

Model of Care Intensive Care Unit v0.7

4.5. Changes to workforce model

Projected Nursing staff requirements based on a 48 bed ICU:

Table 3: Projected Nursing Requirements

Role	WEEKDAY	WEEKEND
ICU		
CNC (RN Level 3.2)	2.1 FTE	Morning shifts only
CCC (RN Level 3.1)	1.0 FTE	To be determined
CSN (RN Level 3.1)	1.0 FTE	No coverage
CDN (RN Level 2)	2.0 FTE	No coverage
Internal Pods (four pods each requiring the following)		
Access Nurse	1.0 FTE	
Bay Leader	1.0 FTE	
RN Level 2	4.0 FTE	
RN Level 1	6.0 FTE	
External Pod – MET Outreach		
CNC (RN Level 3.1)a	1.4 FTE Morning shift only	Morning shift only
CDN (RN Level 2)	1.0 FTE Morning shift	No coverage
MET Nurse (RN Level 2)	2.0 FTE	

4.6. Training, education and research

The ICU is a training unit with a commitment to growing its research capacity. Education for current staff and undergraduate and postgraduate multidisciplinary staff is considered core business in the ICU. All ICU staff both deliver and receive education. There are some individuals whose substantive position or part thereof is related to provision of education, including CSN's and CDN's, as well as the specialist ICU doctors who have education and supervisory roles in their non-clinical portfolios.

Training and education activities within the ICU are delivered in a multidisciplinary format and occur in a variety of settings (bedside, tutorial style, supervision of training, simulated learning environment, half/whole day programs and external courses) with a variety of levels of healthcare professionals including undergraduate, postgraduate, pre-vocational and post-vocational. It would be anticipated that teaching and meeting spaces would be available embedded within clinical care areas to facilitate clinical teaching, with easy access (e.g. in a dedicated teaching and training centre) to larger spaces more appropriate for whole or half-day courses e.g. BASIC (Adult and Paediatric), Beyond BASIC and the Canberra Course.

At minimum the considerations for in-situ teaching and training would include:

- education/meeting room in each pod
- larger education/meeting space in close proximity to the pods, e.g. large enough for all medical staff across the unit to meet in a shift. This would need to be on the same floor as the clinical areas to allow for immediate attendance to a patient if sudden unexpected deterioration occurred. This would need to have appropriate IT support for teaching and training

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- simulation space to allow for teaching of procedures, new equipment and crisis response management within the clinical environment.

ICU staff are frequently involved in other teaching activities across the CH campus and in the ACT, including but not limited to Staff Development Unit coordinated programs, Medical Officer Support and Clinical Training Unit teaching, Australian National University, Canberra University and Canberra Institute of Technology programs. This includes teaching and training for:

- Senior Medical Officers, prevocational and vocational Junior Medical Officers, and medical students
- Nurses and Nursing students
- Allied Health staff and Allied Health students
- administrative and clerical staff.

5. Service support elements

The capacity to deliver ICU services is dependent upon having the relevant clinical and non-clinical support services available and readily accessible. A number of services support the overall team in the delivery of ICU service. These include (but are not limited to) the services discussed below.

5.1. Essential equipment and technology services

Information Communication Technology (ICT) and data entry

- staff will need access to computers at each bedside, staff stations
- electronic medication management
- electronic pathology records
- Meta-Vision computer programs which collect all information from the patient equipment including medication charts and enable nurses to do patient notes
- computers on wheels (at least one per pod) for ward rounds
- disaster contingency plans for each ICT systems
- electronic medical records. Existing systems for medical records management will continue.
- access to ICT support (Help Desk)

Telemedicine/videoconferencing

Selected clinical spaces will be configured to provide remote telemedicine for patients located in the ACT to access services provided elsewhere. These facilities can be located in either the education room or a communal office area.

Communication

- Nurse Call System – electronic communication system within clinical teams, i.e. patient or family can communicate with nursing staff or nurse can communicate with other clinicians
- Everyday communications e.g. phone, fax, page
- Intercom for access to the closed unit.

Wi-Fi

- Provision for medically safe wireless networking throughout the clinical area
- Wi-Fi internet access will be provided throughout the Department (including lounge/wait areas) for use by staff and visitors.

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Printer

Printers are required at the staff station. Space is required for equipment relating to electronic medication/pathology/wristband/programs.

Hearing Loop

Hearing loop is to be available at reception and the capacity installed at various consumer areas within the unit. Specific locations of hearing loop stations will be identified in the design stage of the SPIRE project.

Biomedical equipment management

ICU have a high concentration of specialised, technical and monitoring equipment needed to care for critically ill patients. Clinical Engineering is responsible for the maintenance of this equipment in close collaboration with the ICU. Usually a biomechanical engineer is devoted to the ICU portfolio and is physically located in the unit for the purpose of their work. It is essential that sufficient office space and equipment to support the biomedical engineering role is provided for in the ICU footprint.

5.2. Environmental and supply services

Food Services

- food services are delivered to the unit in a dedicated retherm food trolley. A recess/docking station for the food trolley is required
- meals are not generally provided to families. However, tea and coffee making facilities are provided along with re-heating facilities and a fridge in a shared family space
- external to the closed ICU, the family waiting room area is also equipped with tea and coffee making facilities.

Linen

Capital Linen Service delivers linen to the CH daily. ICU linen is replenished daily and a recess space for the linen trolley is required.

Stores

Large storage capacity for consumables is required. Consumables are monitored by the Purchasing Inventory Control System (PICS) and replacement items delivered daily.

Infection Control and Prevention Unit

- Infection Control and Prevention Unit provides an advisory role and monitors the number of patients with infections or multi-resistant organisms (MRO) and provide coordination and departmental education to facilitate patient isolation in accordance with National guidelines
- Sterilising Services Department (SSD) for sterilisation of equipment as required
- dirty utility space is required for cleaning, decontamination of equipment, stripping back equipment for terminal cleaning and drying of re-usable equipment. Some equipment will then need to be transferred to the SSD for sterilisation.

Waste management

Waste management is provided as per ACT Health facility wide policies. Waste streaming is required within the unit. This includes the management of sharps bins and contaminated waste. Alternative travel routes for waste transport to points of public access and 'clean' items will be available.

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5.3. Core services

5.3.1. Medical Imaging

- internal imaging (e.g. mobile X-ray and ultrasound). Equipment is permanently housed in the ICU
- external imaging in the medical imaging suite (note, MRI compatible transport ventilators and monitoring equipment are used when required).

5.3.2. Pathology

- sampling will occur at the bedside by a suitably qualified ICU staff member. Pathology samples are sent via the pneumatic tube system to the Pathology department
- arterial blood gases are analysed internally using a blood gas analysis machine located within the ICU.

5.3.3. Pharmacy

- bedside trolleys for standard patient medicine, one per patient
- central imprest stock room for all medicines
- lockable cupboards at nurses' desk for S4D and S8 medications in accordance with legislation. One cupboard per nursing station
- monitored medication fridge within a clean utility lockable room, restocked by a pharmacy technician
- urgent requests for medicines are given to the Pharmacists on ward rounds or sent to the pharmacy. The Pharmacist checks the medication stocks and orders as required
- ACT Health plans to move to an Automated Dispensing Machine (ADM) in future (similar to the machines used in the ED). Space and power for the ADM will need to be factored into the design.

5.3.4. Additional core services

Specialty Services

To support continuity of care and provide the right service at the right time ICU will interface with other specialty services such as General Surgery, General Medicine, Infectious Diseases, Paediatrics, Obstetrics, ED, Anaesthetics and the Pain Management Team.

Tissue Viability Team

Tissue Viability Team has an advisory role for wound management and provides a liaison service.

DonateLife ACT

The Organ Donor Coordinators from the DonateLife ACT are available 24 hours a day, seven days a week to provide information and support. When an organ donation is planned, the coordinators ensure the deceased patient is kept in conditions that are optimal for the donated organs in the ICU and coordinate with Operating Theatres at CH and the receiving hospital for organ retrieval.

Pastoral Care

Chaplains from Catholic, Anglican and Uniting churches are located within the hospital. The chaplains provide spiritual support to patients and their relatives or carers. Clergy from most denominations can be contacted on request.

Interpreter services

As required

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Volunteers

- Volunteers provide a supportive link between relatives/families of patients admitted in the ICU and clinical staff. For example, as a locked unit it is necessary to press an intercom to talk to staff in the ICU or to be let into the unit. Volunteers assist in this process.
- Volunteer recruitment and rostering is led by the Personal Assistant to the Director, assisted by the CH Volunteer office.
- Volunteers undertake training prior to work in the ICU.

5.4. Security

At the core of the MoC for ICU is the right of staff, patients and others in the ICU to have a safe environment/workplace with the prevention and management of occupational violence. To this end there are to be appropriate guidelines and policies around the management of aggressive/violent or behaviourally disturbed individuals.

To support staff safety and security fixed duress will be available throughout the unit, particularly in interview rooms and at staff stations.

