury' will be utilised in the next Standard revision if this is accepted at the national and international levels.

Solutions to Prevent and Manage Pressure Ulcers

The solutions to the prevention of pressure ulcers are available through multiple evidenced-based resources. Management of established pressures ulcers has also progressed with the increasing specialisation in wound management. The solutions are available, and what remains to be done is to ensure these solutions are implemented and monitored for compliance. This will require not only education but an acceptance that pressure ulcers are not the sole domain of geriatric patients but all patients with any or all of the associated risk factors and that a pressure ulcer can commence in any setting, including acute areas such as theatre and intensive care.

Specific Roles in Pressure Ulcer Prevention and Management

This list outlines each participant's specific role in ensuring the requirements of the PU Standard are met. These roles are additional to the generic roles for safety and quality listed at the beginning of the Standards.

Participant group	Role
Patients and carers	To raise issues that may impact on compliance with a prevention and treatment plan relating to pressure ulcers.
Clinical workforce	To partner with patients and their carers in developing and implementing a prevention or management treatment plan.
Non-clinical workforce	To notify the clinical workforce when concerns exist or pressure ulcer injury is observed.

Criteria for the PU Standard:

A. Governance and systems for the prevention and management of pressure ulcers
Clinical workforce leaders and senior managers ensure governance structures are in place to support the systems for the prevention and management of pressure ulcers.

PU:A will be achieved by:	*Rationale*	Measure
1. Ensuring the policies, protocols or procedures are based on current agreed best practice guidelines and a review system is in place.	*A pressure ulcer prevention and management system provides a framework for safety and quality outcomes. System review by appropriate committees and individuals ensure the system is monitored for efficacy.* *The system that is supported by documented approved and current policies, protocols or procedures that are accessible will guide the clinical workforce to prevent and manage pressure ulcers.*	**1a.** Evidence of policies, protocols or procedures based on best practice guidelines that are available to the clinical workforce. **1b.** Evidence that the screening and risk-assessment tools attached to the protocols are based on best practice guidelines.
2. Using a risk-assessment framework by implementing or using existing systems for reporting, investigating and taking action against the frequency and severity of pressure ulcers.	*The monitoring and trending of incidents by classification provides insight into the actual issues that occur at the point of care.*	**2a.** Evidence of reporting, monitoring and analysis of the frequency and severity of pressure ulcers at all levels of the organisation. **2b.** Evidence of action taken as a result of the analysis of the frequency and severity of pressure ulcer information. **2c.** Evidence that scheduled audits are conducted to monitor the frequency and severity of pressure ulcers across all areas of the organisation.

PU:A will be achieved by:	*Rationale*	Measure
3. Providing or facilitating access to adequate resources to implement the best practice treatment plan.	*The prevention and management of pressure ulcers requires the availability of the necessary resources such as dressings, devices and equipment.* *Service resources that optimise care delivery including but not limited to: risk assessment; preventative interventions; wound management; nutrition assessment and supplementation; and medical management.*	**3a.** Evidence that adequate physical resources are available to meet the demands of the established treatment plan. **3b.** Evidence that adequate service resources are available for implementation and ongoing review of the treatment plan. **3c.** Evidence that there is a wound management system that meets the need of the evidence-based treatment plan.
4. Undertaking quality improvement activities to address safety risks and monitor the system that incorporates the prevention and management of pressure ulcers.	*Improvement activities assist in maintaining current best practice effective systems that help to reduce adverse events.*	**4a.** Evidence of quality improvement activities to ensure the prevention and management of pressure ulcers is consistent with current best practice guidelines.

B. Screening for existing pressure ulcers
Patients on admission and discharge are screened for existing pressure ulcers.

PU:B will be achieved by:	*Rationale*	Measure
1. Conducting a comprehensive skin inspection within 8 hours of admission and prior to discharge to identify existing pressure ulcers.	*Identification of existing pressure ulcers on admission, on an ongoing basis and prior to discharge will guide ongoing management interventions across health care services.*	**1a.** Evidence of documentation of skin assessments in the health service record. **1b.** Evidence of identified pressure ulcers being included in clinical handover information.

C. Prevention of pressure ulcers

Patients on admission and when clinically indicated are screened for risk factors associated with the development of pressure ulcers and the required pressure ulcer prevention strategies are implemented and monitored.

