


National Safety and Quality Health Service Standards

September 2012



AUSTRALIAN COMMISSION ON
SAFETY AND QUALITY IN HEALTHCARE





National Safety and Quality Health Service Standards, September 2012

Endorsed by Australian Health Ministers September 2011

ISBN: 978-1-921983-04-7

Suggested citation:

Australian Commission on Safety and Quality in Health Care (ACSQHC) (September 2011), *National Safety and Quality Health Service Standards*, ACSQHC, Sydney.

© Commonwealth of Australia 2011

This work is copyright. It may be reproduced in whole or in part for study or training purposes subject to the inclusion of an acknowledgement of the source. Requests and inquiries concerning reproduction and rights for purposes other than those indicated above requires the written permission of the Australian Commission on Safety and Quality in Health Care:

Australian Commission on Safety and Quality in Health Care
GPO Box 5480
Sydney NSW 2001
Email: mail@safetyandquality.gov.au

Acknowledgements

This document was prepared by the Australian Commission on Safety and Quality in Health Care in collaboration with numerous expert working groups and members of the Commission's standing committees who generously gave of their time and expertise. Thanks also go to the numerous individuals and organisations, health services, practitioners, consumers, managers and health departments who have provided the feedback that made these Standards possible.

Contents

	Introduction	3
	Roles for Safety and Quality in Health Care	6
	Terminology	7
	Standard 1 – Governance for Safety and Quality in Health Service Organisations	14
	Standard 2 – Partnering with Consumers	22
	Standard 3 – Preventing and Controlling Healthcare Associated Infections	26
	Standard 4 – Medication Safety	34
	Standard 5 – Patient Identification and Procedure Matching	40
	Standard 6 – Clinical Handover	44
	Standard 7 – Blood and Blood Products	48
	Standard 8 – Preventing and Managing Pressure Injuries	54
	Standard 9 – Recognising and Responding to Clinical Deterioration in Acute Health Care	60
	Standard 10 – Preventing Falls and Harm from Falls	66
	References	73

The Hon Dr Kim Hames
Chair, Australian Health Ministers' Conference
Minister for Health
AHMC Secretariat
PO Box 344
RUNDLE MALL SA 5000

Dear Minister

The National Safety and Quality Health Service Standards

On behalf of the Commission, I am honoured to submit the *National Safety and Quality Health Service Standards* for the consideration of Health Ministers.

The Commission developed the Standards following extensive public and stakeholder consultation. The Standards are a critical component of the Australian Health Services Safety and Quality Accreditation Scheme endorsed by the Australian Health Ministers in November 2010.

The Standards provide a nationally consistent and uniform set of measures of safety and quality for application across a wide variety of health care services. They propose evidence-based improvement strategies to deal with gaps between current and best practice outcomes that affect a large number of patients.

The Standards address the following areas:

- Governance for Safety and Quality in Health Service Organisations
- Partnering with Consumers
- Preventing and Controlling Healthcare Associated Infections
- Medication Safety
- Patient Identification and Procedure Matching
- Clinical Handover
- Blood and Blood Products
- Preventing and Managing Pressure Injuries
- Recognising and Responding to Clinical Deterioration in Acute Health Care
- Preventing Falls and Harm from Falls

The Standards are designed to assist health service organisations to deliver safe and high quality care. The document presents the ten National Safety and Quality Health Service Standards and details the tasks required to fulfil them.

I acknowledge the contribution, effort and enthusiasm of the many clinicians, managers, consumers and organisations involved in their development. And I commend the diligence and commitment of our staff who developed them.

Yours sincerely



William J Beerworth
Chair
19 May 2011



Introduction

This document presents the ten National Safety and Quality Health Service (NSQHS) Standards. The NSQHS Standards were developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC) in consultation and collaboration with jurisdictions, technical experts and a wide range of stakeholders, including health professionals and patients.

The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure minimum

standards of safety and quality are met, and a quality improvement mechanism that allows health services to realise aspirational or developmental goals.

Accreditation is recognised as an important driver for safety and quality improvement and Australia's health accreditation processes are highly regarded internationally¹. The Standards are integral to the accreditation process as they determine how and against what an organisation's performance will be assessed. The Standards have been designed for use by all health services. Health service organisations can use the Standards as part of their internal quality assurance mechanisms or as part of an external accreditation process.

National Safety and Quality Health Service Standards



1. Governance for Safety and Quality in Health Service Organisations which describes the quality framework required for health service organisations to implement safe systems.



2. Partnering with Consumers which describes the systems and strategies to create a consumer-centred health system by including consumers in the development and design of quality health care.



3. Preventing and Controlling Healthcare Associated Infections which describes the systems and strategies to prevent infection of patients within the healthcare system and to manage infections effectively when they occur to minimise the consequences.



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



5. Patient Identification and Procedure Matching which describes the systems and strategies to identify patients and correctly match their identity with the correct treatment.



6. Clinical Handover which describes the systems and strategies for effective clinical communication whenever accountability and responsibility for a patient's care is transferred.



7. Blood and Blood Products which describes the systems and strategies for the safe, effective and appropriate management of blood and blood products so the patients receiving blood are safe.



8. Preventing and Managing Pressure Injuries which describes the systems and strategies to prevent patients developing pressure injuries and best practice management when pressure injuries occur.



9. Recognising and Responding to Clinical Deterioration in Acute Health Care which describes the systems and processes to be implemented by health service organisations to respond effectively to patients when their clinical condition deteriorates.



10. Preventing Falls and Harm from Falls which describes the systems and strategies to reduce the incidence of patient falls in health service organisations and best practice management when falls do occur.

Introduction

The NSQHS Standards

Standard 1 'Governance for Safety and Quality in Health Service Organisations' and Standard 2 'Partnering with Consumers' set the overarching requirements for effective implementation of the remaining eight Standards, which address specific clinical areas of patient care.

Standard 1 provides the safety and quality framework by outlining the expected structures and processes of a safe organisation.

Standard 2 requires effective and meaningful engagement of patients in the review, design and implementation of services as there is evidence that suggests that engaging patients can result in improved safety, quality and efficiency.

The Standards address areas in which there are:

- a large number of patients involved
- known gaps between the current situation and best practice outcomes
- existing improvement strategies that are evidence-based and achievable.

Content of the NSQHS Standards

Each Standard contains:

- the Standard, which outlines the intended actions and strategies to be achieved
- a statement of intent, which describes the intended 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 series of items and actions that are required in order to meet the Standard.

Core and developmental actions

The Standards apply to a wide variety of health services. Because of the variable size, structure, and complexity of health service delivery models, a degree of flexibility is required in the application of the Standards.

To achieve this flexibility, each action within a Standard is designated as either:

- core, which are critical for safety and quality or
- developmental, which are aspirational targets.

Core actions are considered fundamental to safe practice. Developmental actions identify areas where health services can focus activities or investments that improve patient safety and quality. Information about which actions have been designated core and developmental is available on the Commission's web site.



Introduction

Ratings

The Commission has recommended that health service organisations meet the requirements of the Standards. Assessment will be against a three point rating scale:

Not Met – the actions required have not been achieved.

Satisfactorily Met – the actions required have been achieved.

Met with Merit – in addition to achieving the actions required, measures of good quality and a higher level of achievement are evident. This would mean a culture of safety, evaluation and improvement is evident throughout the organisation in relation to the action or standard under review.

This rating system will be used at the level of individual actions in each Standard and can also be applied to the overall Standard.

In exceptional circumstances, a criterion, item or action may be rated as 'not applicable'. Not applicable items are those that are inappropriate in a service-specific context or for which assessment would be meaningless.

Review of the Standards

Australian Health Ministers have charged the ACSQHC with maintaining the Standards. After full implementation of the Standards an evaluation and review will be undertaken to update and amend the Standards. This review is scheduled for completion by 2017.

Roles for Safety and Quality in Health Care

This section outlines the role for each group of participants in ensuring the safe and effective delivery of healthcare services in a health service organisation.

Patients and carers have an important role to play in the safe delivery of health care. As a partner with health service organisations and their healthcare providers, patients and carers will be involved in making decisions for service planning, developing models of care, measuring service and evaluating systems of care. They will also participate in making decisions about their own health care and for this they will need to know and exercise their healthcare rights and be engaged in their health care and treatment decisions. Patients and carers will have a need to access information about options and agreed treatment plans. Health care can be improved when patients and carers share – with their health care provider – issues that may impact on their compliance with treatment plans.

The **clinical workforce** is essential to the delivery of safe and high-quality health care. Improvement to the system can be achieved when the clinical workforce actively participates in organisational processes, safety systems, improvement initiatives, and is trained in the roles and services for which they are accountable. The clinical workforce can make health systems safer and more effective if they:

- understand their broad responsibility for safety and quality in health care
- follow safety and quality procedures
- supervise and educate other members of the workforce
- participate in the review of performance procedures individually, or as part of a team.

When the clinical workforce forms partnerships with patients and carers, not only can a patient's experience of care be improved, but the design and planning of organisational processes, safety systems, quality initiatives and training can be more effective as well.

The role of the **non-clinical workforce** is also important to the delivery of quality health care. This workforce group may be paid or consist of volunteers. By actively participating in organisational processes – including the development and implementation of safety systems, improvement initiatives and related training – the limitations of safety systems can be identified and addressed. A key role for this group is notifying the clinical workforce when concerns exist about a patient.

Health service managers implement and maintain systems, materials, education and training that ensure the clinical workforce delivers safe, effective and reliable health care. They support the establishment of partnerships with patients and carers when designing, implementing and maintaining systems. Their key role is managing performance and facilitating compliance across the organisation and within individual areas of responsibility for the governance of safety and quality systems. They are leaders who can model behaviours that optimise safe and high quality care. Safer systems can be achieved when health service managers consider safety and quality implications in their decision-making processes.

The role of **health service executives and owners** is to plan and review integrated governance systems that promote patient safety and quality and to clearly articulate organisational and individual accountabilities for safety and quality throughout the organisation. The explicit support for the role of patients and carers in safety, models of care, program design and review of the organisations performance is key to the establishment of effective partnerships with health service managers and the clinical workforce.



Terminology

Accreditation: A status that is conferred on an organisation or an individual when they have been assessed as having met particular standards. The two conditions for accreditation are an explicit definition of quality (i.e. standards) and an independent review process aimed at identifying the level of congruence between practices and quality standards.²

Acute health care facility: A hospital or other health care facility providing healthcare services to patients for short periods of acute illness, injury or recovery.³

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

Advance care directive: Instructions that consent to, or refuse the future use of, specified medical treatments (also known as a healthcare directive, advance plan or another similar term).³

Advanced life support: The preservation or restoration of life by the establishment and/or maintenance of airway, breathing and circulation using invasive techniques such as defibrillation, advanced airway management, intravenous access and drug therapy.³

Adverse drug reaction: A drug response that is noxious and unintended, and which occurs at doses normally used or tested in humans for the prophylaxis, diagnosis or therapy of disease, or for the modification of physiological function.⁴

Adverse event: An incident in which harm resulted to a person receiving health care.

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 the 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).⁵

Antibiotic: A substance that kills or inhibits the growth of bacteria.⁶

Antimicrobial: A chemical substance that inhibits or destroys bacteria, viruses and fungi, including yeasts or moulds.⁶

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. Antimicrobial stewardship may incorporate a broad range of strategies including the monitoring and reviews of antimicrobial use.⁶

Approved patient identifiers: Items of information accepted for use in patient identification, including patient name (family and given names), date of birth, gender, address, medical record number and/or Individual Healthcare Identifier. Health service organisations and clinicians are responsible for specifying the approved items for patient identification. Identifiers such as room or bed number are not to be used.

Basic life support: The preservation of life by the initial establishment of, and/or maintenance of, airway, breathing, circulation and related emergency care, including use of an automated external defibrillator.⁷

Blood: Includes homologous and autologous whole blood. Blood including red blood cells, platelets, fresh frozen plasma, cryoprecipitate and cryodepleted plasma.⁸

Blood products: Plasma derivatives and recombinant products, excluding medication products.⁸

Carers: People who provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness or general frailty.⁹ Carers include parents and guardians caring for children.

Terminology

Clinical communication: An exchange of information that occurs between treating clinicians. Communication can be formal (when a message conforms to a predetermined structure for example in a health record or stored electronic data) or informal (when the structure of the message is determined solely by the relevant parties; for example a face-to-face or telephone conversation).¹⁰

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 by allowing excellence in clinical care to flourish.¹¹

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.¹²

Clinical workforce: The nursing, medical and allied health staff who provide patient care and students who provide patient care under supervision. This may also include laboratory scientists.¹³

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.