5.5. External service providers

As well as hospital-based services, the ICU interfaces with a number of external services, such as:

- **ACT Ambulance Service (ACTAS)** is responsible for providing emergency and non-emergency ambulance and aeromedical ambulance services to the ACT community and surrounding south east NSW region. ACTAS also provides Intensive Care Paramedics (ICPs) to the Capital Region Retrieval Service helicopter. [2] Capital Region Retrieval Service is a joint initiative of the governments of New South Wales and the ACT, and provides aeromedical rescue and retrieval services to the ACT and south-eastern New South Wales.
- **Capital Region Retrieval Service and Medical Retrieval Unit** is a joint initiative of the governments of New South Wales and the ACT, and provides aeromedical rescue and retrieval services to the ACT and south-eastern New South Wales. Capital Region Retrieval Service is managed and staffed by ACT Health. The medical crew are highly skilled Emergency, Intensive Care and Anaesthetic consultants and senior registrars. The usual area of responsibility for the service extends from the Victorian border, west to Griffith and Hay, north to Sydney and down the east coast of New South Wales. [8]
- **General Practitioners (GP's)** provide community based services to patients as a part of the medical neighbourhood.
- **Newborn and paediatric Emergency Transport Service (NETS)** is a 24/7 state-wide service of NSW Health that provides: expert clinical advice, clinical coordination, stabilisation, and emergency treatment and inter-hospital retrieval for sick babies and children up to the age of 16 years NETS also provide a referral service for hospitals faced with a neonatal or paediatric emergency. [9]
- **NSW Ambulance service (NSWAS)** is responsible for providing emergency and non-emergency ambulance services in NSW. They also provide aeromedical transport via Toll Rescue Helicopter Service and Air Ambulance, for both emergency and non-emergency transfers. [10]
- **Interstate health services** for transfer of patients requiring specialist services e.g. burns.

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5.6. Other considerations

Other ICU planning considerations are those which involve movement of critically ill patients around the hospital to access interventions and diagnostics. Some examples are provided below.

Proximity to cardiothoracic surgical theatres. The transport of patients to ICU post-cardiothoracic surgery requires substantial monitoring equipment and staff to physically move the patient. If the cardiothoracic theatres are not located on the same floor as the ICU, then direct vertical egress via an extra-large service lift is required to transport these patients.

Proximity to Interventional Cardiology Laboratories (ICL). Transport of critically ill patients to and from the cardiac intervention suite can involve substantial monitoring and organ support equipment, as well as staff to move the patient, similar with the cardiothoracic surgical suite.

Retrieval service access. The ICU requires access to direct retrieval routes from the Helipad and ambulance bays/ED and Medical Imaging.

Proximity to Perioperative and Interventional Centre for the purpose of organ donation, especially for donation after cardiac death where transport between place of palliation and death, and organ retrieval is time critical.

Proximity to Diagnostic Imaging. Critically ill patients are frequently transported to radiology for MRI and CT scans, as well as to angiography suite to undergo procedures. These patients require substantial equipment for monitoring and organ support, as well as staff to transport with them.

6. Benefits (service innovation and efficiency)

6.1 Outline

The ICU MoC aims to provide appropriate access to and patient management within the ICU which is described by the ACT Health principle of providing the right care to the right patient at the right time. Based on the Australian Council on Healthcare Standards (ACHS), monitoring should occur across the following areas at the time of the publication of this document:

- access and exit block to assess delays in patients accessing ICU or being discharged from ICU
- intensive care patient management to assess premature discharge from ICU
- intensive care patient treatment regarding early prophylactic treatment for venous thromboembolism (VTE)
- central line-associated bloodstream infection
- utilisation of patient assessment systems to monitor participation in appropriate data repositories
- compassionate practice towards families of patients.

It is anticipated that these may have changed by the time of implementation of this MoC and will need to be regularly updated.

6.2. Qualitative benefits

Qualitative elements of the ICU model of care will be measured through the patient satisfaction survey. This may include:

- Appropriateness of the waiting space
- Satisfaction with treatment and care provided including communication with families and patients
- Appropriate and empathic treatment of families.

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6.3. Quantitative benefits

Quantitative elements of the ICU MoC will be measured through the ACHS clinical indicators. [11]

These are:

Access and exit block

- 1.1 ICU - adult non-admission due to inadequate resources
- 1.2 ICU - elective adult surgical cases deferred or cancelled due to unavailability of bed
- 1.3 ICU - adult transfer to another facility/ICU due to unavailability of bed
- 1.4 ICU - adult discharge delay more than 12 hours
- 1.5 ICU - adult discharge between 6pm and 6am
- 1.6 ICU - paediatric discharge between 6pm and 6am

Intensive care patient treatment

- 3.1 VTE prophylaxis in adult patients within 24 hours of ICU admission

Central line-associated bloodstream infection

- 4.1 Adult ICU-associated CI-CLABSI
- 4.2 Paediatric ICU-associated PI-CLABSI

Utilisation of patient assessment systems

- 5.1 Participation in the ANZICS CORE Adult Patient Database
- 5.2 Participation in the ANZICS CORE Paediatric Intensive Care registry
- 5.3 Participation in the ANZICS CORE Critical Care Resources survey

In addition, the ICU Executive team have identified a number of evidence based key performance indicators for the service, as follows:

- Outcome measures
 - ICU mortality and SMR
 - Pain management
 - Rate of ICU survivors to home
 - Patient and family satisfaction score
- Process measures
 - Goal Richmond Agitation and Sedation Score documentation
 - DVT prophylaxis compliance
 - Targeted temperature management implemented in out of hospital cardiac arrest
 - Safe tidal volumes delivered
 - Plateau inspiratory pressures not exceeding 32cmH₂O
 - Time to antimicrobials in sepsis not exceeding 60 minutes
- Access measures
 - Admission block
 - Refusals and over capacity transfer to other ICUs
 - Elective surgery cancellation
 - Bed block and avoidable days in ICU
 - After hours discharge
 - MET duration
 - Concurrent MET activation
 - Occupancy – capacity measure
 - Chronically critically ill patients
- Complication measures
 - Central line associated bacteraemia
 - Multi-resistant organism acquisition

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- Hand hygiene compliance
- Unplanned ICU admission <24 hours
- Accidental extubation
- Pressure injuries
- Falls
- Medication errors
- Ventilator-associated pneumonia

7. Monitoring and evaluation

The ICU executive/management team will monitor the adequacy of care being delivered against the Key Performance Indicator suite as outlined above. These indicators will be regularly reviewed for suitability by the management team. This will be reported upwards through the organisation's relevant governance structure and also be reported down to treating clinical staff via direct and group messaging e.g. newsletters and unit meetings.

Monitoring and evaluation will occur via the ACHS Clinical Indicator Program on which the quantitative and qualitative indicators are based. [12]

Monitoring and evaluation will also occur through:

- patient surveys
- staff culture surveys
- critical incidents
- Riskman
- workers compensation claims
- ICU data and long-term outcome data

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8. Abbreviations

Abbreviation	Definition
ACHS	Australian Council of Healthcare Standards
ACT	Australian Capital Territory
ACTAS	ACT Ambulance Service
ADM	Automated Dispensing Machine
ADON	Assistant Director of Nursing
AICU	Adult Intensive Care Unit
AHPRA	Australian Health Practitioner Regulation Agency
ALO	Aboriginal and Torres Strait Islander Liaison Officer
ANZICS CORE	Australian and New Zealand Intensive Care Society Centre for Outcome and Resource Evaluation
ASO	Administrative Services Officer
CCC	Clinical Care Coordinator
CDN	Clinical Development Nurse
CI-CLABSI	Centrally-inserted central line-associated bloodstream infection
CICM	College of Intensive Care Medicine of Australia and New Zealand
CNC	Clinical Nurse Consultant
CPD	Continuing Professional Development
CPHB	Calvary Public Hospital Bruce
CSN	Clinical Support Nurse
ECMO	Extra Corporeal Membrane Oxygenation
ED	Emergency Department
FTE	Full Time Equivalent
HMA	Healthcare Management Advisors
HDU	High Dependency Unit, often beds co-located in the ICU
HP3	Health Practitioner Level 3
HP4	Health Practitioner Level 4

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Abbreviation	Definition
HSO	Hospital Salaried Officer
ICP	Intensive Care Paramedics
ICT	Information and Communication Technologies
ICU	Intensive Care Unit
Imprest	Local supply of medicines kept onsite within a hospital ward/unit
JMO	Junior Medical Officer
MDT	Multidisciplinary Team
MET	Medical Emergency Team
MoC	Model of Care
MRI	Magnetic Resonance Imaging
Class N-isolation room	Negative room air pressure with additional barriers including an Anteroom
NETS	Newborn and Paediatric Emergency Transport Service
NSW	New South Wales
NSWAS	New South Wales Ambulance Service
NICU	Neonatal Intensive Care Unit
NM	Nurse Manager
Class P isolation room	Positive room air pressure with appropriate storage space outside the room
PFU	Patient Flow Unit
PGY	Postgraduate year
PI-CLABSI	Peripherally-inserted central line-associated bloodstream infection
PICU	Paediatric Intensive Care Unit
RMO	Resident Medical Officer
RN	Registered Nurse
Role Delineation	Describes the minimum support services, workforce and other requirements for the safe delivery of clinical services
Separation	The process by which an episode of care for an admitted patient ceases. A separation may be formal or statistical

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Abbreviation	Definition
SMR	Standardised mortality ratio
SSD	Sterilising Supply Department
S4D	Schedule 4 medication. Prescription only medicine
S8	Schedule 8 medication. Controlled drug
Tertiary Hospital	Generally offers services at Level 5 or 6, according to clinical services role delineations
TRACS	Tracheostomy Care Service
VA	Venoarterial extra corporeal membrane oxygen (ECMO)
VV	Venovenous extra corporeal membrane oxygen (ECMO)