PU:C will be achieved by:	*Rationale*	Measure
1. The clinical workforce using an agreed tool to identify risk factors for pressure ulcers for all patients within 8 hours of admission.	*Prevention interventions are dependent upon the comprehensive risk assessment outcomes.*	**1a.** Evidence of an agreed tool for screening pressure ulcer risk being available for the clinical workforce.
		1b. The proportion of health service records that contain a completed pressure ulcer risk assessment.
2. The clinical workforce implementing and monitoring the prevention plan including review as clinically indicated.	*Ongoing assessment of risk factors guides pressure ulcer prevention.* *The provision of pressure reduction support services and devices optimises pressure ulcer prevention.*	**2a.** Evidence that prevention interventions are documented in the health service record.

D. Management of pressure ulcers

Patients who have pressure ulcers are managed according to best practice guidelines.

PU:D will be achieved by:	*Rationale*	Measure
1. Implementing best practice treatment and ongoing monitoring as clinically indicated.	*Best practice treatment regimes are guided by comprehensive assessment and informed clinical decision making.*	**1a.** Evidence of documented comprehensive assessment in the health service record.
		1b. The proportion of patients with documented pressure ulcers and their stage of severity.
		1c. Evidence of a documented best practice care plan in the health service record.

E. Information for patients
Patients and consumers are informed of the risks, prevention strategies and management of pressure ulcers.

PU:E will be achieved by:	*Rationale*	Measure
1. Ensuring that the patients and their carers are informed about the identified risk factors and any actions required to reduce or eliminate the risk.	*The patient, carer and family require access to current information to enable informed participation in their health care.*	**1a.** Evidence that individualised patient information is available in a format that is meaningful for the patient and their carers.
2. Ensuring the treatment plan is developed in partnership with the patient and carers.	*A patient's prognosis and their choices may impact on treatment. For example, a palliative care patient may request pain-management interventions but select not to have wound management interventions such as surgical debridement or alternating pressure-reduction equipment.*	**2a.** Evidence of documentation of ongoing discussion with the patient and their carers during the development and implementation of the treatment plan.

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Draft National Safety and Quality Health Service Standard 9 Recognising and Responding to Clinical Deterioration in Acute Health Care (RR)

The RR Standard

Clinical leaders and senior managers of a Health Service Organisation establish and maintain systems for recognising and responding to clinical deterioration. Clinicians and other staff use the systems.

The intention of this Standard is to:

Ensure that when a patient's condition deteriorates in an acute health care facility this deterioration is recognised promptly and effective action is taken. The recognition and response systems in place should be consistent with the National Consensus Statement. [52] This Standard does not apply to deterioration associated with psychiatric conditions.

Context:

It is expected that this Standard will be applied in conjunction with the ***Governance for Safety and Quality in Health Service Organisations*** requirements and ***Partnering for Consumer Engagement*** as specified in Standards 1 and 2.

Criteria for the RR Standard are:

A. Recognition and response systems
Organisation-wide systems that are consistent with the National Consensus Statement are used to support and promote recognition of, and response to, patients whose condition deteriorates in an acute health care facility.

B. Organisational support
The clinical workforce is aware of and supported to use the organisation's recognition and response systems.

C. Monitoring and feedback
Information about the performance and outcomes of the recognition and response systems is collected and used to improve the care provided to patients.

Explanatory Notes

Background

Observable physiological and clinical abnormalities often precede serious adverse events such as unexpected death and cardiac arrest. There is evidence, however, that these warning signs are not always identified and, if they are, they may not be acted on appropriately. This highlights the importance of implementing systems to identify deterioration early and may lessen the intervention required to stabilise patients whose condition deteriorates in hospital.

The factors that contribute to a failure to recognise and respond to a deteriorating patient are complex and overlapping. These include, but are not limited to:

- not monitoring vital signs consistently or not understanding observed changes in vital signs
- lack of knowledge of signs and symptoms that could signal deterioration
- lack of formal systems for responding to deterioration
- lack of skills to manage patients who are deteriorating
- failure to communicate with other staff about concerns, including in handover situations.