Competency-based training: An approach to training that places emphasis on what a person can do in the workplace as a result of training completion.

Complementary healthcare products: Vitamin, mineral, herbal, aromatherapy and homeopathic products, also known as ‘traditional’ or ‘alternative’ medicines.¹⁴

Consumer (health): Patients and potential patients, carers and organisations representing consumers’ interests.¹⁵

Consumer medicines information: Brand-specific leaflets produced by a pharmaceutical company, in accordance with the Therapeutic Goods Regulations (*Therapeutic Goods Act 1989*), to inform patients about prescription and pharmacist-only medicines. These are available from a variety of sources: for example, a leaflet enclosed within the medication package or supplied by a pharmacist; or a computer printout, provided by a doctor, nurse or hospital, and obtained from the pharmaceutical manufacturer or from the internet.⁴

Continuous improvement: A systematic, ongoing effort to raise an organisation’s performance as measured against a set of standards or indicators.¹⁶

Disease surveillance: An epidemiological practice that involves monitoring the spread of disease to establish progression patterns. The main role of surveillance is to predict, observe and provide a measure for strategies that may minimise the harm caused by outbreak, epidemic and pandemic situations, as well as to increase knowledge of the factors that might contribute to such circumstances.⁶

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.³

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



Terminology

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.³

Fall: An event that results in a person coming to rest inadvertently on the ground or floor or another lower level.¹⁷

Guidelines: Clinical practice guidelines are 'systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific circumstances'.¹⁸

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 an organisation is directed, administered or controlled. Governance arrangements provide the structure through which the corporate objectives (social, fiscal, legal, human resources) of the organisation are set and the means by which the objectives are to be achieved. They also 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 organisation to achieve the organisation's objectives. In these Standards, governance includes both corporate and clinical governance.

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

Healthcare associated infections: Infections that are acquired in healthcare facilities (nosocomial infections) or that occur as a result of healthcare interventions (iatrogenic infections). Healthcare associated infections may manifest after people leave the healthcare facility.¹⁹

Health outcome: The health status of an individual, a group of people or a population that 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, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.

Health service record: Information about a patient held in hard or soft copy. The health service record may comprise of clinical records (e.g. medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records, medication charts), administrative records (e.g. contact and demographic information, legal and occupational health and safety reports) and financial records (e.g. invoices, payments and insurance information).

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.²⁰

Terminology

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

Human factors: Study of the interactions between humans and other elements of a system, and the profession that applies theory, principles, data and methods to design in order to optimise human wellbeing and overall system performance.²¹

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

Infection: The invasion and reproduction of pathogenic or disease-causing organisms inside the body. This may cause tissue injury and disease.⁶

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 surveillance, infectious disease monitoring, hand hygiene and personal protective equipment.⁶

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.²² This communication should ensure the patient has an understanding of all the available options and the expected outcomes such as the success rates and/or side effects for each option.²³

Interventional procedures: Any procedure used for diagnosis or treatment that penetrates the body. These procedures involve incision, puncture, or 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 and endotracheal tubes.

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

Medication authorities: An organisation's formal authorisation of an individual, or group of individuals, to prescribe, dispense or administer medicines or categories of medicine consistent with their scope of practice.

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.²⁴

Medication history: An accurate recording of a patient's of medicines. It comprises a list of all current medicines including all current prescription and non-prescription medicines, complementary healthcare products and medicines used intermittently; recent changes to medicines; past history of adverse drug reactions including allergies; and recreational drug use.²⁵

Medication incident: See *Adverse medicines event*.

Medication management system: The system used to manage the provision of medicines to patients. This system includes dispensing, prescribing, storing, administering, manufacturing, compounding 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.

Medications reconciliation: The process of obtaining, verifying and documenting an accurate list of a patient's current medications on admission and comparing this list to the admission, transfer, and/or discharge medication orders to identify and resolve discrepancies. At the end of the episode of care the verified information is transferred to the next care provider.

Medicine: A chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental welfare of people. Prescription, non-prescription and complementary medicines, irrespective of their administration route, are included.²⁶



Terminology

Monitoring plan: A written plan that documents the type and frequency of observations to be recorded as referred to in Standard 9, 'Recognising and Responding to Clinical Deterioration in Acute Health Care'.³

Near miss: An incident that did not cause harm, but had the potential to do so.²⁷

Non-clinical workforce: The workforce engaged in a health service organisation who do not provide direct clinical care but support the business of health service delivery through administration, hotel service and corporate record management, management support or volunteering.

Non-prescription medicines: Medicines available without a prescription. Some non-prescription medicines 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.²⁶

Open disclosure: An open discussion with a patient about an incident(s) that resulted in harm to that 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.²⁸

Orientation: A formal process of informing and training workforce upon entry into a position or organisation, which covers the policies, processes and procedures applicable to the organisation.

Patient: A person receiving health care. Synonyms for 'patient' include consumer and client.

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 correct 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 of the body 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. Patient-centred care is a dimension of safety and quality.

Patient clinical record: Consists of, but is not limited to, a record of the patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care.

Patient information: Formal information that is provided by health services to a patient. Patient information ensures the patient is informed before making decisions about their health care.

Patient blood management: Involves a precautionary approach and aims to improve clinical outcomes by avoiding unnecessary exposure to blood components. It includes the three pillars of blood management:

- optimisation of blood volume and red cell mass
- minimisation of blood loss
- optimisation of the patient's tolerance of anaemia.²⁹

Patient master index: An organisation's permanent listing or register of health information on patients who have received or are scheduled to receive services.³⁰

Periodic review: Infrequent review, the frequency of which is determined by the subject, risk, scale and nature of the review.

Point of care: The time and location where an interaction between a patient and 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 prescription medicine is any medicine that requires a prescription before it can be supplied. A prescription must be authorised by an appropriately registered practitioner.³¹

Terminology

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

Procedure: The set of instructions to make policies and protocols operational and are specific to an organisation.

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

Rapid response system: The system for providing emergency assistance to patients whose condition is deteriorating. The system includes the clinical team or individual providing emergency assistance, and may include on-site and off-site personnel.³

Recognition and response systems: Formal systems that help workforce promptly and reliably recognise patients who are clinically deteriorating, and appropriately respond to stabilise the patient.³

Regular: Performed at recurring intervals. The specific interval for regular review, evaluation, audit or monitoring and so on need to be determined for each case. In these Standards, the time period should be consistent with best practice, be risk based, and be determined by the subject and nature of the review.

Risk: The chance of something happening that will have a negative impact. It is measured by consequences and likelihood.

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

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
- includes 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 knowledge and skills.

Treatment-limiting orders: Orders, instructions or decisions that involve the reduction, withdrawal or withholding of life-sustaining treatment. These may include 'no cardiopulmonary resuscitation' or 'not for resuscitation'.³

Workforce: All those people employed by a health service organisation.



- Standard 1 – **Governance for Safety and Quality in Health Service Organisations**
- Standard 2 – **Partnering with Consumers**
- Standard 3 – **Preventing and Controlling Healthcare Associated Infections**
- Standard 4 – **Medication Safety**
- Standard 5 – **Patient Identification and Procedure Matching**
- Standard 6 – **Clinical Handover**
- Standard 7 – **Blood and Blood Products**
- Standard 8 – **Preventing and Managing Pressure Injuries**
- Standard 9 – **Recognising and Responding to Clinical Deterioration in Acute Health Care**
- Standard 10 – **Preventing Falls and Harm from Falls**





Governance for Safety and Quality in Health Service Organisations

Standard 1

The Governance for Safety and Quality in Health Service Organisations Standard:

Health service organisation leaders implement governance systems to set, monitor and improve the performance of the organisation and communicate the importance of the patient experience and quality management to all members of the workforce. Clinicians and other members of the workforce use the governance systems.

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 improve patient outcomes.

Context:

This Standard provides the safety and quality governance framework for health service organisations. It is expected that this Standard will apply to the implementation of all other Standards in conjunction with Standard 2, 'Partnering with Consumers'.

Criteria to achieve the Governance for Safety and Quality in Health Service Organisations Standard:

Governance and quality improvement systems

There are integrated systems of governance to actively manage patient safety and quality risks.

Clinical practice

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

Performance and skills management

Managers and the clinical workforce have the right qualifications, skills and approach to provide safe, high-quality health care.

Incident and complaints management

Patient safety and quality incidents are recognised, reported and analysed, and this information is used to improve safety systems.

Patient rights and engagement

Patient rights are respected and their engagement in their care is supported.

Standard 1 – Governance for Safety and Quality in Health Service Organisations

Explanatory notes

Although most health care in Australia is associated with good clinical outcomes, patients still do not always receive all the care that is recommended to them, and preventable adverse events continue to occur across the Australian healthcare system.³²

Presently, the data that measures the extent to which problems are occurring are unavailable or unreliable. This prevents the establishment of a baseline value from which improvements in safety and quality of care can be measured.

However, in recent years, there has been a shift in both the awareness of, and investment in, safety and quality by Australian health services. Health Service organisations have developed and implemented policy, educational materials and processes for improvement (including credentialing, mortality reviews, incident monitoring and root-cause analysis). These changes have improved the safety and quality of health care for patients. Still, more needs to be done to ensure all patients are protected from harm and receive the highest possible standard of care.

Economic projections for total health expenditure indicate that fiscal pressure on the system will only rise in the future. An increase of \$90.9 billion in total health expenditure was predicted between 2003 and 2032–33.³³ This figure could be reduced or the rate of increase slowed, if safer and higher quality care is provided.

A systematic approach to quality improvement identifies those accountable for action in health service organisations, and focuses on risk, quality and patient safety to ensure that the necessary monitoring and actions are taken to improve services. Safety and high quality care requires the vigilance and cooperation of the whole healthcare workforce.



Governance for Safety and Quality in Health Service Organisations

Standard 1



Governance and quality improvement systems

There are integrated systems of governance to actively manage patient safety and quality risks.

This criterion will be achieved by:	Actions required:
1.1 Implementing a governance system that sets out the policies, procedures and/or protocols for: <ul style="list-style-type: none"> establishing and maintaining a clinical governance framework identifying safety and quality risks collecting and reviewing performance data implementing prevention strategies based on data analysis analysing reported incidents implementing performance management procedures ensuring compliance with legislative requirements and relevant industry standards communicating with and informing the clinical and non-clinical workforce undertaking regular clinical audits 	1.1.1 An organisation-wide management system is in place for the development, implementation and regular review of policies, procedures and/or protocols
	1.1.2 The impact on patient safety and quality of care is considered in business decision making
1.2 The board, chief executive officer and/or other higher level of governance within a health service organisation taking responsibility for patient safety and quality of care	1.2.1 Regular reports on safety and quality indicators and other safety and quality performance data are monitored by the executive level of governance
	1.2.2 Action is taken to improve the safety and quality of patient care
1.3 Assigning workforce roles, responsibilities and accountabilities to individuals for: <ul style="list-style-type: none"> patient safety and quality in their delivery of health care the management of safety and quality specified in each of these Standards 	1.3.1 Workforce are aware of their delegated safety and quality roles and responsibilities
	1.3.2 Individuals with delegated responsibilities are supported to understand and perform their roles and responsibilities, in particular to meet the requirements of these Standards
	1.3.3 Agency or locum workforce are aware of their designated roles and responsibilities



Standard 1 – Governance for Safety and Quality in Health Service Organisations

This criterion will be achieved by:	Actions required:
1.4 Implementing training in the assigned safety and quality roles and responsibilities	1.4.1 Orientation and ongoing training programs provide the workforce with the skill and information needed to fulfil their safety and quality roles and responsibilities
	1.4.2 Annual mandatory training programs to meet the requirements of these Standards
	1.4.3 Locum and agency workforce have the necessary information, training and orientation to the workplace to fulfil their safety and quality roles and responsibilities
	1.4.4 Competency-based training is provided to the clinical workforce to improve safety and quality
1.5 Establishing an organisation-wide risk management system that incorporates identification, assessment, rating, controls and monitoring for patient safety and quality	1.5.1 An organisation-wide risk register is used and regularly monitored
	1.5.2 Actions are taken to minimise risks to patient safety and quality of care
1.6 Establishing an organisation-wide quality management system that monitors and reports on the safety and quality of patient care and informs changes in practice	1.6.1 An organisation-wide quality management system is used and regularly monitored
	1.6.2 Actions are taken to maximise patient quality of care

Governance for Safety and Quality in Health Service Organisations

Standard 1



Clinical practice

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

This criterion will be achieved by:	Actions required:
1.7 Developing and/or applying clinical guidelines or pathways that are supported by the best available evidence	1.7.1 Agreed and documented clinical guidelines and/or pathways are available to the clinical workforce
	1.7.2 The use of agreed clinical guidelines by the clinical workforce is monitored
1.8 Adopting processes to support the early identification, early intervention and appropriate management of patients at increased risk of harm	1.8.1 Mechanisms are in place to identify patients at increased risk of harm
	1.8.2 Early action is taken to reduce the risks for at-risk patients
	1.8.3 Systems exist to escalate the level of care when there is an unexpected deterioration in health status
1.9 Using an integrated patient clinical record that identifies all aspects of the patient's care	1.9.1 Accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point of care
	1.9.2 The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards



Standard 1 – Governance for Safety and Quality in Health Service Organisations

Performance and skills management

Managers and the clinical workforce have the right qualifications, skills and approach to provide safe, high quality health care.