9. References

- [1] College of Intensive Care Medicine of Australia and New Zealand, "Minimum Standards For Intensive Care Units," CICM, Melbourne, 2011.
- [2] ACT Emergency Service Agency, "ACT Ambulance Service," 2018. [Online]. Available: <http://esa.act.gov.au/actas/>. [Accessed 2018].
- [3] Australasian Health Facility Guidelines, "Part D - Infection Prevention and Control - Building Elements, Revision 7.0," 2016.
- [4] T. Iwashyna, C. Hodgson, D. Pilcher, M. Baily, A. van Lint, S. Chavan and R. Bellomo, "Timing of onset and burden of persistent critical illness in Australia and New Zealand : a retrospective population-based observational study," *Lancet Respiratory Medicine*, vol. 4, pp. 566-73, 2016.
- [5] College of Intensive Care Medicine of Australia and New Zealand, "Professional Documents," 2018. [Online]. Available: <http://www.cicm.org.au/Resources/Professional-Documents>.
- [6] College of Intensive Care Medicine of Australia and New Zealand, "About," [Online]. Available: <https://www.cicm.org.au/About>. [Accessed 2018].
- [7] College of Intensive Care Medicine, "Administrative Services To Intensive Care Units," 2013.
- [8] ACT Health, "Capital Region Retrieval Service," [Online]. Available: <http://www.health.act.gov.au/our-services/capital-region-retrieval-service>. [Accessed 2018].
- [9] Newborn and Paediatric Emergency Transport Service, 2018. [Online]. Available: <https://www.nets.org.au/>. [Accessed 2018].
- [10] NSW Health, "NSW Ambulance Service - Patient Transport Service," [Online]. Available: <http://www.ambulance.nsw.gov.au/about-us/Patient-Transport-Service.html>. [Accessed 2018].
- [11] Australian Council on Healthcare Standards, "Australasian Clinical Indicator Report: 2009-2016 18th Edition," ACHS, Sydney, 2017.

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- [12] Australasian Council of Healthcare Standards, "Clinical Indicator Program," 2018. [Online]. Available: <https://www.achs.org.au/programs-services/clinical-indicator-program/>. [Accessed 2018].

10. MoC development participants

Participants in the development of the MoC	
Position	Name
Director of ICU	Bronwyn Avar
Assistant Director of Nursing (Ag)	Carly Silberberg
HSPU Senior Planning Officer	Barry Lapthorne
Director of Nursing	Karen O'Brien
Deputy Director of ICU	Simon Robertson
HSPU Senior Planning Officer	Sally-Anne Kinghorne
HSPU Clinical Liaison Officer	Kathleen Evans



ACT
Government

ACT Health

ACT HEALTH

DATE: NOVEMBER 2018

Agenda

MEETING	SPIRE Next Step Workshop
DATE / TIME	9:00am – 12:00pm Wednesday, 22 of May 2019
VENUE	Ernest & Young 121 Marcus Clarke St, Canberra ACT 2601

1	INTRODUCTION AND PRESENTATION (background, project scope and business case)
2	KEY TIMING OBJECTIVES (key milestone dates for the project)
3	KEY ACTIVITIES (what needs to be done)
4	RESOURCING (personnel and advisors)
5	PROGRAM
6	ORGANISATIONAL ARRANGEMENTS

Attwood, Courtney (Health)

From: Lindemann, Monica (Health)
Sent: Wednesday, 22 May 2019 3:55 PM
To: Lopa, Liz (Health)
Cc: Culver, Jakob (Health); Burch, Brad (Health)
Subject: draft SPIRE Consumer Reference Group submission paper
Attachments: Consumer Reference Group paper.docx; 1. National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf; Consumer Reference Committees-Draft TOR.docx; Consumer and Carer Participation Policy.docx

UNCLASSIFIED For-Official-Use-Only

Hi Liz

Attached is a draft SPIRE Consumer Reference Group submission paper for decision at the next SPIRE ESC.

The supporting papers include relevant policies and draft TOR.

Once we have feedback on the structure and purpose of the Group, we can craft a service funding agreement with HCAA based on our needs.

I've met with the CHS patient experience team and they are working on a range of policies and procedures relevant to working with consumer representatives that will be helpful in supporting health care consumer reps, including those engaged in the SPIRE development project. It is anticipated that a new CHS consumer rep training program will be available prior to the proposed first meeting of the SPIRE Consumer Reference Group.

Happy to discuss

Monica



Submission Paper

Consumer Reference Group

Surgical Procedures, Interventional
Radiology and Emergency (SPIRE) Centre
Executive Steering Committee

Meeting Date: 28 May 2019

Agenda Item No: X.X

Subject: SPIRE Consumer Reference Group: Role, function and membership

Author: Strategic Infrastructure Division/Strategic Infrastructure Branch

Purpose: For decision

Consumer Reference Group

Surgical Procedures, Interventional Radiology and Emergency (SPIRE) Centre Executive Steering Committee

Background

1. *Partnering with consumers and carers in the decision-making process is crucial to the effective delivery of a health service. Consumer and carer participation is vital and relevant in all areas of ACT Health, including participation at the individual care level, the program and department level, and at the organisation level (Consumer and Carer Participation in ACT Health Policy DGD15-005).*
2. The ACT Health Directorate (ACTHD) and Canberra Health Services (CHS) are committed to the National Safety and Quality Health Standards (NSQHS) which provide a nationally consistent statement of the level of care that consumers and carers should be able to expect from health services. They are the standard by which a health service is measured to determine whether relevant systems are in place to ensure that expected standards of safety and quality are met.
3. There are eight NSQHS standards. The first two, "Clinical Governance" and "Partnering with Consumers" (attached), are of particular relevance to the SPIRE project and the proposed engagement of consumers in project design, implementation and governance.
4. Health care consumers are people who use, have previously used, or may use in the future, any health service.
5. ACTHD has service funding agreements in place with health care consumer-related representative bodies, such as the Health Care Consumers Association, Carers ACT, Palliative Care ACT, Cancer Council ACT and ACT Mental Health Consumer Network, that include a range of advisory services.

Issues

6. The ACT Minister for Health has approved a SPIRE project governance structure that includes a Consumer Reference Group (image 1)
7. This paper seeks approval from the SPIRE Executive Steering Committee in relation to:
 - the role and function,
 - terms of reference,
 - and membership
 of the SPIRE Consumer Reference Group, as drafted in the Terms of Reference (Attachment 2).
8. In approving the nominated Reference Group members, consideration should be given to ensuring the effective participation of Aboriginal, Torres Strait Islander, culturally and linguistically diverse peoples, young people and people living with a disability in the decision-making processes (ACTHD Policy DGD15-005).
9. Approval is also sought to fund costs associated with the SPIRE Consumer Reference Group from the project budget. Expenses include member reimbursement, in line with the ACTHD Consumer, Carer and Community Representative Reimbursement Policy, DGD 16-018. This cost is estimated to be \$2,250 per annum based on five Group members attending four meetings and two training sessions.
10. In addition to the Consumer Reference Group, consumer or public engagement in the SPIRE project will be sought through mechanisms such as project working groups, the development of Models of Care, the ACT Government *Your Say* website, or CHS patient surveys.

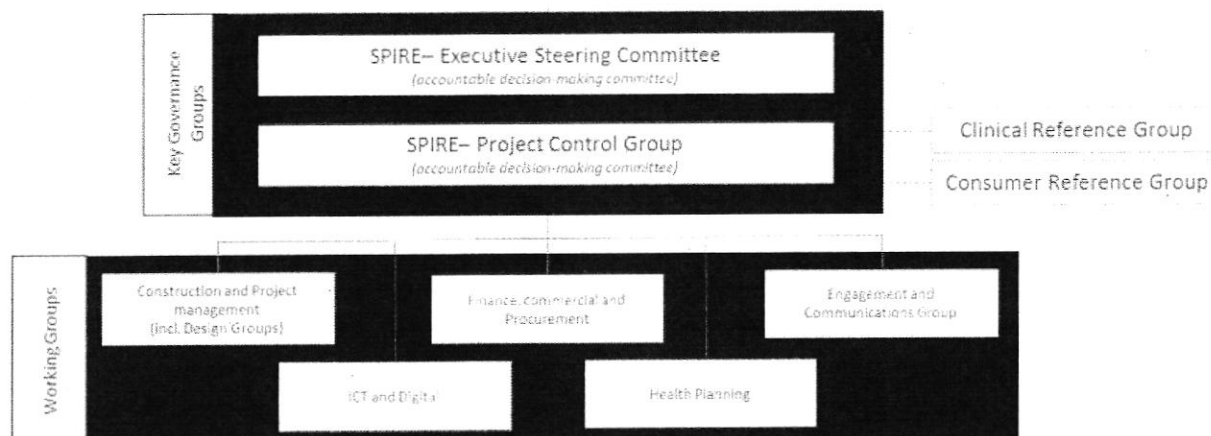


Image: SPIRE Project Governance Structure

Recommendation

10. It is recommended that the Executive Steering Committee approve:
- the role and function of the Consumer Reference Group,
 - the draft Terms of Reference,
 - Consumer Reference Group membership; and
 - payment of Reference Group expenses from the SPIRE project budget.