Solutions to Drive Safe and Appropriate Health Care

The Commission developed the National Consensus Statement: *Essential Elements for Recognising and Responding to Clinical Deterioration* to describe the elements that are essential for prompt and reliable recognition of, and response to, clinical deterioration. These elements are: measurement and documentation of observations; escalation of care; rapid response systems; clinical communication; organisational supports; education; evaluation, audit and feedback; and technological systems and solutions. [52]

The National Consensus Statement has been endorsed by Health Ministers as the national approach for recognising and responding to clinical deterioration in acute care facilities in Australia. This endorsement ensures that there is a consistent national framework to support clinical, organisational and strategic efforts to improve recognition and response systems. The National Consensus Statement provides a set of essential elements for organisations when planning and implementing systems for recognising and responding to the needs of patients whose condition is deteriorating in acute care facilities. The Commission drew on published evidence and worked with a group of technical experts to develop the National Consensus Statement and it provides the basis for this Standard. The Standard builds on the National Consensus Statement to drive implementation in acute care facilities.

This Standard applies to all patients in an acute health care facility, including adults, adolescents, children and babies and to all types of patients, including medical, surgical, maternity and mental health patients. Acute health care facilities range from large tertiary referral centres, to small district and community hospitals.

Specific Roles in Recognising and Responding to Clinical Deterioration in Acute Health Care

This list outlines each participant's specific role in ensuring the requirements of the RR Standard are met. These roles are additional to the generic roles for safety and quality listed at the beginning of the Standards.

Participant group	Role
Patient and carers	To use communication pathways and systems for escalating care.
Clinical workforce	To escalate care when they are concerned about a patient until they are satisfied an effective response has been made.
Non-clinical workforce	To call for emergency assistance when they have concerns about a patient.

Criteria of the RR Standard

A. Recognition and response systems
Organisation-wide systems that are consistent with the National Consensus Statement are used to support and promote recognition of, and response to, patients whose condition deteriorates in an acute care facility.

RR:A will be achieved by:	RR:A Measure
1. Developing, implementing and regularly reviewing the effectiveness of organisational polices that are consistent with the requirements of the National Consensus Statement.	**1a.** Evidence of policies, protocols or procedures being implemented and monitored including: • measurement and documentation of observations • escalation of care • establishment of a rapid response system • clinical communication.
2. Using an organisation-wide general observation chart that: • is designed according to human factors principles • includes the capacity to record information about respiratory rate, oxygen saturation, heart rate, blood pressure, temperature and level of consciousness graphically over time • includes thresholds for each physiological parameter or combination of parameters that indicate abnormality • specifies the physiological abnormalities and other factors that trigger the escalation of care • includes actions required when care is escalated.	**2a.** Evidence of an approved observation chart meeting the specified requirements.
	2b. Proportion of observation charts that have complete sets of observations for respiratory rate, oxygen saturation, heart rate, blood pressure, temperature and level of consciousness.
3. Having access at all times to at least one clinician, either on-site or in close proximity, who can practice advanced life support.	**3a.** Evidence of allocation of responsibility and formal agreements.

B. Organisational support

The clinical workforce is aware of and supported to use the organisation's recognition and response systems.

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RR:B will be achieved by:	RR:B Measure
1. The clinical and non-clinical workforce being aware of how to call for emergency assistance if they have concerns that the patient's condition is deteriorating.	**1a.** Evidence of information about how to call for emergency assistance being included in orientation and ongoing training.
2. Organisations supporting individual clinicians in their responsibility to use the available recognition and response systems to care for patients whose conditions are deteriorating.	**2a.** Evidence that the responsibility of individual clinicians for responding to patients whose condition is deteriorating is defined in organisational policies and procedures.
	2b. Evidence that the organisation seeks information from its clinical workforce on the responsiveness of the recognition and response systems.

C. Monitoring and feedback

Information about the performance and outcomes of the recognition and response system is collected and used to improve the care provided to patients.

RR:C will be achieved by:	RR:C Measure
1. Collecting data about the implementation and effectiveness of recognition and response systems, including: • existence of required policies • compliance with policies • circumstances associated with calls for emergency assistance • outcomes of calls for emergency assistance.	**1a.** Evidence that the recognition and response systems are monitored and actions are taken to ensure their appropriateness and effectiveness.
2. Using information about recognition and response systems to feed back to the clinical workforce and track outcomes and changes in performance over time.	**2a.** Evidence that data and resulting actions are incorporated into the feedback systems for the clinical workforce.