This criterion will be achieved by:	Actions required:
1.10 Implementing a system that determines and regularly reviews the roles, responsibilities, accountabilities and scope of practice for the clinical workforce	1.10.1 A system is in place to define and regularly review the scope of practice for the clinical workforce
	1.10.2 Mechanisms are in place to monitor that the clinical workforce are working within their agreed scope of practice
	1.10.3 Organisational clinical service capability, planning and scope of practice is directly linked to the clinical service roles of the organisation
	1.10.4 The system for defining the scope of practice is used whenever a new clinical service, procedure or other technology is introduced
	1.10.5 Supervision of the clinical workforce is provided whenever it is necessary for individuals to fulfil their designated role
1.11 Implementing a performance development system for the clinical workforce that supports performance improvement within their scope of practice	1.11.1 A valid and reliable performance review process is in place for the clinical workforce
	1.11.2 The clinical workforce participates in regular performance reviews that support individual development and improvement
1.12 Ensuring that systems are in place for ongoing safety and quality education and training	1.12.1 The clinical and relevant non-clinical workforce have access to ongoing safety and quality education and training for identified professional and personal development
1.13 Seeking regular feedback from the workforce to assess their level of engagement with, and understanding of, the safety and quality system of the organisation	1.13.1 Analyse feedback from the workforce on their understanding and use of safety and quality systems
	1.13.2 Action is taken to increase workforce understanding and use of safety and quality systems

Governance for Safety and Quality in Health Service Organisations

Standard 1



Incident and complaints management

Patient safety and quality incidents are recognised, reported and analysed, and this information is used to improve safety systems.

This criterion will be achieved by:	Actions required:
1.14 Implementing an incident management and investigation system that includes reporting, investigating and analysing incidents (including near misses), which all result in corrective actions	1.14.1 Processes are in place to support the workforce recognition and reporting of incidents and near misses
	1.14.2 Systems are in place to analyse and report on incidents
	1.14.3 Feedback on the analysis of reported incidents is provided to the workforce
	1.14.4 Action is taken to reduce risks to patients identified through the incident management system
	1.14.5 Incidents and analysis of incidents are reviewed at the highest level of governance in the organisation
1.15 Implementing a complaints management system that includes partnership with patients and carers	1.15.1 Processes are in place to support the workforce to recognise and report complaints
	1.15.2 Systems are in place to analyse and implement improvements in response to complaints
	1.15.3 Feedback is provided to the workforce on the analysis of reported complaints
	1.15.4 Patient feedback and complaints are reviewed at the highest level of governance in the organisation
1.16 Implementing an open disclosure process based on the national open disclosure standard	1.16.1 An open disclosure program is in place and is consistent with the national open disclosure standard
	1.16.2 The clinical workforce are trained in open disclosure processes



Standard 1 – Governance for Safety and Quality in Health Service Organisations

Patient rights and engagement

Patient rights are respected and their engagement in their care is supported.

This criterion will be achieved by:	Actions required:
1.17 Implementing through organisational policies and practices a patient charter of rights that is consistent with the current national charter of healthcare rights ³⁴	1.17.1 The organisation has a charter of patient rights that is consistent with the current national charter of healthcare rights
	1.17.2 Information on patient rights is provided and explained to patients and carers
	1.17.3 Systems are in place to support patients who are at risk of not understanding their healthcare rights
1.18 Implementing processes to enable partnership with patients in decisions about their care, including informed consent to treatment	1.18.1 Patients and carers are partners in the planning for their treatment
	1.18.2 Mechanisms are in place to monitor and improve documentation of informed consent
	1.18.3 Mechanisms are in place to align the information provided to patients with their capacity to understand
	1.18.4 Patients and carers are supported to document clear advance care directives and/or treatment-limiting orders
1.19 Implementing procedures that protect the confidentiality of patient clinical records without compromising appropriate clinical workforce access to patient clinical information	1.19.1 Patient clinical records are available at the point of care
	1.19.2 Systems are in place to restrict inappropriate access to and dissemination of patient clinical information
1.20 Implementing well designed, valid and reliable patient experience feedback mechanisms and using these to evaluate the health service performance	1.20.1 Data collected from patient feedback systems are used to measure and improve health services in the organisation



Partnering with Consumers

Standard 2

The Partnering with Consumers Standard:

Leaders of a health service organisation implement systems to support partnering with patients, carers and other consumers to improve the safety and quality of care. Patients, carers, consumers, clinicians and other members of the workforce use the systems for partnering with consumers.

The intention of this Standard is to:

Create a health service that is responsive to patient, carer and consumer input and needs.

Context:

This Standard provides the framework for 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', in the implementation of all other Standards.

Criteria to achieve the Partnering with Consumers Standard:

Consumer partnership in service planning

Governance structures are in place to form partnerships with consumers and/or carers.

Consumer partnership in designing care

Consumers and/or carers are supported by the health service organisation to actively participate in the improvement of the patient experience and patient health outcomes.

Consumer partnership in service measurement and evaluation

Consumers and/or carers receive information on the health service organisation's performance and contribute to the ongoing monitoring, measurement and evaluation of performance for continuous quality improvement.

Standard 2 – Partnering with Consumers

Explanatory notes

There is growing evidence about the importance of partnerships between health service organisations and health professionals, and patients, families, carers and consumers. Studies have demonstrated significant benefits from such partnerships in clinical quality and outcomes, the experience of care, and the business and operations of delivering care. The clinical benefits that have been identified as being associated with better patient experience and patient-centred care include:

- decreased mortality³⁵
- decreased readmission rates³⁶
- decreased rates of healthcare acquired infections³⁷
- reduced length of stay³⁸
- improved adherence to treatment regimens³⁹
- improved functional status.³⁸

Operational benefits that have been identified include lower costs per case, improved liability claims experiences, and increased workforce satisfaction and retention rates.⁴⁰

The importance of health systems and health services that are based on partnerships with patients, families, carers and consumers is reflected in national and international quality frameworks.³⁹ In Australia, consumer-centred care is one of the three dimensions in the Australian Safety and Quality Framework for Health Care.⁴⁰ Partnerships with patients and consumers also form the basis of a range of national and jurisdictional health policies and programs.



Partnering with Consumers

Standard 2



Consumer partnership in service planning

Governance structures are in place to form partnerships with consumers and/or carers.

This criterion will be achieved by:	Actions required:
2.1 Establishing governance structures to facilitate partnerships with consumers and/or carers	2.1.1 Consumers and/or carers are involved in the governance of the health service organisation
	2.1.2 Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people who do not usually provide feedback
2.2 Implementing policies, procedures and/or protocols for partnering with patients, carers and consumers in: <ul style="list-style-type: none"> • strategic and operational/services planning • decision making about safety and quality initiatives • quality improvement activities 	2.2.1 The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation
	2.2.2 Consumers and/or carers are actively involved in decision making about safety and quality
2.3 Facilitating access to relevant orientation and training for consumers and/or carers partnering with the organisation	2.3.1 Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role
2.4 Consulting consumers on patient information distributed by the organisation	2.4.1 Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for distribution to patients)
	2.4.2 Action is taken to incorporate consumer and/or carers' feedback into publications prepared by the health service organisation for distribution to patients



Standard 2 – Partnering with Consumers

Consumer partnership in designing care

Consumers and/or carers are supported by the health service organisation to actively participate in the improvement of the patient experience and patient health outcomes.

This criterion will be achieved by:	Actions required:
2.5 Partnering with consumers and/or carers to design the way care is delivered to better meet patient needs and preferences	2.5.1 Consumers and/or carers participate in the design and redesign of health services
2.6 Implementing training for clinical leaders, senior management and the workforce on the value of and ways to facilitate consumer engagement and how to create and sustain partnerships	2.6.1 Clinical leaders, senior managers and the workforce access training on patient-centred care and the engagement of individuals in their care 2.6.2 Consumers and/or carers are involved in training the clinical workforce

Consumer partnership in service measurement and evaluation

Consumers and/or carers receive information on the health service organisation's performance and contribute to the ongoing monitoring, measurement and evaluation of performance for continuous quality improvement.

This criterion will be achieved by:	Actions required:
2.7 Informing consumers and/or carers about the organisation's safety and quality performance in a format that can be understood and interpreted independently	2.7.1 The community and consumers are provided with information that is meaningful and relevant on the organisation's safety and quality performance
2.8 Consumers and/or carers participating in the analysis of safety and quality performance information and data, and the development and implementation of action plans	2.8.1 Consumers and/or carers participate in the analysis of organisational safety and quality performance 2.8.2 Consumers and/or carers participate in the planning and implementation of quality improvements
2.9 Consumers and/or carers participating in the evaluation of patient feedback data and development of action plans	2.9.1 Consumers and/or carers participate in the evaluation of patient feedback data 2.9.2 Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data



Preventing and Controlling Healthcare Associated Infections

Standard 3

The Preventing and Controlling Healthcare Associated Infections Standard:

Clinical leaders and senior managers of a health service organisation implement systems to prevent and manage healthcare associated infections and communicate these to the workforce to achieve appropriate outcomes. Clinicians and other members of the workforce use the healthcare associated infection prevention and control systems.

The intention of this Standard is to:

Prevent patients from acquiring preventable healthcare associated infections and effectively manage infections when they occur by using evidence-based strategies.

Context:

It is expected that this Standard will be applied in conjunction with Standard 1, 'Governance for Safety and Quality in Health Service Organisations' and Standard 2, 'Partnering with Consumers'.

Criteria to achieve the Preventing and Controlling Healthcare Associated Infections Standard:

Governance and systems for infection prevention, control and surveillance

Effective governance and management systems for healthcare associated infections are implemented and maintained.

Infection prevention and control strategies

Strategies for the prevention and control of healthcare associated infections are developed and implemented.

Managing patients with infections or colonisations

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

Antimicrobial stewardship

Safe and appropriate antimicrobial prescribing is a strategic goal of the clinical governance system.

Cleaning, disinfection and sterilisation

Healthcare facilities and the associated environment are clean and hygienic. Reprocessing of equipment and instrumentation meets current best practice guidelines.

Communicating with patients and carers

Information on healthcare associated infections is provided to patients, carers, consumers and service providers.

Standard 3 – Preventing and Controlling Healthcare Associated Infections

Explanatory notes

Infectious organisms evolve over time and continue to present new challenges for infection prevention and management within health care. Of major current concern is the emergence and transmission of antimicrobial resistant bacteria, such as methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin-resistant enterococci (VRE). Other new challenges have arisen with the increase of infection with *Clostridium difficile* and multi-resistant Gram-negative bacteria, including those producing extended-spectrum beta-lactamases (ESBLs) or carbapenemases.

In Australian healthcare settings, large numbers of patients are treated in close proximity to each other. They often undergo invasive procedures, have medical devices inserted and receive broad-spectrum antibiotics or immunosuppressive therapies. These conditions provide ideal opportunities for the adaption and spread of pathogenic, infectious organisms.

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 medicines (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 use of health services (such as extending length of stay and reducing access to available beds) and place greater demands on the clinical workforce (such as laboratory tests and other tools to diagnose the infection).

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 caused by these agents.