Attachments

Attachment	Title
1	NSQHS standards 1 and 2.
2	SPIRE Consumer Reference Group Draft Terms of Reference
3	Consumer and Carer Participation in ACT Health Policy DGD15-005



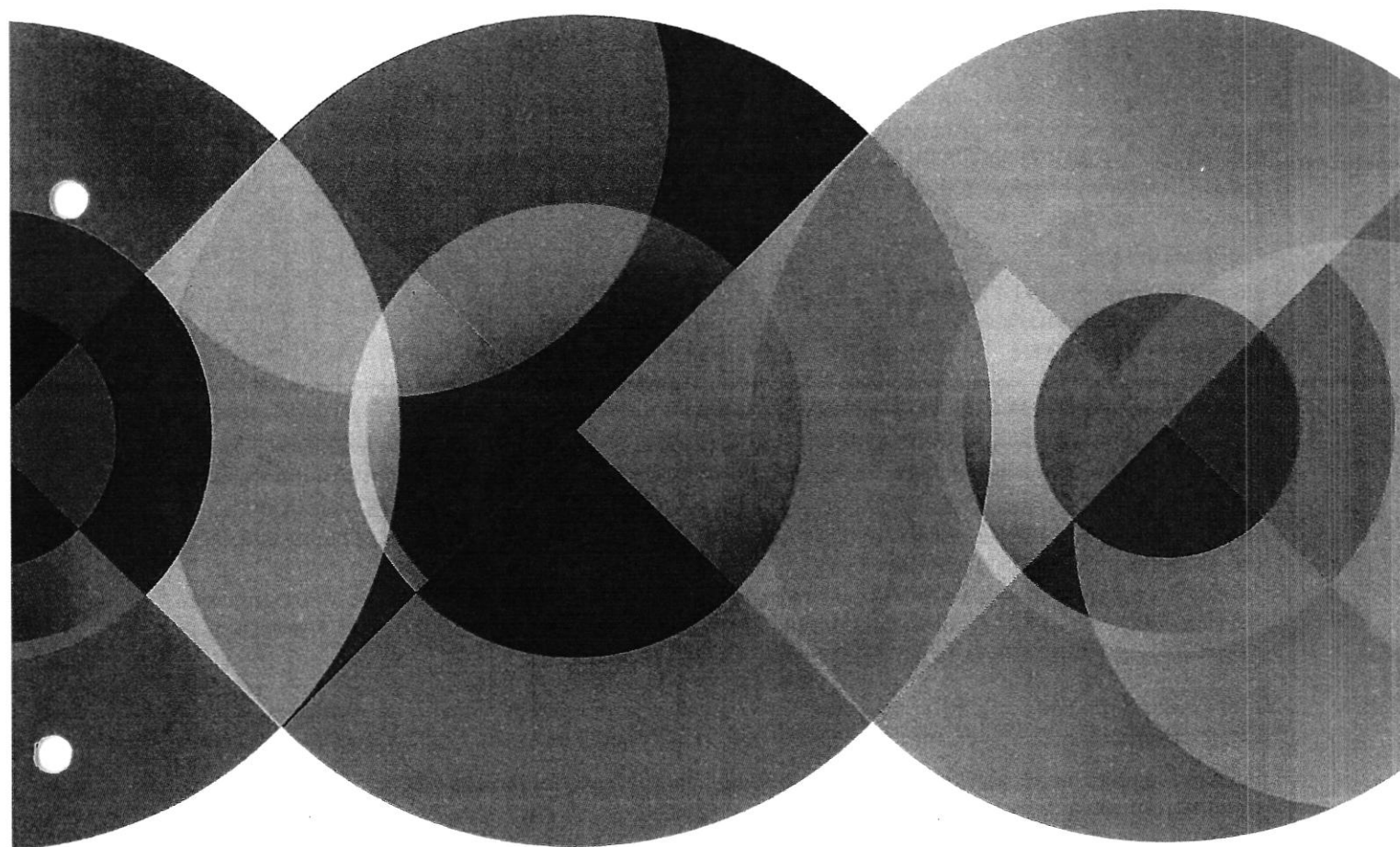
TERMS OF REFERENCE

Surgical Procedures, Interventional Radiology & Emergency Centre (SPIRE) Consumer Reference Group

Role	The SPIRE Consumer Reference Group is an advisory body providing guidance, advice and health service consumer insights on matters of design, accessibility, safety (including cultural safety) and amenity in relation to the development and construction of the SPIRE Centre.
Reporting Mechanism	<p>As an advisory body to the SPIRE Project Control Group (PCG), the Group will report directly to the PCG.</p> <p>The Group receives information from the SPIRE Project Director and, as required, from Working Groups.</p>
Functions	<p>The group provides advice and consumer insights with a focus on:</p> <ul style="list-style-type: none"> • building design • service accessibility – from a range of consumer perspectives • consumer safety, including cultural safety • consumer communications and engagement during the design and construction phases • way-finding and user journeys <p>The group may provide advice on matters in relation to SPIRE referred to it by the PCG.</p>
Membership	<p>Members:</p> <ul style="list-style-type: none"> • SPIRE Project Director, (ACTHD) Chair • Communications & Engagement Advisor, (ACTHD) • SPIRE Clinical Director, (CHS) • Patient Experience Team Senior Manager, (CHS) • Health Care Consumer Association staff member • Consumer, Carer and Community representative* • Consumer, Carer and Community representative* • Consumer, Carer and Community representative* • People with Disabilities ACT Inc staff member • Aboriginal & Torres Strait Islander Elected Body, Health Directorate representative • Multicultural Advisory Council ACT representative <p>* Consumer representatives are to have completed the required ACTHD/CHS training, project induction and agreed to terms of service detailed in Policy DGD16-019</p>

	Attendees: IFCW Design contractor Construction contractor The Consumer Reference Group may invite other attendees at the Chair's discretion.
Secretariat	Strategic Infrastructure Branch
Agenda requests	The secretariat is to receive requests for agenda items 10 working days before the meeting, unless otherwise advised. Papers are to be distributed no later than 8 working days before the meeting.
Meeting Frequency	Commencing September 2019, quarterly for up to 2 hours, or out-of-session as required. Meet first week of September, December, March and June from 2019 – 2024.
TOR Review Frequency	Annually
TOR Approved	The TOR is to be tabled for formal approval by the SPIRE PCG.

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ON SAFETY AND QUALITY IN HEALTH CARE



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Acknowledgement

The Commission would like to thank all of our partners for their contributions to the development of the NSQHS Standards and their continuing commitment to improving safety and quality across the Australian healthcare system.

This document was released in November 2017.

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Introduction

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

There are eight NSQHS Standards, which cover high-prevalence adverse events, healthcare-associated infections, medication safety, comprehensive care, clinical communication, the prevention and management of pressure injuries, the prevention of falls, and responding to clinical deterioration. Importantly, these NSQHS Standards have provided a nationally consistent statement about the standard of care consumers can expect from their health service organisations.

The eight NSQHS Standards are:



Clinical Governance, which describes the clinical governance, and safety and quality systems that are required to maintain and improve the reliability, safety and quality of health care, and improve health outcomes for patients.



Partnering with Consumers, which describes the systems and strategies to create a person-centred health system by including patients in shared decision making, to ensure that patients are partners in their own care, and that consumers are involved in the development and design of quality health care.



Preventing and Controlling Healthcare-Associated Infection, which describes the systems and strategies to prevent infection, to manage infections effectively when they occur, and to limit the development of antimicrobial resistance through prudent use of antimicrobials, as part of effective antimicrobial stewardship.



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



Comprehensive Care, which describes the integrated screening, assessment and risk identification processes for developing an individualised care plan, to prevent and minimise the risks of harm in identified areas.



Communicating for Safety, which describes the systems and strategies for effective communication between patients, carers and families, multidisciplinary teams and clinicians, and across the health service organisation.



Blood Management, which describes the systems and strategies for the safe, appropriate, efficient and effective care of patients' own blood, as well as other supplies of blood and blood products.



Recognising and Responding to Acute Deterioration, which describes the systems and processes to respond effectively to patients when their physical, mental or cognitive condition deteriorates.

Each standard contains:

- A description of the standard
- A statement of intent
- A list of criteria that describe the key areas covered by the standard
- Explanatory notes on the content of the standard
- Item headings for groups of actions in each criterion
- Actions that describe what is required to meet the standard.

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The NSQHS Standards require the implementation of organisation-wide systems for clinical governance, partnering with consumers, healthcare-associated infections, medication safety, comprehensive care, effective communication, blood management, and recognising and responding to acute deterioration.

The Clinical Governance Standard and the Partnering with Consumers Standard set the overarching system requirements for the effective implementation of the remaining six standards, which consider specific high-risk clinical areas of patient care. The NSQHS Standards describe the patient care journey and are designed to be implemented in an integrated way. Similar implementation strategies apply to multiple actions across the NSQHS Standards. It is important to identify the links between actions across each of the eight NSQHS Standards. This will help health service organisations to ensure that their safety and quality systems are integrated, and reduce the duplication of effort in implementing the eight standards separately.