RR:C will be achieved by:	RR:C Measure
3. Ensuring that when there is a death or cardiac arrest for a patient without a treatment-limiting order that: • there is a thorough review process to examine whether there were failures in the recognition and response systems, or use of these systems • necessary changes are made to reduce the risk of future adverse events associated with failures of the recognition and response systems.	**3a.** Evidence of a thorough system for reviewing serious adverse events for failures in recognition and response systems and the resulting actions are incorporated in an organisational quality improvement process.

Bibliography for Recognising and Responding to Clinical Deterioration in Acute Health Care Standard

Australian Commission on Safety and Quality in Healthcare (2009) Windows into Safety and Quality in Health Care, Sydney, ACSQHC

Draft National Safety and Quality Health Service Standard 10
Preventing Falls and Harm from Falls (PFHF)

The PFHF Standard:
Clinical leaders and senior managers of a Health Service Organisation put in place systems for the prevention of patient falls. Clinicians and other staff implement and monitor the systems and their outcomes.

The intention of this Standard is to:
Reduce the incidence of patient falls and harm from falls during the provision of health care.

Context:
It is expected that this Standard will be applied in conjunction with the ***Governance for Safety and Quality in Health Service Organisations*** requirements and ***Partnering for Consumer Engagement*** as specified in Standards 1 and 2.

Criteria for the PFHF Standard are:

A.   Governance and systems for the prevention of falls
Health Service Organisations have in place governance structures and systems to reduce falls and minimise harm from falls.

B.   Screening for falls risk and harm from falls
All patients on admission or presentation are screened for risk factors and the associated potential for harm from falls.

C.   Prevention of falls and harm from falls
Based on an assessment, the required prevention strategies are documented, implemented and monitored.

D.   Information for patients
Patients and carers are informed of the identified risks and are engaged in the development of the associated falls prevention plan.

Explanatory Notes

National figures are not currently available on the impact of falls from a patient and health service perspective. However, jurisdictions have collated statewide data. For example, in NSW each year, falls lead to approximately 30,000 hospitalisations and at least 300 deaths in people aged 65 years and over. Rates of fall-related age-standardised hospitalisations have continued to steadily increase. Fall-related hospital separations in people aged 65 years and over have increased by 2.5% per annum for males and 0.9% per annum for females over the past ten years [44]. Data from other jurisdictions demonstrates a similar patient impact as a result of falls.

Besides the cost implications of data such as the NSW data, the impact of falls has a far reaching social impact due to the reduction in independence through fear, the potential for loss of independence and the increased burden on their family.

While these issues are well documented for the elderly, there is the need to ensure that mobility is viewed as a consideration in assessing falls risk. Impaired mobility is not age-defined therefore we should not limit our falls screening to the aged.

The focus of this Standard is on prevention of falls, it is not intended to address physical or psychological injury management.

Scope of the Application of the PFHF Standard:

The strategies for falls prevention differ across settings. To reflect these differences the Standards include criteria that are service specific. For example, criteria B and C specify separate items for acute and community services.

Solutions to Preventing Falls and Harm from Falls:

The Commission, with expert assistance developed a revised set of Guidelines for falls prevention in older people in the three major areas of health service delivery, hospitals and residential aged and community care.

These guidelines were not intended to be applied outside the specified group of older people; they do however provide a valuable set of resources that can be utilised by services when they are considering the specific needs of people with impaired mobility including paediatric patients and the younger disabled who may have a temporary or permanent reduction in mobility.

Specific Roles in Preventing Falls and Harm from Falls

This list outlines each participant's specific role in ensuring the requirements of the PFHF Standard are met. These roles are additional to the generic roles for safety and quality listed at the beginning of the Standards.

Participant group	Role
Patients and carers	To raise issues that may impact on their compliance with a falls prevention plan and work in partnership with the health service providers to address the issues.
Clinical workforce	To work in partnership with patients and careers and other members of the team when developing a falls-prevention plan.
Non-clinical workforce	Be aware of and support falls-prevention strategies.

Criteria of the PFHF Standard:

A.   Governance and systems for the prevention of falls
Health Service Organisations have in place governance structures and systems for the prevention of falls and harm from falls.