Infection prevention and control aims to reduce the development of resistant pathogens and minimise risk of transmission through the isolation of the infectious organism or the patient, and by using standard and transmission-based precautions. However, 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. These strategies include infection control, hand hygiene surveillance and improving the safe and appropriate use of antimicrobials through antimicrobial stewardship.

Systems and governance for infection prevention, control and surveillance must be consistent with relevant national documents, including *Australian Guidelines for the Prevention and Control of Infections in Health Care*.¹⁹



Preventing and Controlling Healthcare Associated Infections

Standard 3



Governance and systems for infection prevention, control and surveillance

Effective governance and management systems for healthcare associated infections are implemented and maintained.

This criterion will be achieved by:	Actions required:
3.1 Developing and implementing governance systems for effective infection prevention and control to minimise the risks to patients of healthcare associated infections	3.1.1 A risk management approach is taken when implementing policies, procedures and/or protocols for: <ul style="list-style-type: none"> • standard infection control precautions • transmission-based precautions • aseptic non-touch technique • safe handling and disposal of sharps • prevention and management of occupational exposure to blood and body substances • environmental cleaning and disinfection • antimicrobial prescribing • outbreaks or unusual clusters of communicable infection • processing of reusable medical devices • single-use devices • surveillance and reporting of data where relevant • reporting of communicable and notifiable diseases • provision of risk assessment guidelines to workforce • exposure-prone procedures
	3.1.2 The use of policies, procedures and/or protocols is regularly monitored
	3.1.3 The effectiveness of the infection prevention and control systems is regularly reviewed at the highest level of governance in the organisation
	3.1.4 Action is taken to improve the effectiveness of infection prevention and control policies, procedures and/or protocols
3.2 Undertaking surveillance of healthcare associated infections	3.2.1 Surveillance systems for healthcare associated infections are in place
	3.2.2 Healthcare associated infections surveillance data are regularly monitored by the delegated workforce and/or committees



Standard 3 – Preventing and Controlling Healthcare Associated Infections

This criterion will be achieved by:	Actions required:
3.3 Developing and implementing systems and processes for reporting, investigating and analysing healthcare associated infections, and aligning these systems to the organisation's risk management strategy	3.3.1 Mechanisms to regularly assess the healthcare associated infection risks are in place
	3.3.2 Action is taken to reduce the risks of healthcare associated infection
3.4 Undertaking quality improvement activities to reduce healthcare associated infections through changes to practice	3.4.1 Quality improvement activities are implemented to reduce and prevent healthcare associated infections
	3.4.2 Compliance with changes in practice are monitored
	3.4.3 The effectiveness of changes to practice are evaluated

Preventing and Controlling Healthcare Associated Infections

Standard 3



Infection prevention and control strategies

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

This criterion will be achieved by:	Actions required:
3.5 Developing, implementing and auditing a hand hygiene program consistent with the current national hand hygiene initiative ⁴³	3.5.1 Workforce compliance with current national hand hygiene guidelines is regularly audited
	3.5.2 Compliance rates from hand hygiene audits are regularly reported to the highest level of governance in the organisation
	3.5.3 Action is taken to address non-compliance, or the inability to comply, with the requirements of the current national hand hygiene guidelines
3.6 Developing, implementing and monitoring a risk-based workforce immunisation program in accordance with the current National Health and Medical Research Council Australian immunisation guidelines ⁴⁴	3.6.1 A workforce immunisation program that complies with current national guidelines is in use
3.7 Promoting collaboration with occupational health and safety programs to decrease the risk of infection or injury to healthcare workers	3.7.1 Infection prevention and control consultation related to occupational health and safety policies, procedures and/or protocols are implemented to address: <ul style="list-style-type: none"> • communicable disease status • occupational management and prophylaxis • work restrictions • personal protective equipment • assessment of risk to healthcare workers for occupational allergies • evaluation of new products and procedures
3.8 Developing and implementing a system for use and management of invasive devices based on the current national guidelines for preventing and controlling infections in health care ¹⁹	3.8.1 Compliance with the system for the use and management of invasive devices is monitored
3.9 Implementing protocols for invasive device procedures regularly performed within the organisation	3.9.1 Education and competency-based training in invasive devices protocols and use is provided for the workforce who perform procedures with invasive devices



Standard 3 – Preventing and Controlling Healthcare Associated Infections

This criterion will be achieved by:	Actions required:
3.10 Developing and implementing protocols for aseptic technique	3.10.1 The clinical workforce is trained in aseptic technique
	3.10.2 Compliance with aseptic technique is regularly audited
	3.10.3 Action is taken to increase compliance with the aseptic technique protocols

Managing patients with infections or colonisations

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

This criterion will be achieved by:	Actions required:
3.11 Implementing systems for using standard precautions and transmission-based precautions	3.11.1 Standard precautions and transmission-based precautions consistent with the current national guidelines are in use
	3.11.2 Compliance with standard precautions is monitored
	3.11.3 Action is taken to improve compliance with standard precautions
	3.11.4 Compliance with transmission-based precautions is monitored
	3.11.5 Action is taken to improve compliance with transmission-based precautions
3.12 Assessing the need for patient placement based on the risk of infection transmission	3.12.1 A risk analysis is undertaken to consider the need for transmission-based precautions including: <ul style="list-style-type: none"> • accommodation based on the mode of transmission • environmental controls through air flow • transportation within and outside the facility • cleaning procedures • equipment requirements
	3.12.2 A process for communicating a patient's infectious status is in place whenever responsibility for care is transferred between service providers or facilities
3.13 Developing and implementing protocols relating to the admission, receipt and transfer of patients with an infection	3.13.1 Mechanisms are in use for checking for pre-existing healthcare associated infections or communicable disease on presentation for care
	3.13.2 A process for communicating a patient's infectious status is in place whenever responsibility for care is transferred between service providers or facilities

Preventing and Controlling Healthcare Associated Infections

Standard 3



Antimicrobial stewardship

Safe and appropriate antimicrobial prescribing is a strategic goal of the clinical governance system.

This criterion will be achieved by:	Actions required:
3.14 Developing, implementing and regularly reviewing the effectiveness of the antimicrobial stewardship system	3.14.1 An antimicrobial stewardship program is in place
	3.14.2 The clinical workforce prescribing antimicrobials have access to current endorsed therapeutic guidelines on antibiotic usage ⁴⁵
	3.14.3 Monitoring of antimicrobial usage and resistance is undertaken
	3.14.4 Action is taken to improve the effectiveness of antimicrobial stewardship

Cleaning, disinfection and sterilisation

Healthcare facilities and the associated environment are clean and hygienic. Reprocessing of equipment and instrumentation meets current best practice guidelines.

This criterion will be achieved by:	Actions required:
3.15 Using risk management principles to implement systems that maintain a clean and hygienic environment for patients and healthcare workers	3.15.1 Policies, procedures and/or protocols for environmental cleaning that address the principles of infection prevention and control are implemented, including: <ul style="list-style-type: none"> • maintenance of building facilities • cleaning resources and services • risk assessment for cleaning and disinfection based on transmission-based precautions and the infectious agent involved • waste management within the clinical environment • laundry and linen transportation, cleaning and storage • appropriate use of personal protective equipment
	3.15.2 Policies, procedures and/or protocols for environmental cleaning are regularly reviewed
	3.15.3 An established environmental cleaning schedule is in place and environmental cleaning audits are undertaken regularly
3.16 Reprocessing reusable medical equipment, instruments and devices in accordance with relevant national or international standards and manufacturers' instructions	3.16.1 Compliance with relevant national or international standards and manufacturer's instructions for cleaning, disinfection and sterilisation of reusable instruments and devices is regularly monitored



Standard 3 – Preventing and Controlling Healthcare Associated Infections

This criterion will be achieved by:	Actions required:
3.17 Implementing systems to enable the identification of patients on whom the reusable medical devices have been used	3.17.1 A traceability system that identifies patients who have a procedure using sterile reusable medical instruments and devices is in place
3.18 Ensuring workforce who decontaminate reusable medical devices undertake competency-based training in these practices	3.18.1 Action is taken to maximise coverage of the relevant workforce trained in a competency-based program to decontaminate reusable medical devices

Communicating with patients and carers

Information on healthcare associated infection is provided to patients, carers, consumers and service providers.

This criterion will be achieved by:	Actions required:
3.19 Ensuring consumer-specific information on the management and reduction of healthcare associated infections is available at the point of care	3.19.1 Information on the organisation's corporate and clinical infection risks and initiatives implemented to minimise patient infection risks is provided to patients and/or carers
	3.19.2 Patient infection prevention and control information is evaluated to determine if it meets the needs of the target audience



Medication Safety

Standard 4

The Medication Safety Standard:

Clinical leaders and senior managers of a health service organisation implement systems to reduce the occurrence of medication incidents, and improve the safety and quality of medicine use. Clinicians and other members of the workforce use the systems to safely manage medicines.

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 Standard 1, 'Governance for Safety and Quality in Health Service Organisations' and Standard 2, 'Partnering with Consumers'.

Criteria to achieve the Medication Safety Standard:

Governance and systems for medication safety

Health service organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing, manufacturing, compounding and monitoring of the effects of medicines.

Documentation of patient information

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

Medication management processes

The clinical workforce is supported for the prescribing, dispensing, administering, storing, manufacturing, compounding and monitoring of medicines.

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.

Communicating with patients and carers

The clinical workforce informs patients about their options, risks and responsibilities for an agreed medication management plan.

Standard 4 – Medication Safety

Explanatory notes

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. Some of these events are costly and potentially avoidable.

Over 1.5 million Australians are estimated to experience an adverse event from medicines each year.⁴⁶ This results in at least 400 000 visits to general practitioners and 190 000 hospital admissions⁴⁷, which represents 2–3% of all admissions. As many as 30% of unplanned geriatric admissions are associated with an adverse medicine event.⁵ Approximately 50% of these admissions are considered potentially avoidable.⁴⁸

The cost of these adverse events to individual patients and the healthcare system is significant. A study published in 2009 reported that medicine-related hospital admissions in Australia were estimated to cost \$660 million.⁴⁷ The impact on patients' quality of life is more difficult to quantify.

Many solutions to prevent medication errors are found in standardisation and systemisation of processes. Other recognised solutions for reducing common causes of medication errors include:

- improving clinician-workforce and clinician-patient communication
- using technology to support information recording and transfer
- providing better access to patient information and clinical decision support at the point of care.



Medication Safety

Standard 4



Governance and systems for medication safety

Health service organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing, manufacturing, compounding and monitoring of the effects of medicines.

This criterion will be achieved by:	Actions required:
4.1 Developing and implementing governance arrangements and organisational policies, procedures and/or protocols for medication safety, which are consistent with national and jurisdictional legislative requirements, policies and guidelines	4.1.1 Governance arrangements are in place to support the development, implementation and maintenance of organisation-wide medication safety systems
	4.1.2 Policies, procedures and/or protocols are in place that are consistent with legislative requirements, national, jurisdictional and professional guidelines
4.2 Undertaking a regular, comprehensive assessment of medication use systems to identify risks to patient safety and implementing system changes to address the identified risks	4.2.1 The medication management system is regularly assessed
	4.2.2 Action is taken to reduce the risks identified in the medication management system
4.3 Authorising the relevant clinical workforce to prescribe, dispense and administer medications	4.3.1 A system is in place to verify that the clinical workforce have medication authorities appropriate to their scope of practice
	4.3.2 The use of the medication authorisation system is regularly monitored
	4.3.3 Action is taken to increase the effectiveness of the medication authority system
4.4 Using a robust organisation-wide system of reporting, investigating and managing change to respond to medication incidents	4.4.1 Medication incidents are regularly monitored, reported and investigated
	4.4.2 Action is taken to reduce the risk of adverse medication incidents
4.5 Undertaking quality improvement activities to enhance the safety of medicines use	4.5.1 The performance of the medication management system is regularly assessed
	4.5.2 Quality improvement activities are undertaken to reduce the risk of patient harm and increase the quality and effectiveness of medicines use



Standard 4 – Medication Safety

Documentation of patient information

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

This criterion will be achieved by:	Actions required:
4.6 The clinical workforce taking an accurate medication history when a patient presents to a health service organisation, or as early as possible in the episode of care, which is then available at the point of care	4.6.1 A best possible medication history is documented for each patient
	4.6.2 The medication history and current clinical information is available at the point of care
4.7 The clinical workforce documenting the patient's previously known adverse drug reactions on initial presentation and updating this if an adverse reaction to a medicine occurs during the episode of care	4.7.1 Known medication allergies and adverse drug reactions are documented in the patient clinical record
	4.7.2 Action is taken to reduce the risk of adverse reactions
	4.7.3 Adverse drug reactions are reported within the organisation and to the Therapeutic Goods Administration
4.8 The clinical workforce reviewing the patient's current medication orders against their medication history and prescriber's medication plan, and reconciling any discrepancies	4.8.1 Current medicines are documented and reconciled at admission and transfer of care between healthcare settings

Medication Safety

Standard 4



Medication management processes

The clinical workforce is supported for the prescribing, dispensing, administering, storing, manufacturing compounding and monitoring of medicines.