Important improvements in the safety and quality of patient care have been documented following implementation of the first edition of the NSQHS Standards from 2011, including:

- A decline in the *Staphylococcus aureus* bacteraemia rate per 10,000 patient days under surveillance between 2010 and 2014, from 1.1 to 0.87 cases
- A drop in the yearly number of methicillin-resistant *S. aureus* bacteraemia cases between 2010 and 2014, from 505 to 389
- A decline of almost one-half in the national rate of central line-associated bloodstream infections between 2012–13 and 2013–14, from 1.02 to 0.6 per 1,000 line days.
- Greater prioritisation of antimicrobial stewardship activities in health service organisations
- Better documentation of adverse drug reactions and medication history
- Reduction in yearly red blood cell issues by the National Blood Authority between mid-2010 and mid-2015, from approximately 800,000 units to 667,000 units
- Declining rates of in-hospital cardiac arrest and intensive care unit admissions following cardiac arrests.

The Commission has worked closely with partners to review the NSQHS Standards and develop the second edition, embedding person-centred care and addressing the needs of people who may be at greater risk of harm. The NSQHS Standards (second edition) set requirements for providing comprehensive care for all patients, and include actions related to health literacy, end-of-life care, care for Aboriginal and Torres Strait Islander people, and care for people with lived experience of mental illness or cognitive impairment.

More information

A range of other supporting resources to assist health service organisations to implement the NSQHS Standards are available on the Commission's website.

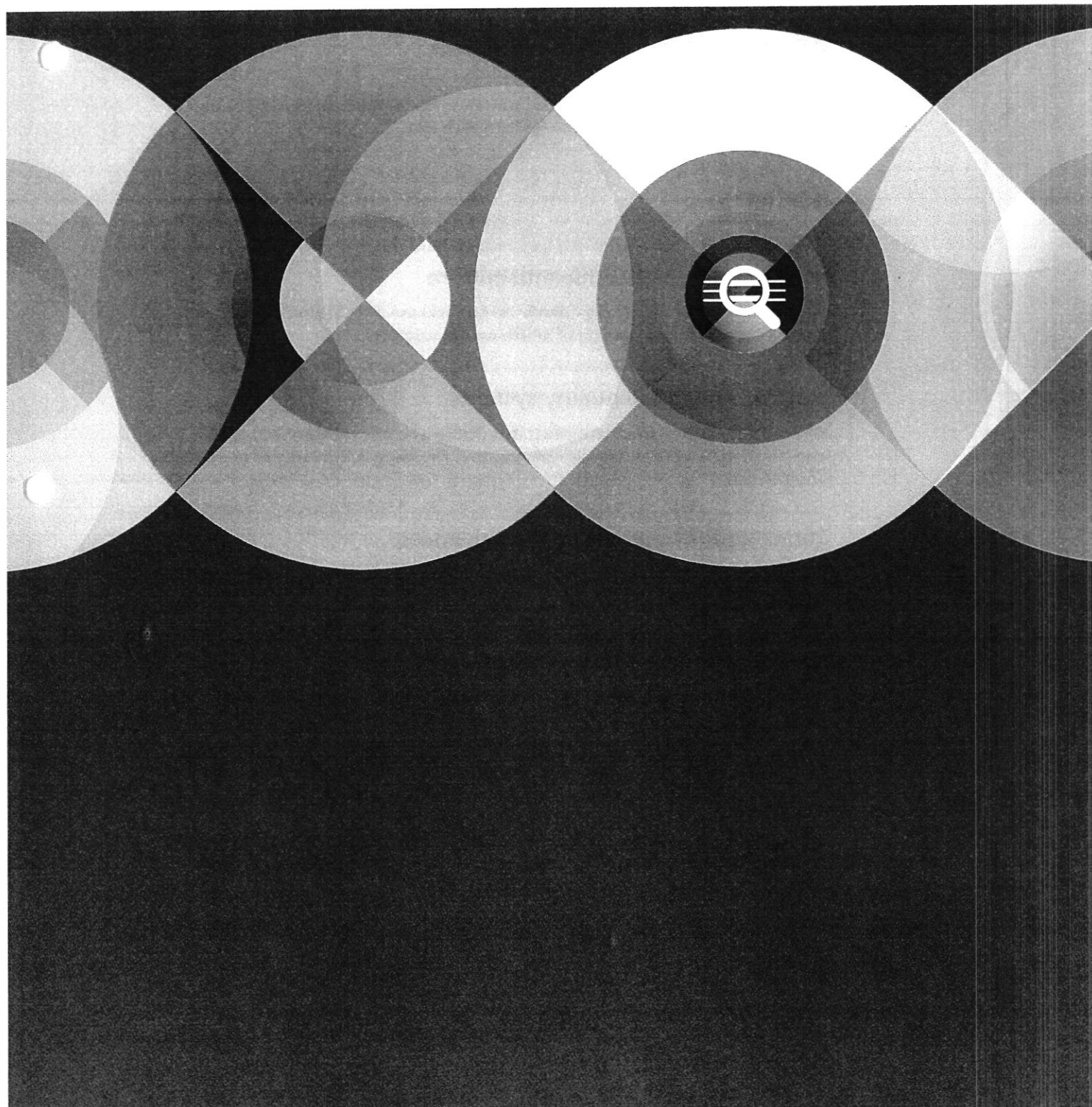
The Advice Centre provides support for health service organisations, surveyors and accrediting agencies on NSQHS Standards implementation.

Email: accreditation@safetyandquality.gov.au

Phone: 1800 304 056

1

Clinical Governance Standard





Clinical Governance Standard

Leaders of a health service organisation have a responsibility to the community for continuous improvement of the safety and quality of their services, and ensuring that they are person centred, safe and effective.

Intention of this standard

To implement a clinical governance framework that ensures that patients and consumers receive safe and high-quality health care.

Criteria

Governance, leadership and culture

Leaders at all levels in the organisation set up and use clinical governance systems to improve the safety and quality of health care for patients.

Patient safety and quality systems

Safety and quality systems are integrated with governance processes to enable organisations to actively manage and improve the safety and quality of health care for patients.

Clinical performance and effectiveness

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

Safe environment for the delivery of care

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

Explanatory notes

Thorough research has identified the elements of an effective clinical governance system and the effect of good clinical governance on health service performance.¹ Research in Australia² and overseas³ notes the importance of leaders in influencing the quality of care by supporting the workforce, shaping culture, setting direction, and monitoring progress in safety and quality performance. Engaging managers and clinicians in governance and quality improvement activities is important for aligning clinical and managerial priorities.⁴

Clinical governance is the set of relationships and responsibilities established by a health service organisation between its department of health (for the public sector), governing body, executive, clinicians, patients, consumers and other stakeholders to ensure good clinical outcomes.⁵ It ensures that the community and health service organisations can be confident that systems are in place to deliver safe and high-quality health care and continuously improve services.

Clinical governance is an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of health services that are safe, effective, integrated, high quality and continuously improving.

Each health service organisation needs to put in place strategies for clinical governance that consider its local circumstances.

This standard includes actions related to the role of leaders and others in safety and quality, Aboriginal and Torres Strait Islander health and e-health.

To support the delivery of safe and high-quality care for patients and consumers, the Australian Commission on Safety and Quality in Health Care (the Commission) has developed the National Model Clinical Governance Framework.⁵ Health service organisations should refer to the framework for more details on clinical governance, and the associated roles and responsibilities.

Governance, leadership and culture

Leaders at all levels in the organisation set up and use clinical governance systems to improve the safety and quality of health care for patients.

Item	Action
Governance, leadership and culture	1.1 The governing body: <ul style="list-style-type: none"> a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance
	1.2 The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people
Organisational leadership	1.3 The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality
	1.4 The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people
	1.5 The health service organisation considers the safety and quality of health care for patients in its business decision-making
Clinical leadership	1.6 Clinical leaders support clinicians to: <ul style="list-style-type: none"> a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients

Patient safety and quality systems

Safety and quality systems are integrated with governance processes to enable organisations to actively manage and improve the safety and quality of health care for patients.

Item	Action
Policies and procedures	<p>1.7 The health service organisation uses a risk management approach to:</p> <ul style="list-style-type: none"> a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements
Measurement and quality improvement	<p>1.8 The health service organisation uses organisation-wide quality improvement systems that:</p> <ul style="list-style-type: none"> a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems <p>1.9 The health service organisation ensures that timely reports on safety and quality systems and performance are provided to:</p> <ul style="list-style-type: none"> a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations
Risk management	<p>1.10 The health service organisation:</p> <ul style="list-style-type: none"> a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters

Item	Action
Incident management systems and open disclosure	<p>1.11 The health service organisation has organisation-wide incident management and investigation systems, and:</p> <ul style="list-style-type: none"> a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems
	<p>1.12 The health service organisation:</p> <ul style="list-style-type: none"> a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework⁶ b. Monitors and acts to improve the effectiveness of open disclosure processes
Feedback and complaints management	<p>1.13 The health service organisation:</p> <ul style="list-style-type: none"> a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems
	<p>1.14 The health service organisation has an organisation-wide complaints management system, and:</p> <ul style="list-style-type: none"> a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system

Item	Action
Diversity and high-risk groups	<p>1.15 The health service organisation:</p> <ul style="list-style-type: none"> a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care
Healthcare records	<p>1.16 The health service organisation has healthcare record systems that:</p> <ul style="list-style-type: none"> a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used <p>1.17 The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that:</p> <ul style="list-style-type: none"> a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies <p>1.18 The health service organisation providing clinical information into the My Health Record system has processes that:</p> <ul style="list-style-type: none"> a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system