PFHF:A will be achieved by:	*Rationale:*	Measure:
1. Ensuring the policies, protocols or procedures, including the associated tools, are based on the current National Guidelines '*Preventing falls and Harm from Falls*' and a review system is in place. [46]	*A system that is supported by documented approved and current policies, protocols or procedures that are accessible will guide the clinical workforce to prevent falls.*	**1a.** Evidence of policies, protocols or procedures based on National Guidelines for *Preventing Falls and Harm from Falls*, and which are available to the workforce. [44]
		1b. Evidence that the screening and assessment tools attached to the protocols are based on best-practice falls guidelines.
2. Falls being included in the incident reporting and management system as a data source to assessing the risk of falls in the organisation.	*The monitoring and trending of incidents by classification provides insight into the actual issues that occur at the point of care and enhance the knowledge base to implement strategies to reduce falls.*	**2a.** Evidence of reporting, monitoring and analysis of the frequency, severity and contributing factors of falls.
		2b. Evidence of action taken as a result of the analysis.
3. Undertaking quality improvement activities to address safety risks and ensure the effectiveness of the falls-prevention system.	*Improvement activities assist in maintaining current best practice effective systems that help to reduce adverse events.*	**3a.** Evidence of quality improvement activities to ensure the prevention of falls is consistent with the National Guidelines on *Preventing Falls and Harm from Falls*. [44]

B.   Screening for falls risk and harm from falls
All patients on admission or presentation are screened for risk factors and their potential for harm from falls.

PFHF:B will be achieved by:	*Rationale:*	Measure:
NB: Item B1 applies to inpatient hospital services only		
1. The clinical workforce screening all patients for risk of falls at admission, using a best practice based tool.	*The patient's individual risk factors when known are the basis for preventing falls.*	**1a.** Evidence of a best practice based screening tool being available for the clinical workforce.
		1b. The proportion of health service records that contain a completed admission falls risk screening.
NB: Item B2 applies to community-based services only		
2. All patients being screened for falls risk factors on initial presentation. [44]	*Access to services in the community may require patients to receive assistance while receiving care.*	**2a.** Evidence that at the initial presentation falls risks are included in the patient's history.
		2b. Evidence that actions to initiate falls prevention strategies have been implemented.

C.   Prevention of falls and harm from falls
Based on an assessment the required prevention strategies are documented, implemented and monitored.

PFHF:C will be achieved by:	*Rationale:*	Measure:
NB: Item C1, 3, 4 & 5 applies to inpatient hospital services only		
1. The clinical workforce completing a risk assessment for patients whose initial screening identified the need.	*The assessment of risk factors is a major contributor to successful prevention of falls.*	**1a.** Evidence of documentation within the health service record of a full falls risk assessment for patients identified in the initial screening assessment.
2. The development and implementation of a multifactorial falls prevention plan that addresses the identified risks in the risk assessment.	*The assessed falls risks must have strategies for prevention that are implemented.*	**2a.** Evidence of documentation within the health service record of an implemented multifactorial falls prevention plan.

PFHF:C will be achieved by:	*Rationale:*	Measure:
3. The ongoing reassessment of the effectiveness and appropriateness of the falls prevention plan.	*The health status of the patient may change over time.*	**3a.** Evidence of documentation within the health service record of ongoing reassessment of the effectiveness and appropriateness of the falls prevention plan.
4. Providing or facilitating access to adequate resources to implement the best practice prevention plan.	*The current guidelines require the availability of physical equipment such as bed alarms and mobility aids.* *Service resources that permit the required strategies to be implemented, for example assisted toileting at set intervals.*	**4a.** Evidence of monitoring of the availability of physical equipment against the need and action taken when required.
5. Patients at a high risk of falls are referred within the discharge planning process to minimise the potential harm from falls post discharge.	*High risk falls Patients being discharged from acute care require ongoing support.*	**5a.** Evidence of documentation within the discharge planning of referral to appropriate support post discharge.

D. Information for patients

Patients and carers are informed of the identified risks and are engaged in the development of the associated falls prevention plan.

PFHF:D will be achieved by:	*Rationale:*	Measure:
1. Patients and their carer being informed about the falls risk factors and prevention strategies.	*The patient and carer require access to current information to enable informed participation in their health care.*	**1a.** Evidence that patient information on falls prevention is available in a format that is meaningful and understood by the patient and their carer.
2. Ensuring the falls prevention plan is developed in partnership with the patient and carer and monitored.	*A patient's status may inform the risk reduction in the prevention plan.*	**2a.** Evidence of documentation of ongoing discussion with the patient and carer during the development and implementation of the falls prevention plan.
		2b. Evidence of documentation of monitoring the falls prevention plan within the health service record.

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