This criterion will be achieved by:	Actions required:
4.9 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	4.9.1 Information and decision support tools for medicines are available to the clinical workforce at the point of care
	4.9.2 The use of information and decision support tools is regularly reviewed
	4.9.3 Action is taken to improve the availability and effectiveness of information and decision support tools
4.10 Ensuring that medicines are distributed and stored securely, safely and in accordance with the manufacturer's directions, legislation, jurisdictional orders and operational directives	4.10.1 Risks associated with secure storage and safe distribution of medicines are regularly reviewed
	4.10.2 Action is taken to reduce the risks associated with storage and distribution of medicines
	4.10.3 The storage of temperature-sensitive medicines is monitored
	4.10.4 A system that is consistent with legislative and jurisdictional requirements for the disposal of unused, unwanted or expired medications is in place
	4.10.5 The system for disposal of unused, unwanted or expired medications is regularly monitored
	4.10.6 Action is taken to increase compliance with the system for storage, distribution and disposal of medications
4.11 Identifying high-risk medicines in the organisation and ensuring they are stored, prescribed, dispensed and administered safely	4.11.1 The risks for storing, prescribing, dispensing and administration of high-risk medicines are regularly reviewed
	4.11.2 Action is taken to reduce the risks of storing, prescribing, dispensing and administering high-risk medicines



Standard 4 – Medication Safety

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.

This criterion will be achieved by:	Actions required:
4.12 Ensuring a current comprehensive list of medicines, and the reason(s) for any change, is provided to the receiving clinician and the patient during clinical handovers	4.12.1 A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in medicines
	4.12.2 A current and comprehensive list of medicines is provided to the patient and/or carer when concluding an episode of care
	4.12.3 A current comprehensive list of medicines is provided to the receiving clinician during clinical handover
	4.12.4 Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover

Communicating with patients and carers

The clinical workforce informs patients about their options, risks and responsibilities for an agreed medication management plan.

This criterion will be achieved by:	Actions required:
4.13 The clinical workforce informing patients and carers about medication treatment options, benefits and associated risks	4.13.1 The clinical workforce provides patients with patient specific medicine information, including medication treatment options, benefits and associated risks
	4.13.2 Information that is designed for distribution to patients is readily available to the clinical workforce
4.14 Developing a medication management plan in partnership with patients and carers	4.14.1 An agreed medication management plan is documented and available in the patient's clinical record
4.15 Providing current medicines information to patients in a format that meets their needs whenever new medicines are prescribed or dispensed	4.15.1 Information on medicines is provided to patients and carers in a format that is understood and meaningful
	4.15.2 Action is taken in response to patient feedback to improve medicines information distributed by the health service organisation to patients



Patient Identification and Procedure Matching

Standard 5

The Patient Identification and Procedure Matching Standard:

Clinical leaders and senior managers of a health service organisation establish systems to ensure the correct identification of patients and correct matching of patients with their intended treatment. Clinicians and other members of the workforce use the patient identification and procedure matching systems.

The intention of this Standard is to:

Correctly identify all patients whenever care is provided and correctly match patients to their intended treatment.

Context:

It is expected that this Standard will be applied in conjunction with Standard 1, 'Governance for Safety and Quality in Health Service Organisations' and Standard 2, 'Partnering with Consumers'.

Criteria to achieve the Patient Identification and Procedure Matching Standard:

Identification of individual patients

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

Processes to transfer care

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

Processes to match patients and their care

Health service organisations have explicit processes to correctly match patients with their intended care.

Standard 5 – Patient Identification and Procedure Matching

Explanatory notes

Patient identification and the matching of a patient to an intended treatment is an activity that is performed routinely in all care settings. Risks to patient safety occur when there is a mismatch between a given patient and components of their care, whether those components are diagnostic, therapeutic or supportive.

Much of the information about the number of patient mismatching events comes from incident reporting systems. In 2008–09 there were eleven events in Australia with procedures involving the wrong patient or body part resulting in a death or major permanent loss of function.³² When less serious events from nonsurgical areas – such as pathology and radiology – are included in reporting systems the number of reported events can rise considerably.⁴⁹

Since patient identification is an activity that is performed frequently, it can often be seen as a relatively unimportant task. Taking human factors into account when planning patient safety emphasises the design of systems to consider human capabilities, limitations and characteristics.⁵⁰ This approach suggests that the development of safety routines for common tasks (such as patient identification) provides a powerful defence against simple mistakes that may progress and cause harm. These routines allow the workforce to focus their attention on those activities that require more cognitive processing and judgement, such as the provision of clinical care.⁵¹ The use of tools such as the World Health Organization Surgical Safety Checklist⁵² and Ensuring Correct Patient, Correct Site, Correct Procedure protocols⁵³ provide a basis for the development of such routines.



Patient Identification and Procedure Matching

Standard 5



Identification of individual patients

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

This criterion will be achieved by:	Actions required:
<p>5.1 Developing, implementing and regularly reviewing the effectiveness of a patient identification system including the associated policies, procedures and/or protocols that:</p> <ul style="list-style-type: none"> • 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 • require at least three approved patient identifiers whenever clinical handover, patient transfer or discharge documentation is generated 	<p>5.1.1 Use of an organisation-wide patient identification system is regularly monitored</p> <hr/> <p>5.1.2 Action is taken to improve compliance with the patient identification matching system</p>
<p>5.2 Implementing a robust organisation-wide system of reporting, investigation and change management to respond to any patient care mismatching events</p>	<p>5.2.1 The system for reporting, investigating and analysis of patient care mismatching events is regularly monitored</p> <hr/> <p>5.2.2 Action is taken to reduce mismatching events</p>
<p>5.3 Ensuring that when a patient identification band is used, it meets the national specifications for patient identification bands⁵⁴</p>	<p>5.3.1 Inpatient bands are used that meet the national specifications for patient identification bands</p>



Standard 5 – Patient Identification and Procedure Matching

Processes to transfer care

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

This criterion will be achieved by:	Actions required:
5.4 Developing, implementing and regularly reviewing the effectiveness of the patient identification and matching system at patient handover, transfer and discharge	5.4.1 A patient identification and matching system is implemented and regularly reviewed as part of structured clinical handover, transfer and discharge processes

Processes to match patients and their care

Health service organisations have explicit processes to correctly match patients with their intended care.

This criterion will be achieved by:	Actions required:
5.5 Developing and implementing a documented process to match patients to their intended procedure, treatment or investigation and implementing the consistent national guidelines for patient procedure matching protocol or other relevant protocols ⁵³	5.5.1 A documented process to match patients and their intended treatment is in use
	5.5.2 The process to match patients to any intended procedure, treatment or investigation is regularly monitored
	5.5.3 Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation



Clinical Handover

Standard 6

The Clinical Handover Standard:

Clinical leaders and senior managers of a health service organisation implement documented systems for effective and structured clinical handover. Clinicians and other members of the workforce use the clinical handover systems.

The intention of this Standard is to:

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

Context:

It is expected that this Standard will be applied in conjunction with Standard 1, 'Governance for Safety and Quality in Health Service Organisations' and Standard 2, 'Partnering with Consumers'.

Criteria to achieve the Clinical Handover Standard:

Governance and leadership for effective clinical handover

Health service organisations implement effective clinical handover systems.

Clinical handover processes

Health service organisations have documented and structured clinical handover processes in place.

Patient and carer involvement in clinical handover

Health service organisations establish mechanisms to include patients and carers in clinical handover processes.

Standard 6 – Clinical Handover

Explanatory notes

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.^{12 55}

Clinical handovers can vary depending on patient circumstance, including:

- The *situation* of handover, such as
 - during a shift change
 - when patients are transferred inter and intrahospital
 - during patient admission, referral or discharge
- The *method* of handover, such as
 - face-to-face
 - via telephone
 - via written orders
 - when aided by electronic handover tools
- The *venue* where handover takes place, such as
 - at the patient's bedside
 - in a common staff area
 - at a hospital or clinic reception.

Clinical handovers can also take place in the presence or absence of the patient and carer.

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.⁵⁶

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 has been identified as one of the most important contributing factors in serious adverse events and is a major preventable cause of patient harm.⁵⁷

Achieving sustainable improvement in clinical handover requires standardised processes and information sets. Clinical handover solutions must be fit for purpose and appropriate to the clinical context in which handover occurs. 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.⁵⁸⁻⁶¹



Clinical Handover

Standard 6



Governance and leadership for effective clinical handover

Health service organisations implement effective clinical handover systems.

This criterion will be achieved by:	Actions required:
6.1 Developing and implementing an organisational system for structured clinical handover that is relevant to the healthcare setting and specialities, including: <ul style="list-style-type: none">documented policy, procedures and/or protocolsagreed tools and guides	6.1.1 Clinical handover policies, procedures and/or protocols are used by the workforce and regularly monitored
	6.1.2 Action is taken to maximise the effectiveness of clinical handover policies, procedures and/or protocols
	6.1.3 Tools and guides are periodically reviewed



Standard 6 – Clinical Handover

Clinical handover processes

Health service organisations have documented and structured clinical handover processes in place.

This criterion will be achieved by:	Actions required:
6.2 Establishing and maintaining structured and documented processes for clinical handover	6.2.1 The workforce has access to documented structured processes for clinical handover that include: <ul style="list-style-type: none"> • preparing for handover, including setting the location and time while maintaining continuity of patient care • organising relevant workforce members to participate • being aware of the clinical context and patient needs • participating in effective handover resulting in transfer of responsibility and accountability for care
6.3 Monitoring and evaluating the agreed structured clinical handover processes, including: <ul style="list-style-type: none"> • regularly reviewing local processes based on current best practice in collaboration with clinicians, patients and carers • undertaking quality improvement activities and acting on issues identified from clinical handover reviews • reporting the results of clinical handover reviews at executive level of governance 	6.3.1 Regular evaluation and monitoring processes for clinical handover are in place
	6.3.2 Local processes for clinical handover are reviewed in collaboration with clinicians, patients and carers
	6.3.3 Action is taken to increase the effectiveness of clinical handover
	6.3.4 The actions taken and the outcomes of local clinical handover reviews are reported to the executive level of governance
6.4 Implementing a robust organisation-wide system of reporting, investigation and change management to respond to any clinical handover incidents	6.4.1 Regular reporting, investigating and monitoring of clinical handover incidents is in place
	6.4.2 Action is taken to reduce the risk of adverse clinical handover incidents

Patient and carer involvement in clinical handover

Health service organisations establish mechanisms to include patients and carers in clinical handover processes.

This criterion will be achieved by:	Actions required:
6.5 Developing and implementing mechanisms to include patients and carers in the clinical handover process that are relevant to the healthcare setting	6.5.1 Mechanisms to involve a patient and, where relevant, their carer in clinical handover are in use



Blood and Blood Products

Standard 7

The Blood and Blood Products Standard:

Clinical leaders and senior managers of a health service organisation implement systems to ensure the safe, appropriate, efficient and effective use of blood and blood products. Clinicians and other members of the workforce use the blood and blood product safety systems.

The intention of this Standard is to:

Ensure that the patients who receive blood and blood products do so appropriately and safely.

Context:

It is expected that this Standard will be applied in conjunction with Standard 1, 'Governance for Safety and Quality in Health Service Organisations' and Standard 2, 'Partnering with Consumers'.

Criteria to achieve the Blood and Blood Products Standard:

Governance and systems for blood and blood product prescribing and clinical use

Health service organisations have systems in place for the safe and appropriate prescribing and clinical use of blood and blood products.

Documenting patient information

The clinical workforce accurately records a patient's blood and blood product transfusion history and indications for use of blood and blood products.

Managing blood and blood product safety

Health service organisations have systems to receive, store, transport and monitor wastage of blood and blood products safely and efficiently.

Communicating with patients and carers

Patients and carers are informed about the risks and benefits of using blood and blood products, and the available alternatives when a plan for treatment is developed.