Clinical performance and effectiveness

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

Item	Action
Safety and quality training	1.19 The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: <ol style="list-style-type: none"> Members of the governing body Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation
	1.20 The health service organisation uses its training systems to: <ol style="list-style-type: none"> Assess the competency and training needs of its workforce Implement a mandatory training program to meet its requirements arising from these standards Provide access to training to meet its safety and quality training needs Monitor the workforce's participation in training
	1.21 The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients
Performance management	1.22 The health service organisation has valid and reliable performance review processes that: <ol style="list-style-type: none"> Require members of the workforce to regularly take part in a review of their performance Identify needs for training and development in safety and quality Incorporate information on training requirements into the organisation's training system
Credentialing and scope of clinical practice	1.23 The health service organisation has processes to: <ol style="list-style-type: none"> Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered
	1.24 The health service organisation: <ol style="list-style-type: none"> Conducts processes to ensure that clinicians are credentialed, where relevant Monitors and improves the effectiveness of the credentialing process

Item	Action
Safety and quality roles and responsibilities	<p>1.25 The health service organisation has processes to:</p> <ul style="list-style-type: none"> a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff
	<p>1.26 The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate</p>
Evidence-based care	<p>1.27 The health service organisation has processes that:</p> <ul style="list-style-type: none"> a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care
Variation in clinical practice and health outcomes	<p>1.28 The health service organisation has systems to:</p> <ul style="list-style-type: none"> a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system

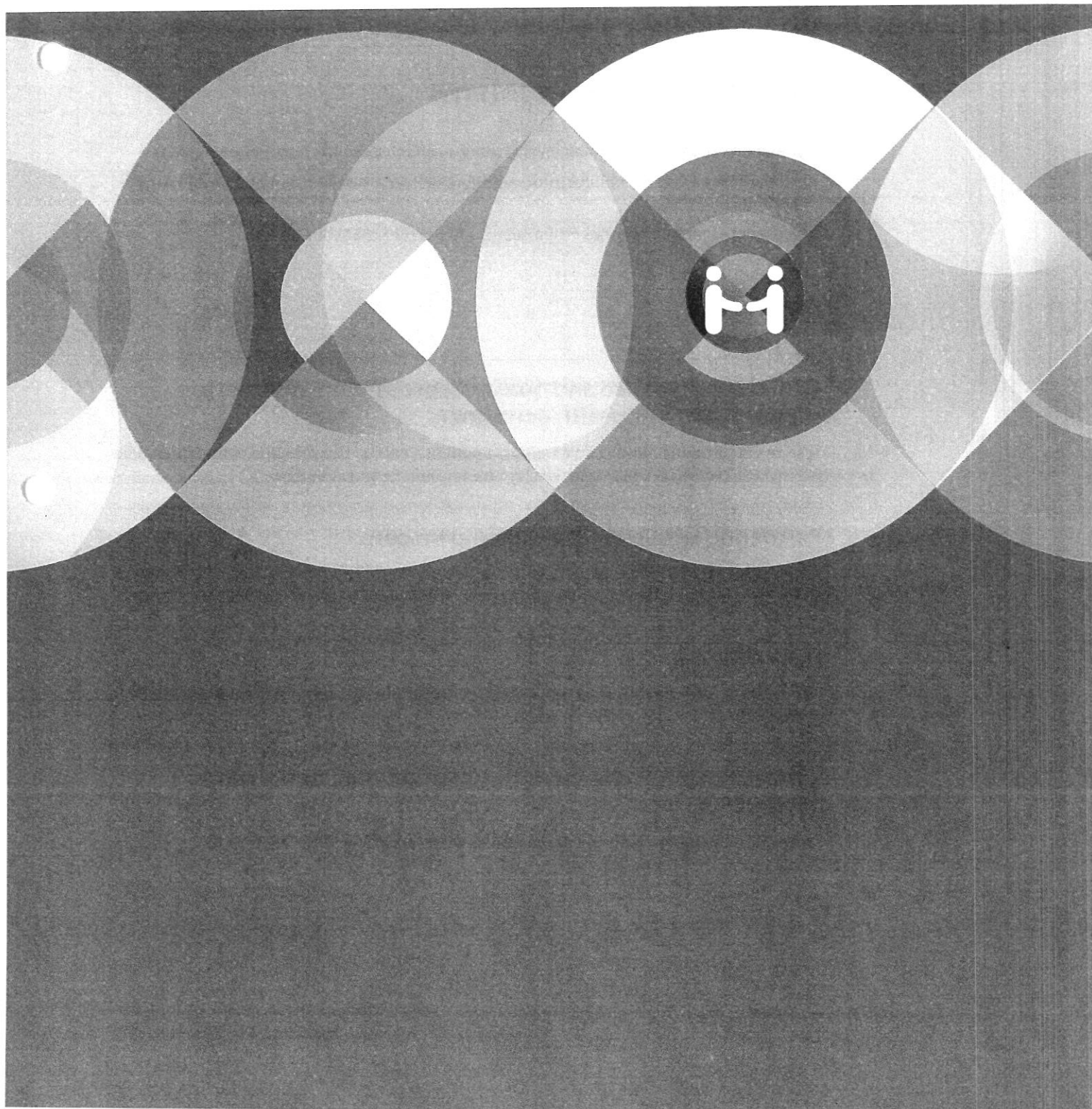
Safe environment for the delivery of care

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

Item	Action
Safe environment	1.29 The health service organisation maximises safety and quality of care: <ul style="list-style-type: none"> a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose
	1.30 The health service organisation: <ul style="list-style-type: none"> a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required
	1.31 The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose
	1.32 The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so
	1.33 The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people

2

Partnering with Consumers Standard





Partnering with Consumers Standard

Leaders of a health service organisation develop, implement and maintain systems to partner with consumers. These partnerships relate to the planning, design, delivery, measurement and evaluation of care. The workforce uses these systems to partner with consumers.

Intention of this standard

To create an organisation in which there are mutually valuable outcomes by having:

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

Criteria

Clinical governance and quality improvement systems to support partnering with consumers

Systems are designed and used to support patients, carers, families and consumers to be partners in healthcare planning, design, measurement and evaluation.

Partnering with patients in their own care

Systems that are based on partnering with patients in their own care are used to support the delivery of care. Patients are partners in their own care to the extent that they choose.

Health literacy

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

Partnering with consumers in organisational design and governance

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

Explanatory notes

Effective partnerships exist when people are treated with dignity and respect, information is shared with them, and participation and collaboration in healthcare processes are encouraged and supported to the extent that people choose.⁷

Different types of partnerships with patients and consumers exist within the healthcare system. These partnerships are not mutually exclusive, and are needed at all levels to ensure that a health service organisation achieves the best possible outcome for all parties.⁸ Partnerships with patients and consumers comprise many different, interwoven practices that reflect the three key levels at which partnerships are needed⁹:

1. At the level of the individual

Partnerships relate to the interaction between clinicians and patients when care is provided. At this level, a partnership involves providing care that is respectful; sharing information in an ongoing way; working with patients, carers and families to make decisions and plan care; and supporting and encouraging patients in their own care.

2. At the level of a service, department or program of care

Partnerships relate to the organisation and delivery of care within specific areas. At this level, a partnership involves the participation of patients, carers, families and consumers in the overall design of the service, department or program. This could be as full members of quality improvement and redesign teams, and participating in planning, implementing and evaluating change.

3. At the level of the health service

Partnerships relate to the involvement of consumers in overall governance, policy and planning. This level overlaps with the previous level, since a health service is made up of various services, departments and programs. At this level, partnerships relate to the involvement of consumers and consumer representatives as full members of key organisational governance committees in areas such as patient safety, facility design, quality improvement, patient or family education, ethics and research. This level can also involve partnerships with local community organisations and members of local communities.

Delivering care that is based on partnerships provides many benefits for patients, consumers, clinicians, health service organisations and the health system. Effective partnerships, a positive experience for patients, and high-quality health care and improved safety are linked.⁹⁻¹¹ The involvement of patients and consumers in planning, delivery, monitoring and evaluation can also have a positive effect on service planning and development, information development and dissemination, and the attitudes of healthcare providers.^{9,12,13} Delivering health care that is based on partnerships can result in reduced hospital costs, lower cost per case and reduced length of stay.^{14,15}

Clinical governance and quality improvement systems to support partnering with consumers

Systems are designed and used to support patients, carers, families and consumers to be partners in healthcare planning, design, measurement and evaluation.

Item	Action
Integrating clinical governance	2.1 Clinicians use the safety and quality systems from the Clinical Governance Standard when: <ol style="list-style-type: none"> Implementing policies and procedures for partnering with consumers Managing risks associated with partnering with consumers Identifying training requirements for partnering with consumers
Applying quality improvement systems	2.2 The health service organisation applies the quality improvement system from the Clinical Governance Standard when: <ol style="list-style-type: none"> Monitoring processes for partnering with consumers Implementing strategies to improve processes for partnering with consumers Reporting on partnering with consumers

Partnering with patients in their own care

Systems that are based on partnering with patients in their own care are used to support the delivery of care. Patients are partners in their own care to the extent that they choose.