Standard 7 – Blood and Blood Products

Explanatory notes

Treatment with blood and blood products can be lifesaving however, as biological materials they are not without risk. Screening and testing of donors and donated blood and ensuring that decisions to transfuse follow consideration of all treatment options, their risks and benefits all contribute to minimising the inherent risks.

The scope of this Standard covers all elements of the clinical process, including:

- making clinical decisions
- obtaining recipient samples and assessing compatibility with donated products
- safely administering the products to the intended recipient
- disposing of the product
- reporting and investigating any adverse reactions or incidents.

This Standard also aims to ensure that safe, appropriate, effective and efficient blood management systems are in place.

The principles of good patient blood management that provide for clinically appropriate and safe management of patients while avoiding blood and blood product transfusions and its associated risks are supported by this Standard.

National and international research demonstrates that the dual approach of implementing governance structures and evidence-based clinical guidelines is the most effective methodology to ensure the appropriate and safe use of blood and blood products.



Blood and Blood Products

Standard 7



Governance and systems for blood and blood product prescribing and clinical use

Health service organisations have systems in place for the safe and appropriate prescribing and clinical use of blood and blood products.

This criterion will be achieved by:	Actions required:
7.1 Developing governance systems for safe and appropriate prescription, administration and management of blood and blood products	7.1.1 Blood and blood product policies, procedures and/or protocols are consistent with national evidence-based guidelines for pre-transfusion practices, prescribing and clinical use of blood and blood products
	7.1.2 The use of policies, procedures and/or protocols is regularly monitored
	7.1.3 Action is taken to increase the safety and appropriateness of prescribing and clinically using blood and blood products
7.2 Undertaking a regular, comprehensive assessment of blood and blood product systems to identify risks to patient safety and taking action to reduce risks	7.2.1 The risks associated with transfusion practices and clinical use of blood and blood products are regularly assessed
	7.2.2 Action is taken to reduce the risks associated with transfusion practices and the clinical use of blood and blood products
7.3 Ensuring blood and blood product adverse events are included in the incidents management and investigation system	7.3.1 Reporting on blood and blood product incidents is included in regular incident reports
	7.3.2 Adverse blood and blood product incidents are reported to and reviewed by the highest level of governance in the health service organisation
	7.3.3 Health service organisations participate in relevant haemovigilance activities conducted by the organisation or at state or national level
7.4 Undertaking quality improvement activities to improve the safe management of blood and blood products	7.4.1 Quality improvement activities are undertaken to reduce the risks of patient harm from transfusion practices and the clinical use of blood and blood products



Standard 7 – Blood and Blood Products

Documenting patient information

The clinical workforce accurately records a patient's blood and blood product transfusion history and indications for use of blood and blood products.

This criterion will be achieved by:	Actions required:
7.5 As part of the patient treatment plan, the clinical workforce accurately documenting: <ul style="list-style-type: none"> • relevant medical conditions • indications for transfusion • any special product or transfusion requirements • known patient transfusion history • type and volume of product transfusion • patient response to transfusion 	7.5.1 A best possible history of blood product usage and relevant clinical and product information is documented in the patient clinical record
	7.5.2 The patient clinical records of transfused patients are periodically reviewed to assess the proportion of records completed
	7.5.3 Action is taken to increase the proportion of patient clinical records of transfused patients with a complete patient clinical record
7.6 The clinical workforce documenting any adverse reactions to blood or blood products	7.6.1 Adverse reactions to blood or blood products are documented in the patient clinical record
	7.6.2 Action is taken to reduce the risk of adverse events from administering blood or blood products
	7.6.3 Adverse events are reported internally to the appropriate governance level and externally to the pathology service provider, blood service or product manufacturer whenever appropriate

Blood and Blood Products

Standard 7



Managing blood and blood product safety

Health services organisations have systems to receive, store, transport and monitor wastage of blood and blood products safely and efficiently.

This criterion will be achieved by:	Actions required:
7.7 Ensuring the receipt, storage, collection and transport of blood and blood products within the organisation are consistent with best practice and/or guidelines	7.7.1 Regular review of the risks associated with receipt, storage, collection and transport of blood and blood products is undertaken
	7.7.2 Action is taken to reduce the risk of incidents arising from the use of blood and blood product control systems
7.8 Minimising unnecessary wastage of blood and blood products	7.8.1 Blood and blood product wastage is regularly monitored
	7.8.2 Action is taken to minimise wastage of blood and blood products



Standard 7 – Blood and Blood Products

Communicating with patients and carers

Patients and carers are informed about the risks and benefits of using blood and blood products and about the available alternatives when a plan for treatment is developed.

This criterion will be achieved by:	Actions required:
7.9 The clinical workforce informing patients and carers about blood and blood product treatment options, and the associated risks and benefits	7.9.1 Patient information relating to blood and blood products, including risks, benefits and alternatives, is available for distribution by the clinical workforce
	7.9.2 Plans for care that include the use of blood and blood products are developed in partnership with patients and carers
7.10 Providing information to patients about blood and blood product use and possible alternatives in a format that can be understood by patients and carers	7.10.1 Information on blood and blood products is provided to patients and their carers in a format that is understood and meaningful
7.11 Implementing an informed consent process for all blood and blood product use	7.11.1 Informed consent is undertaken and documented for all transfusions of blood or blood products in accordance with the informed consent policy of the health service organisation



Preventing and Managing Pressure Injuries

Standard 8

The Preventing and Managing Pressure Injuries Standard:

Clinical leaders and senior managers of the health service organisation implement evidence-based systems to prevent pressure injuries and manage them when they do occur. Clinicians and other members of the workforce use the pressure injury prevention and management systems.

The intention of this Standard is to:

Prevent patients from developing pressure injuries and effectively managing pressure injuries when they do occur.

Context:

It is expected that this Standard will be applied in conjunction with Standard 1, 'Governance for Safety and Quality in Health Service Organisations' and Standard 2, 'Partnering with Consumers'.

Criteria to achieve the Preventing and Managing Pressure Injuries Standard:

Governance and systems for the prevention and management of pressure injuries

Health service organisations have governance structures and systems in place for the prevention and management of pressure injuries.

Preventing pressure injuries

Patients are screened on presentation and pressure injury prevention strategies are implemented when clinically indicated.

Managing pressure injuries

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

Communicating with patients and carers

Patients and carers are informed of the risks, prevention strategies and management of pressure injuries.

Standard 8 – Preventing and Managing Pressure Injuries

Explanatory notes

Immobility, such as that associated with extended bed rest in hospital, can cause pressure injuries. Research shows that pressure injuries are a major contributor to the care needs of patients within the health industry.⁶²⁻⁶³ In the majority of cases pressure injuries are preventable.

Pressure injuries not only occur in geriatric patients, but in all patients with any or all of the associated risk factors. These factors are not restricted to increased immobility, but include factors such as nutritional status, skin integrity, age and the level of oxygenation of the blood supply to pressure point injuries. A pressure injury can commence in any setting, including acute areas such as theatre and intensive care.

Solutions to the prevention of pressure injuries have been identified and are available in multiple evidence-based resources. Management of established pressure injuries has also progressed with the increasing specialisation in wound management. Implementing solutions and monitoring for compliance will require education and an awareness of all risk factors.

Note: National and international bodies are currently discussing the correct terminology for pressure-induced wounds, often known as bed sores or ulcers. This Standard adopts the alternate term 'pressure injury', which is in line with national and international moves to recognise that ulcers are only one form of a pressure injury.



Preventing and Managing Pressure Injuries

Standard 8



Governance and systems for the prevention and management of pressure injuries

Health service organisations have governance structures and systems in place for the prevention and management of pressure injuries.

This criterion will be achieved by:	Actions required:
8.1 Developing and implementing policies, procedures and/or protocols that are based on current best practice guidelines	8.1.1 Policies, procedures and/or protocols are in use that are consistent with best practice guidelines and incorporate screening and assessment tools
	8.1.2 The use of policies, procedures and/or protocols is regularly monitored
8.2 Using a risk assessment framework and reporting systems to identify, investigate and take action to reduce the frequency and severity of pressure injuries	8.2.1 An organisation-wide system for reporting pressure injuries is in use
	8.2.2 Administrative and clinical data are used to regularly monitor and investigate the frequency and severity of pressure injuries
	8.2.3 Information on pressure injuries is regularly reported to the highest level of governance in the health service organisation
	8.2.4 Action is taken to reduce the frequency and severity of pressure injuries
8.3 Undertaking quality improvement activities to address safety risks and monitor the systems that prevent and manage pressure injuries	8.3.1 Quality improvement activities are undertaken to prevent pressure injuries and/or improve the management of pressure injuries
8.4 Providing or facilitating access to equipment and devices to implement effective prevention strategies and best practice management plans	8.4.1 Equipment and devices are available to effectively implement prevention strategies for patients at risk and plans for the management of patients with pressure injuries



Standard 8 – Preventing and Managing Pressure Injuries

Preventing pressure injuries

Patients are screened on presentation and pressure injury prevention strategies are implemented when clinically indicated.

This criterion will be achieved by:	Actions required:
8.5 Identifying risk factors for pressure injuries using an agreed screening tool for all presenting patients within timeframes set by best practice guidelines	8.5.1 An agreed tool to screen for pressure injury risk is used by the clinical workforce to identify patients at risk of a pressure injury
	8.5.2 The use of the screening tool is monitored to identify the proportion of at-risk patients that are screened for pressure injuries on presentation
	8.5.3 Action is taken to maximise the proportion of patients who are screened for pressure injury on presentation
8.6 Conducting a comprehensive skin inspection in timeframes set by best practice guidelines on patients with a high risk of developing pressure injuries at presentation, regularly as clinically indicated during a patient's admission, and before discharge	8.6.1 Comprehensive skin inspections are undertaken and documented in the patient clinical record for patients at risk of pressure injuries
	8.6.2 Patient clinical records, transfer and discharge documentation are periodically audited to identify at-risk patients with documented skin assessments
	8.6.3 Action is taken to increase the proportion of skin assessments documented on patients at risk of pressure injuries
8.7 Implementing and monitoring pressure injury prevention plans and reviewing when clinically indicated	8.7.1 Prevention plans for all patients at risk of a pressure injury are consistent with best practice guidelines and are documented in the patient clinical record
	8.7.2 The effectiveness and appropriateness of pressure injury prevention plans are regularly reviewed
	8.7.3 Patient clinical records are monitored to determine the proportion of at-risk patients that have an implemented pressure injury prevention plan
	8.7.4 Action is taken to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan

Preventing and Managing Pressure Injuries

Standard 8



Managing pressure injuries

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

This criterion will be achieved by:	Actions required:
8.8 Implementing best practice management and ongoing monitoring as clinically indicated	8.8.1 An evidence-based wound management system is in place within the health service organisation
	8.8.2 Management plans for patients with pressure injuries are consistent with best practice and documented in the patient clinical record
	8.8.3 Patient clinical records are monitored to determine compliance with evidence-based pressure injury management plans
	8.8.4 Action is taken to increase compliance with evidence-based pressure injury management plans



Standard 8 – Preventing and Managing Pressure Injuries

Communicating with patients and carers

Patients and carers are informed of the risks, prevention strategies and management of pressure injuries.

This criterion will be achieved by:	Actions required:
8.9 Informing patients with a high risk of pressure injury, and their carers, about the risks, prevention strategies and management of pressure injuries	8.9.1 Patient information on prevention and management of pressure injuries is provided to patients and carers in a format that is understood and is meaningful
8.10 Developing a plan of management in partnership with patients and carers	8.10.1 Pressure injury management plans are developed in partnership with patients and carers



Recognising and Responding to Clinical Deterioration in Acute Health Care

Standard 9

The Recognising and Responding to Clinical Deterioration in Acute Health Care Standard:

Health service organisations establish and maintain systems for recognising and responding to clinical deterioration. Clinicians and other members of the workforce use the recognition and response systems.

The intention of this Standard is to:

Ensure a patient's deterioration is recognised promptly, and appropriate action is taken.[#]

Context:

It is expected that this Standard will be applied in conjunction with Standard 1, 'Governance for Safety and Quality in Health Service Organisations' and Standard 2, 'Partnering with Consumers'.

Criteria to achieve the Recognising and Responding to Clinical Deterioration Standard:

Establishing recognition and response systems

Organisation-wide systems consistent with the National Consensus Statement³ are used to support and promote recognition of, and response to, patients whose condition deteriorates in an acute health care facility.

Recognising clinical deterioration and escalating care

Patients whose condition is deteriorating are recognised and appropriate action is taken to escalate care.

Responding to clinical deterioration

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

Communicating with patients and carers

Patients, families and carers are informed of recognition and response systems and can contribute to the processes of escalating care.

[#] This Standard does not apply to deterioration of a patient's mental state.

Standard 9 – Recognising and Responding to Clinical Deterioration in Acute Health Care

Explanatory notes

Serious adverse events such as unexpected death and cardiac arrest are often preceded by observable physiological and clinical abnormalities.⁶⁴ Early identification of deterioration may improve outcomes and lessen the intervention required to stabilise patients whose condition deteriorates in hospital.⁶⁵

There is evidence that the warning signs of clinical deterioration are not always identified or acted on appropriately.⁶⁶ The organisation and workforce 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:⁶⁷⁻⁶⁹

- not monitoring physiological observations consistently or not understanding observed changes in physiological observations
- 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 clinical concerns, including in handover situations.

Systems to recognise deterioration early and respond to it appropriately need to deal with all of these factors, and need to apply across a healthcare facility. The *National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration* (National Consensus Statement) was developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC) and has been endorsed by Australian Health Ministers as the national approach for recognising and responding to clinical deterioration in acute care facilities in Australia.³ It provides a consistent national framework to support clinical, organisational and strategic efforts to improve recognition and response systems. This Standard builds on the National Consensus Statement to drive implementation in acute care facilities.

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

Note: This Standard does not apply to deterioration of a patient's mental state.



Recognising and Responding to Clinical Deterioration in Acute Health Care

Standard 9



Establishing recognition and response systems

Organisation-wide systems 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.

This criterion will be achieved by:	Actions required:
9.1 Developing, implementing and regularly reviewing the effectiveness of governance arrangements and the policies, procedures and/or protocols that are consistent with the requirements of the National Consensus Statement	9.1.1 Governance arrangements are in place to support the development, implementation, and maintenance of organisation-wide recognition and response systems
	9.1.2 Policies, procedures and/or protocols for the organisation are implemented in areas such as: <ul style="list-style-type: none"> • measurement and documentation of observations • escalation of care • establishment of a rapid response system • communication about clinical deterioration
9.2 Collecting information about the recognition and response systems, providing feedback to the clinical workforce, and tracking outcomes and changes in performance over time	9.2.1 Feedback is actively sought from the clinical workforce on the responsiveness of the recognition and response systems
	9.2.2 Deaths or cardiac arrests for a patient without an agreed treatment-limiting order (such as not for resuscitation or do not resuscitate) are reviewed to identify the use of the recognition and response systems, and any failures in these systems
	9.2.3 Data collected about recognition and response systems are provided to the clinical workforce as soon as practicable
	9.2.4 Action is taken to improve the responsiveness and effectiveness of the recognition and response systems



Standard 9 – Recognising and Responding to Clinical Deterioration in Acute Health Care

Recognising clinical deterioration and escalating care

Patients whose condition is deteriorating are recognised and appropriate action is taken to escalate care.

This criterion will be achieved by:	Actions required:
9.3 Implementing mechanism(s) for recording physiological observations that incorporates triggers to escalate care when deterioration occurs	9.3.1 When using a general observation chart, ensure that it: <ul style="list-style-type: none"> • 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
	9.3.2 Mechanisms for recording physiological observations are regularly audited to determine the proportion of patients that have complete sets of observations recorded in agreement with their monitoring plan
	9.3.3 Action is taken to increase the proportion of patients with complete sets of recorded observations, as specified in the patient's monitoring plan
9.4 Developing and implementing mechanisms to escalate care and call for emergency assistance where there are concerns that a patient's condition is deteriorating	9.4.1 Mechanisms are in place to escalate care and call for emergency assistance
	9.4.2 Use of escalation processes, including failure to act on triggers for seeking emergency assistance, are regularly audited
	9.4.3 Action is taken to maximise the appropriate use of escalation processes

Recognising and Responding to Clinical Deterioration in Acute Health Care

Standard 9



Responding to clinical deterioration

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

This criterion will be achieved by:	Actions required:
9.5 Using the system in place to ensure that specialised and timely care is available to patients whose condition is deteriorating	9.5.1 Criteria for triggering a call for emergency assistance are included in the escalation policies, procedures and/or protocols
	9.5.2 The circumstances and outcome of calls for emergency assistance are regularly reviewed
9.6 Having a clinical workforce that is able to respond appropriately when a patient’s condition is deteriorating	9.6.1 The clinical workforce is trained and proficient in basic life support
	9.6.2 A system is in place for ensuring access at all times to at least one clinician, either on-site or in close proximity, who can practise advanced life support



Standard 9 – Recognising and Responding to Clinical Deterioration in Acute Health Care

Communicating with patients and carers

Patients, families and carers are informed of recognition and response systems and can contribute to the processes of escalating care.

This criterion will be achieved by:	Actions required:
9.7 Ensuring patients, families and carers are informed about, and are supported so that they can participate in, recognition and response systems and processes	9.7.1 Information is provided to patients, families and carers in a format that is understood and meaningful. The information should include: <ul style="list-style-type: none"> the importance of communicating concerns and signs/symptoms of deterioration, which are relevant to the patient's condition, to the clinical workforce local systems for responding to clinical deterioration, including how they can raise concerns about potential deterioration
9.8 Ensuring that information about advance care plans and treatment-limiting orders is in the patient clinical record, where appropriate	9.8.1 A system is in place for preparing and/or receiving advance care plans in partnership with patients, families and carers 9.8.2 Advance care plans and other treatment-limiting orders are documented in the patient clinical record
9.9 Enabling patients, families and carers to initiate an escalation of care response	9.9.1 Mechanisms are in place for a patient, family member or carer to initiate an escalation of care response 9.9.2 Information about the system for family escalation of care is provided to patients, families and carers 9.9.3 The performance and effectiveness of the system for family escalation of care is periodically reviewed 9.9.4 Action is taken to improve the system performance for family escalation of care



Preventing Falls and Harm from Falls

Standard 10

The Preventing Falls and Harm from Falls Standard:

Clinical leaders and senior managers of a health service organisation implement systems to prevent patient falls and minimise harm from falls. Clinicians and other members of the workforce use the falls prevention and harm minimisation systems.

The intention of this Standard is to:

Reduce the incidence of patient falls and minimise harm from falls.

Context:

It is expected that this Standard will be applied in conjunction with Standard 1, 'Governance for Safety and Quality in Health Service Organisations' and Standard 2, 'Partnering with Consumers'.

Criteria to achieve the Preventing Falls and Harm from Falls Standard:

Governance and systems for preventing falls

Health service organisations have governance structures and systems in place to reduce falls and minimise harm from falls.

Screening and assessing risks of falls and harm from falling

Patients on presentation, during admission, and when clinically indicated, are screened for risk of a fall and the potential to be harmed from falls.

Preventing falls and harm from falling

Prevention strategies are in place for patients at risk of falling.

Communicating with patients and carers

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

Standard 10 – Preventing Falls and Harm from Falls

Explanatory notes

Falls occur in all age groups; however the risk of falls and harm from falls varies between individuals due to factors such as eyesight, balance, muscle strength, bone density and medication use.

The focus of this Standard is on prevention of falls and the minimisation of harm from falls. It is not intended to address physical or psychological harm management.

Falls remains a significant issue in the safety of patients. Rates of fall-related age-standardised hospitalisations have continued to steadily increase. Besides the cost implications, the impact of falls on individuals is far reaching. The social impact of reduced independence through fear, the potential for loss of independence and the increased burden on families can be significant.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) has developed guidelines for falls prevention in older people in hospitals, residential aged and community care.⁷⁰⁻⁷² They are based on evidence specific to these groups of older people. They provide a valuable set of resources that can be used by health services when they are considering the needs of older people with impaired mobility or with temporary or permanent reduction in mobility.

Although the risk of falls is well documented for the elderly, impaired mobility is also a major falls risk and it is not age defined. Therefore, strategies such as screening to reduce falls and the harm from falls should not be limited to older Australians. Policies, procedures and protocols for other age groups need to be based on the available evidence and best practice.



Preventing Falls and Harm from Falls

Standard 10



Governance and systems for the prevention of falls

Health service organisations have governance structures and systems in place to reduce falls and minimise harm from falls.

This criterion will be achieved by:	Actions required:
10.1 Developing, implementing and reviewing policies, procedures and/or protocols, including the associated tools, that are based on the current national guidelines for preventing falls and harm from falls	10.1.1 Policies, procedures and/or protocols are in use that are consistent with best practice guidelines (where available) and incorporate screening and assessment tools
	10.1.2 The use of policies, procedures and/or protocols is regularly monitored
10.2 Using a robust organisation-wide system of reporting, investigation and change management to respond to falls incidents	10.2.1 Regular reporting, investigating and monitoring of falls incidents is in place
	10.2.2 Administrative and clinical data are used to monitor and investigate regularly the frequency and severity of falls in the health service organisation
	10.2.3 Information on falls is reported to the highest level of governance in the health service organisation
	10.2.4 Action is taken to reduce the frequency and severity of falls in the health service organisation
10.3 Undertaking quality improvement activities to address safety risks and ensure the effectiveness of the falls prevention system	10.3.1 Quality improvement activities are undertaken to prevent falls and minimise patient harm
10.4 Implementing falls prevention plans and effective management of falls	10.4.1 Equipment and devices are available to implement prevention strategies for patients at risk of falling and management plans to reduce the harm from falls



Standard 10 – Preventing Falls and Harm from Falls

Screening and assessing risks of falls and harm from falling

Patients on presentation, during admission, and when clinically indicated, are screened for risk of a fall and the potential to be harmed from falls.

This criterion will be achieved by:	Actions required:
10.5 Using a best practice-based tool to screen patients on presentation, during admission and when clinically indicated for the risk of falls	10.5.1 A best practice screening tool is used by the clinical workforce to identify the risk of falls
	10.5.2 Use of the screening tool is monitored to identify the proportion of at-risk patients that were screened for falls
	10.5.3 Action is taken to increase the proportion of at-risk patients who are screened for falls upon presentation and during admission
10.6 Conducting a comprehensive risk assessment for patients identified at risk of falling in initial screening processes	10.6.1 A best practice assessment tool is used by the clinical workforce to assess patients at risk of falling
	10.6.2 The use of the assessment tool is monitored to identify the proportion of at-risk patients with a completed falls assessment
	10.6.3 Action is taken to increase the proportion of at-risk patients undergoing a comprehensive falls risk assessment

Preventing Falls and Harm from Falls

Standard 10



Preventing falls and harm from falling

Prevention strategies are in place for patients at risk of falling.