Item	Action
Healthcare rights and informed consent	2.3 The health service organisation uses a charter of rights that is: <ul style="list-style-type: none"> a. Consistent with the Australian Charter of Healthcare Rights¹⁶ b. Easily accessible for patients, carers, families and consumers
	2.4 The health service organisation ensures that its informed consent processes comply with legislation and best practice
	2.5 The health service organisation has processes to identify: <ul style="list-style-type: none"> a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves
Sharing decisions and planning care	2.6 The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care
	2.7 The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care

Health literacy

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

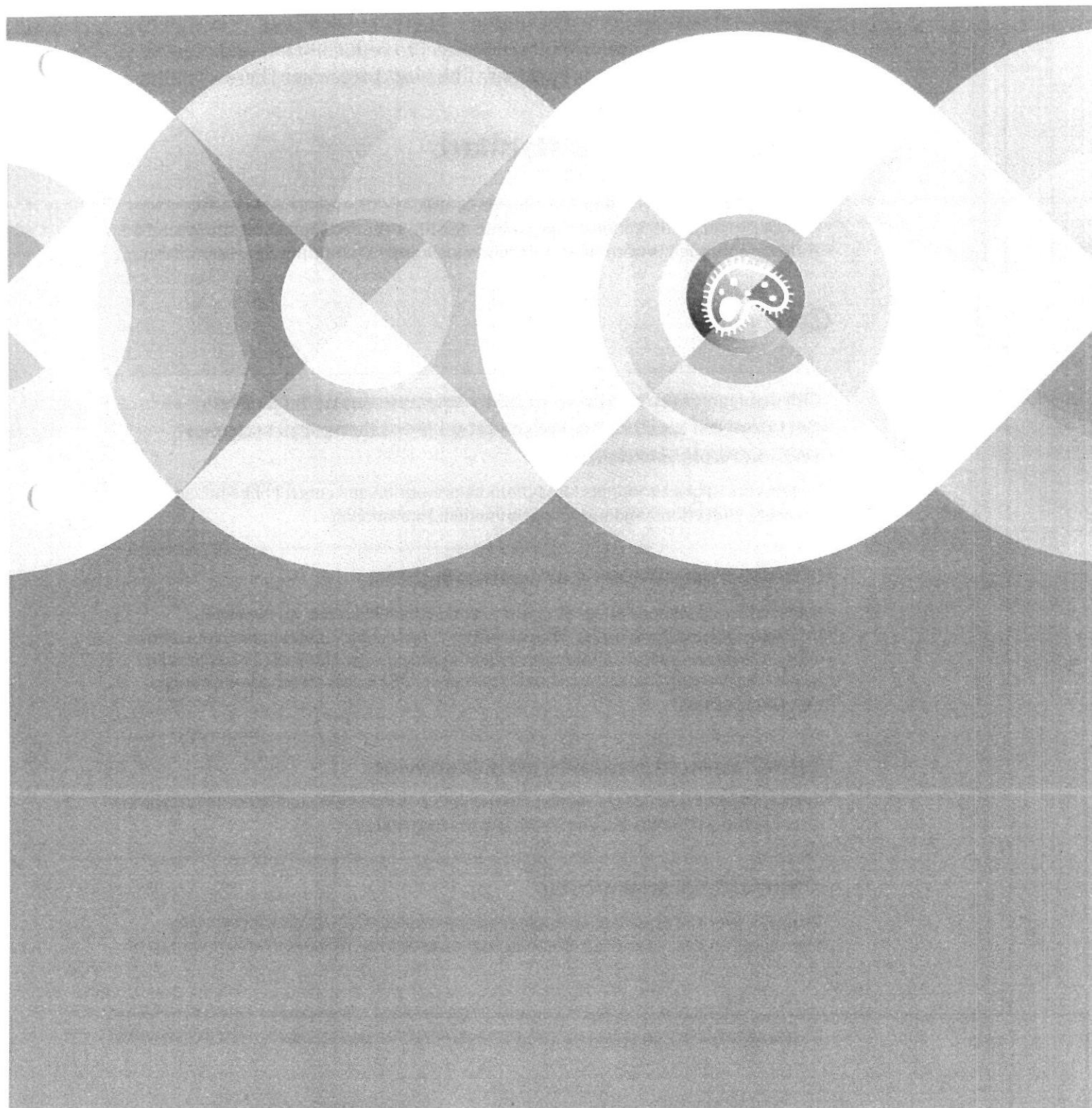
Item	Action
Communication that supports effective partnerships	2.8 The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community
	2.9 Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review
	2.10 The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: <ul style="list-style-type: none"> a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge

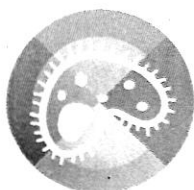
Partnering with consumers in organisational design and governance

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

Item	Action
Partnerships in healthcare governance planning, design, measurement and evaluation	2.11 The health service organisation: <ul style="list-style-type: none"> a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community
	2.12 The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation
	2.13 The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs
	2.14 The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce

Preventing and Controlling Healthcare-Associated Infection Standard





Preventing and Controlling Healthcare-Associated Infection Standard

Leaders of a health service organisation describe, implement and monitor systems to prevent, manage or control healthcare-associated infections and antimicrobial resistance, to reduce harm and achieve good health outcomes for patients. The workforce uses these systems.

Intention of this standard

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

Criteria

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

Systems are in place to support and promote prevention and control of healthcare-associated infections, and improve antimicrobial stewardship.

Infection prevention and control systems

Evidence-based systems are used to prevent and control healthcare-associated infections. Patients presenting with, or with risk factors for, infection or colonisation with an organism of local, national or global significance are identified promptly, and receive the necessary management and treatment. The health service organisation is clean and hygienic.

Reprocessing of reusable medical devices

Reprocessing of reusable equipment, instruments and devices is consistent with relevant current national standards, and meets current best practice.

Antimicrobial stewardship

The health service organisation implements systems for the safe and appropriate prescribing and use of antimicrobials as part of an antimicrobial stewardship program.

Explanatory notes

In Australian healthcare settings, patients are often treated in close proximity to each other. They undergo invasive procedures, have medical devices inserted, and receive broad-spectrum antibiotics and immunosuppression therapies. These conditions create ideal opportunities for the adaptation and spread of pathogenic infectious agents.

Each year, many infections are associated with the provision of health care and affect a large number of patients.¹⁷ Healthcare-associated infections are one of the most common complications affecting patients. Some of these infections require stronger and more expensive medicines (with increased risk of complications), and may result in lifelong disability or death. Such infections:

- Cause considerable harm
- Increase patient use of health services – for example, extended length of stay, and increased use of health resources such as inpatient beds, treatment options and investigations
- Place greater demands on the clinical workforce.

Infectious microorganisms evolve over time, and continue to present new challenges for infection prevention and control. Currently, the main concerns are the emergence and transmission of antibiotic-resistant bacteria such as carbapenemase-producing Enterobacteriaceae, transmission of existing organisms such as multidrug-resistant *Staphylococcus aureus* and vancomycin-resistant *Enterococcus*, and the increase in *Clostridium difficile* infections being identified in health service organisations.

Infection prevention and control aims to reduce the development of resistant organisms and minimise the risk of transmission through the isolation of the infectious agent or the patient. This is done, in part, by applying standard and transmission-based precautions as safe work practices in the healthcare setting. 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 prevention and control requires a collaborative approach and several strategies across all levels of the healthcare system. These strategies include:

- Governance
- Risk identification and management
- Surveillance activities to identify areas for action and quality improvement activities (hand hygiene assessment, awareness and practice of aseptic technique)
- Safe and appropriate prescribing and use of antimicrobial agents through antimicrobial stewardship and consumer engagement.

Although all infection prevention and control programs have essential elements that must be considered, programs will need to be tailored to reflect local context and risk.

Systems and governance for infection prevention and surveillance must be consistent with relevant national resources, including the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*.¹⁸

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

Systems are in place to support and promote prevention and control of healthcare-associated infections, and improve antimicrobial stewardship.

Item	Action
Integrating clinical governance	3.1 The workforce uses the safety and quality systems from the Clinical Governance Standard when: <ol style="list-style-type: none"> Implementing policies and procedures for healthcare-associated infections and antimicrobial stewardship Managing risks associated with healthcare-associated infections and antimicrobial stewardship Identifying training requirements for preventing and controlling healthcare-associated infections, and antimicrobial stewardship
Applying quality improvement systems	3.2 The health service organisation applies the quality improvement system from the Clinical Governance Standard when: <ol style="list-style-type: none"> Monitoring the performance of systems for prevention and control of healthcare-associated infections, and the effectiveness of the antimicrobial stewardship program Implementing strategies to improve outcomes and associated processes of systems for prevention and control of healthcare-associated infections, and antimicrobial stewardship Reporting on the outcomes of prevention and control of healthcare-associated infections, and the antimicrobial stewardship program
Partnering with consumers	3.3 Clinicians use organisational processes from the Partnering with Consumers Standard when preventing and managing healthcare-associated infections, and implementing the antimicrobial stewardship program to: <ol style="list-style-type: none"> Actively involve patients in their own care Meet the patient's information needs Share decision-making
Surveillance	3.4 The health service organisation has a surveillance strategy for healthcare-associated infections and antimicrobial use that: <ol style="list-style-type: none"> Collects data on healthcare-associated infections and antimicrobial use relevant to the size and scope of the organisation Monitors, assesses and uses surveillance data to reduce the risks associated with healthcare-associated infections and support appropriate antimicrobial prescribing Reports surveillance data on healthcare-associated infections and antimicrobial use to the workforce, the governing body, consumers and other relevant groups

Infection prevention and control systems

Evidence-based systems are used to prevent and control healthcare-associated infections. Patients presenting with, or with risk factors for, infection or colonisation with an organism of local, national or global significance are identified promptly, and receive the necessary management and treatment. The health service organisation is clean and hygienic.