This criterion will be achieved by:	Actions required:
10.7 Developing and implementing a multifactorial falls prevention plan to address risks identified in the assessment	10.7.1 Use of best practice multifactorial falls prevention and harm minimisation plans is documented in the patient clinical record
	10.7.2 The effectiveness and appropriateness of the falls prevention and harm minimisation plan are regularly monitored
	10.7.3 Action is taken to reduce falls and minimise harm for at-risk patients
10.8 Patients at risk of falling are referred to appropriate services, where available, as part of the discharge process	10.8.1 Discharge planning includes referral to appropriate services, where available



Standard 10 – Preventing Falls and Harm from Falls

Communicating with patients and carers

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

This criterion will be achieved by:	Actions required:
10.9 Informing patients and carers about the risk of falls, and falls prevention strategies	10.9.1 Patient information on falls risks and prevention strategies is provided to patients and their carers in a format that is understood and meaningful
10.10 Developing falls prevention plans in partnership with patients and carers	10.10.1 Falls prevention plans are developed in partnership with patients and carers

This page is left intentionally blank



References

1. Paterson R, The Review Team for the Review of Future Governance Arrangements for Safety and Quality in Health Care. *National arrangements for safety & quality of health care in Australia: the report of the review of future governance arrangements for safety and quality in health care*. Canberra: Australian Health Ministers' Conference, 2005.
2. Australian Council for Safety and Quality in Health Care. Standard for Credentialling and Defining the Scope of Clinical Practice: A National Standard for credentialling and defining the scope of clinical practice of medical practitioners, for use in public and private hospitals, 2004.
3. Australian Commission on Safety and Quality in Health Care. National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration. Sydney: ACSQHC, 2010.
4. Australian Commission on Safety and Quality in Health Care. The National Medication Safety and Quality Scoping Study Committee Report. Sydney: ACSQHC, 2009.
5. Australian Council for Safety and Quality in Healthcare. *Second National Report on Patient Safety – Improving Medication Safety*. Canberra: Australian Council for Safety and Quality in Healthcare, 2002.
6. Cruickshank M, Ferguson J, editors. *Reducing Harm to Patients from Health Care Associated Infection: The Role of Surveillance*. Sydney: Australian Commission on Safety and Quality in Health Care, 2008.
7. Any Attempt at Resuscitation is Better Than no Attempt, Forward to Guidelines: Glossary of Terms. Australian Resuscitation Council, 2010 (Accessed 27 April 2011, at http://www.resus.org.au/policy/guidelines/admin/glossary_of_terms.htm.)
8. Factsheets, Blood and Blood Products in Australia. National Blood Authority Australia, 2009. (Accessed 29 March 2011, at <http://www.nba.gov.au/pubs/factsheets-blood-products.html>.)
9. About Carers. Carers Australia. (Accessed 28 March 2011, at <http://national.carersaustralia.com.au/?/national/section/2:about-carers>.)
10. Coiera EW, Jayasuriya RA, Hardy J, Bannan A, Thorpe MEC. Communication loads on clinical staff in the emergency department. *Medical Journal of Australia* 2002;176:415-418.
11. Scally G, Donaldson LJ. Clinical governance and the drive for quality improvement in the new NHS in England *British Medical Journal* 1998;317 61.
12. National Patient Safety Agency. Seven steps to patient safety. London: National Patient Safety Agency, 2004.
13. Department of Health and Ageing. National Mental Health Report 2007: Summary of Twelve Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2005. Canberra, 2007.
14. Different Types of Medicines, MSD. 2007. (Accessed 20 April 2011, at <http://www.msd-australia.com.au/content/corporate/products/TypesMed.html>.)
15. Consumer representative program policy. Consumers Health Forum of Australia, 2011. (Accessed 24 March 2011, at <https://www.chf.org.au/consumer-representatives-program-policy.php#link11>.)
16. Aged Care Standards and Accreditation Agency Ltd. Audit Handbook. Paramatta: ACSAA, June 2009.
17. Falls, Fact Sheet No 344. WHO, 2010. (Accessed 14 April 2011, at <http://www.who.int/mediacentre/factsheets/fs344/en/>.)

References

18. Field M, Lohr K, editors. *Guidelines for clinical practice: from development to use*. Washington DC.: National Academy Press, 1992.
19. National Health & Medical Research Council. Australian Guidelines for the Prevention and Control of Infection in Healthcare. Canberra: NHMRC, 2010:260.
20. ISMP's List of High-Alert Medications. Institute for Safe Medication Practices, 2008. (Accessed 20 April 2011, at <http://www.ismp.org/Tools/highalertmedications.pdf>.)
21. Carayon P, editor. *Handbook of Human Factors and Ergonomics in Health Care and Patient Safety*. Hillsdale, NJ: Lawrence Erlbaum Associates, 2007.
22. Patient Physician Relationship Topics: Informed Consent. American Medical Association. (Accessed 22 March 2011, at <http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/informed-consent.page>.)
23. Carey-Hazell, K. Improving patient information and decision making. *The Australian Health Consumer Issue 1: Consumers Health Forum of Australia*, 2005.
24. What is a medication error? National Coordinating Council for Medication Error Reporting and Prevention. (Accessed 28 March 2011, at <http://www.nccmerp.org/aboutMedErrors.html>.)
25. Explanatory Notes, Completing Medication History Form. WA Department of Health. (Accessed 30 March 2011, at http://www.watag.org.au/wamsg/docs/Explanatory_Notes_Medication_History_Form.pdf.)
26. Australian Pharmaceutical Advisory Council. Guiding principles for medication management in the community. Canberra: Commonwealth of Australia, 2006.
27. Barach P, Small SD. Reporting and preventing medical mishaps: lessons from non-medical near miss reporting systems. *British Medical Journal* 2000;320(7237):759-763.
28. Australian Commission on Safety and Quality in Health Care. Open Disclosure Standard, Sydney, ACSQHC, 2008.
29. National Blood Authority. Patient Blood Management Guidelines: Module 1. Canberra: Commonwealth of Australia, 2011:11.
30. New South Wales Department of Health. Patient Matters Manual. Chapter 9. Sydney: New South Wales Department of Health, 2008.
31. Prescription medicines, Fact Sheet 1-3. Victorian Government. (Accessed 28 March 2011, at www.betterhealth.gov.au.)
32. Australian Commission on Safety and Quality in Health Care. *Windows into Safety and Quality in Health Care 2010*. Sydney: ACSQHC, 2010.
33. Elshaug A, Moss J, Littlejohns P, Karnon J, Merlin T, J. H. Identifying existing health care services that do not provide value for money. *Medical Journal of Australia* 2009;190(5):269-273.
34. Australian Commission on Safety and Quality in Health Care. Australian Charter for Health Care Rights. Sydney: ACSQHC, 2008.
35. Meterko M, Wright S, Lin H, Lowy E, Cleary PD. Mortality among patients with acute myocardial infarction: The influences of patient-centered care and evidence-based medicine. *Health Services Research* 2010;45(5p1):1188-1204..
36. Boulding W, Glickman S, Manary M, Schulman K, Staelin R. Relationship between patient satisfaction with inpatient care and hospital readmission within 30 days. *The American Journal of Managed Care* 2011;17(1):41-48.



References

37. Edgcumbe D. Patients' perceptions of hospital cleanliness are correlated with rates of methicillin-resistant *Staphylococcus aureus* bacteraemia. *Journal of Hospital Infection* 2009;71(1):99-101.
38. DiGioia A, Greenhouse P, Levison T. Patient and family-centered collaborative care: An orthopaedic model. *Clinical Orthopaedics and Related Research* 2007;463(13-19).
39. Arbuthnott A, Sharpe D. The effect of physician-patient collaboration on patient adherence in non-psychiatric medicine. *Patient Education and Counseling* 2009;77(1):60-67.
40. Charmel P, Frampton S. Building the business case for patient-centred care. *Healthcare Financial Management* 2008;March 62 (3):80-85.
41. Institute of Medicine. *Crossing The Quality Chasm: A New Health System for the 21st Century*. Washington DC: National Academy Press, 2001.
42. Australian Commission on Safety and Quality in Health Care. Australian Safety and Quality Framework for Health Care. Sydney: ACSQHC, 2010.
43. The National Hand Hygiene Initiative. Hand Hygiene Australia, 2011. (Accessed 9 May 2011, 2011, at <http://www.hha.org.au/>)
44. National Health and Medical Research Council. The Australian Immunisation Handbook 9th Edition Canberra: Australian Government 2008..
45. Duguid M, Cruickshank M, editors. *Antimicrobial Stewardship in Australian Hospitals*. Sydney: ACSQHC, 2011.
46. Roughead EE, Lexchin J. Adverse Drug Events: counting is not enough, action is needed. *Medical Journal of Australia* 2006;184(7):315-316.
47. Roughead EE, Semple SJ. Medication safety in acute care in Australia: where are we now? Part 1: a review of the extent and causes of medication problems 2002–2008. *Australia and New Zealand Health Policy* 2009;6(18).
48. Roughead EE, Semple S. Literature review: medication safety in acute care in Australia. Sydney: ACSQHC, 2008.
49. Australian Commission on Safety and Quality in Health Care. *Windows into safety and quality in health care 2008*. Sydney: ACSQHC, 2008.
50. Gosbee J. Human factors engineering and patient safety. *Quality and Safety in Health Care* 2002;11:352-354.
51. Karsh B-T, Holden R, Alper S, Or C. A human factors engineering paradigm for patient safety: Designing to support the performance of the healthcare professional. *Quality and Safety in Health Care* 2006;15:59-65.
52. Surgical Safety Checklist. Royal Australasian College of Surgeons, 2009. (Accessed 19 April 2011, at <http://www.surgeons.org/racs/fellows/resources-for-surgeons#WHO>.)
53. Ensuring Correct Patient, Correct Site, Correct Procedure Protocols. Australian Commission on Safety and Quality in Health Care, 2008. (Accessed 19 April 2011, at http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PatientID-Resources-Exp_Correct-Pat-Site-Proc.)
54. A national standard for patient identification bands in Australia. ACSQHC, 2009. (accessed 17 May 2011, at http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-04_Initiatives#std.)
55. Australian Medical Association. Safe Handover: Safe Patients. Guidance on clinical handover for clinicians and managers, 2006.
56. Australian Institute of Health and Welfare. Australia's Health 2006. Canberra, 2006.

References

57. Wong MC, Yee KC, Turner P. Clinical Handover Literature Review, eHealth Services Research Group, University of Tasmania Australia: Australian Commission on Safety and Quality in Health Care, 2008.
58. Clark E, Squire S, Heyme A, Mickle MA, Petrie E. The PACT Project: improving communication at handover. *Medical Journal of Australia* 2009;190(11):S125-S127.
59. Hatten-Masterton S, Griffiths M. SHARED maternity care: enhancing clinical communication in a private maternity setting. *Medical Journal of Australia* 2009;190(11):S150-S151.
60. Aldrich R, Duggan A, Lane K, Nair K, Hill K. ISBAR revisited: identifying and solving barriers to effective clinical handover in inter-hospital transfer – public report on pilot study. Newcastle: Hunter New England Health 2009.
61. Wong MC, Yee KC, Turner P. Nursing and medical handover in general surgery, emergency medicine and general medicine at the Royal Hobart Hospital – public report on pilot study. Hobart: University of Tasmania, 2008.
62. Graves N, Birrell FA, Whitby M. Modeling the economic losses from pressure ulcers among hospitalized patients in Australia. *Wound Repair and Regeneration* 2005;13(5):462-467.
63. Van Den Bos J, Rustagi K, Gray T, Halford M, Ziemkiewicz E, Shreve J. The \$17.1 Billion Problem: The Annual Cost Of Measurable Medical Errors. *Health Affairs* 2011;30(4):596-603.
64. Buist M, Bernard S, Nguyen TV, Moore G, Anderson J. Association between clinical abnormal observations and subsequent in-hospital mortality: a prospective study. *Resuscitation* 2004;62:137-141.
65. Calzavacca P, Licari E, Tee A, Egi M, Downey A, Quach J, et al. The impact of rapid response system on delayed emergency team activation patient characteristics and outcomes – A follow-up study. *Resuscitation* 2010;81:31-35
66. MERIT Study Investigators. Introduction of the medical emergency team (MET) system: a cluster-randomised controlled trial. *Lancet* 2005;365:2091-2097.
67. Cioffi J, Salter C, Wilkes L, Vonu-Boriceanu O, Scott J. Clinicians' responses to abnormal vital signs in an emergency department. *Australian critical care* 2007;20:100-105.
68. Endacott R, Kidd T, Chaboyer W, Edington J. Recognition and communication of patient deterioration in a regional hospital: A multi-methods study. *Australian critical care* 2007;20:100-105.
69. McQuillan P, Pilkington S, Allan A, Taylor B, Short A, Morgan G, et al. Confidential inquiry into quality of care before admission to intensive care. *British Medical Journal* 1998;316:1853-1858.
70. Australian Commission on Safety and Quality in Health Care. *Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Residential Aged Care Facilities* 2009. Sydney. ACSQHC, 2009.
71. Australian Commission on Safety and Quality in Health Care. *Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Community Care Facilities* 2009. Sydney. ACSQHC, 2009.
72. Australian Commission on Safety and Quality in Health Care. *Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Hospitals* 2009. Sydney. ACSQHC, 2009.

Commission Staff Contributing to the NSQHS Standards

Suellen Allen, Chris Baggoley, Margaret Banks, Marilyn Cruickshank, Margaret Duguid, Nicola Dunbar, Kelvin Genn, Lisa Gray, Bill Lawrence, Liz Metelovski, Kirsten Peddie, Michael Smith, Sara Twohill, Ann Young.

Australian Commission on Safety and Quality in Health Care

Level 7, 1 Oxford Street, Darlinghurst NSW 2010
GPO Box 5480, Sydney NSW 2001

Phone: (02) 9126 3600 (international +61 2 9126 3600)

Fax: (02) 9126 3613 (international +61 2 9126 3613)

Email: mail@safetyandquality.gov.au

www.safetyandquality.gov.au