Item	Action
Standard and transmission-based precautions	3.5 The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the <i>Australian Guidelines for the Prevention and Control of Infection in Healthcare</i> ¹⁸ , and jurisdictional requirements
	3.6 Clinicians assess infection risks and use transmission-based precautions based on the risk of transmission of infectious agents, and consider: <ul style="list-style-type: none"> a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated when clinically required during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs to manage infection risks d. The need to control the environment e. Precautions required when the patient is moved within the facility or to external services f. The need for additional environmental cleaning or disinfection g. Equipment requirements
	3.7 The health service organisation has processes for communicating relevant details of a patient's infectious status whenever responsibility for care is transferred between clinicians or health service organisations
Hand hygiene	3.8 The health service organisation has a hand hygiene program that: <ul style="list-style-type: none"> a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with the current National Hand Hygiene Initiative
Aseptic technique	3.9 The health service organisation has processes for aseptic technique that: <ul style="list-style-type: none"> a. Identify the procedures where aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique

Item	Action
Invasive medical devices	3.10 The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the <i>Australian Guidelines for the Prevention and Control of Infection in Healthcare</i> ¹⁸
Clean environment	<p>3.11 The health service organisation has processes to maintain a clean and hygienic environment – in line with the current edition of the <i>Australian Guidelines for the Prevention and Control of Infection in Healthcare</i>¹⁸, and jurisdictional requirements – that:</p> <ul style="list-style-type: none"> a. Respond to environmental risks b. Require cleaning and disinfection in line with recommended cleaning frequencies c. Include training in the appropriate use of specialised personal protective equipment for the workforce <p>3.12 The health service organisation has processes to evaluate and respond to infection risks for:</p> <ul style="list-style-type: none"> a. New and existing equipment, devices and products used in the organisation b. Maintaining, repairing and upgrading buildings, equipment, furnishings and fittings c. Handling, transporting and storing linen
Workforce immunisation	<p>3.13 The health service organisation has a risk-based workforce immunisation program that:</p> <ul style="list-style-type: none"> a. Is consistent with the current edition of the <i>Australian Immunisation Handbook</i>¹⁹ b. Is consistent with jurisdictional requirements for vaccine-preventable diseases c. Addresses specific risks to the workforce and patients

Reprocessing of reusable medical devices

Reprocessing of reusable equipment, instruments and devices is consistent with relevant current national standards, and meets current best practice.

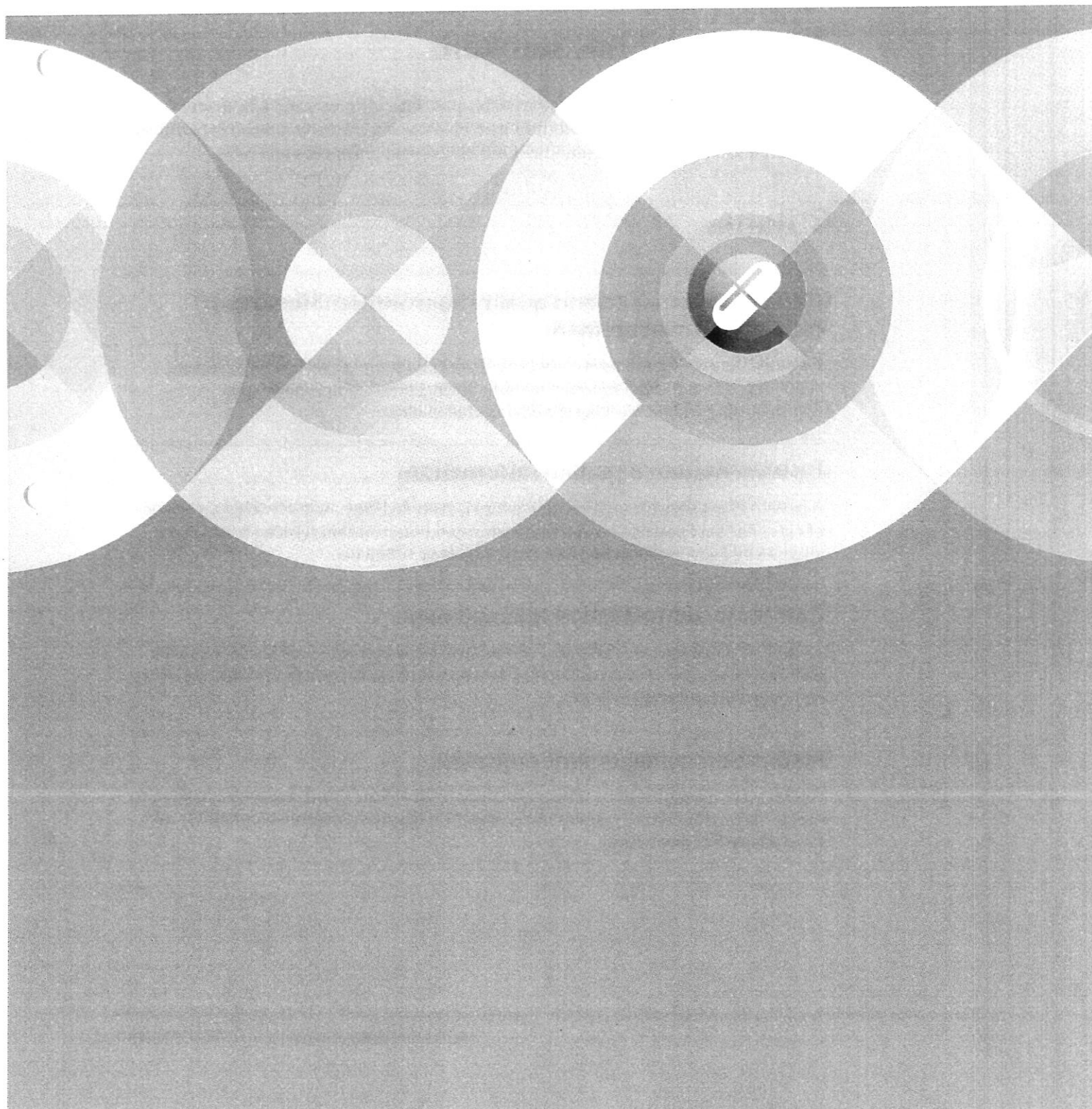
Item	Action
Reprocessing of reusable devices	<p>3.14 Where reusable equipment, instruments and devices are used, the health service organisation has:</p> <ul style="list-style-type: none">a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelinesb. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying<ul style="list-style-type: none">• the patient• the procedure• the reusable equipment, instruments and devices that were used for the procedure

Antimicrobial stewardship

The health service organisation implements systems for the safe and appropriate prescribing and use of antimicrobials as part of an antimicrobial stewardship program.

Item	Action
Antimicrobial stewardship	<p>3.15 The health service organisation has an antimicrobial stewardship program that:</p> <ul style="list-style-type: none"> a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard²⁰
	<p>3.16 The antimicrobial stewardship program will:</p> <ul style="list-style-type: none"> a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding <ul style="list-style-type: none"> • compliance with the antimicrobial stewardship policy • antimicrobial use and resistance • appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing

Medication Safety Standard





Medication Safety Standard

Leaders of a health service organisation describe, implement and monitor systems to reduce the occurrence of medication incidents, and improve the safety and quality of medication use. The workforce uses these systems.

Intention of this standard

To ensure clinicians are competent to safely prescribe, dispense and administer appropriate medicines and to monitor medicine use. To ensure consumers are informed about medicines and understand their individual medicine needs and risks.

Criteria

Clinical governance and quality improvement to support medication management

Organisation-wide systems are used to support and promote safety for procuring, supplying, storing, compounding, manufacturing, prescribing, dispensing, administering and monitoring the effects of medicines.

Documentation of patient information

A patient's best possible medication history is recorded when commencing an episode of care. The best possible medication history, and information relating to medicine allergies and adverse drug reactions are available to clinicians.

Continuity of medication management

A patient's medicines are reviewed, and information is provided to them about their medicine needs and risks. A medicines list is provided to the patient and the receiving clinician when handing over care.

Medication management processes

Health service organisations procure medicines for safety. Clinicians are supported to supply, store, compound, manufacture, prescribe, dispense, administer, monitor and safely dispose of medicines.

Explanatory notes

Medicines are the most common treatment used in health care. Although appropriate use of medicines contributes to significant improvements in health, medicines can also be associated with harm.²¹ 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 adverse events are costly, and up to 50% are potentially avoidable.²²

The proportion of medicine-related hospital admissions has been estimated at approximately 2–3%.²³ This proportion remains consistent, and, based on 2011–12 Australian hospital data of 9.3 million separations, suggests a medicine-related hospital admission rate of 230,000 annually. Some subpopulations have higher estimates – for example, 12% of medical admissions and 20–30% of admissions for those aged 65 years and over.²¹ Studies have also revealed an average of three medicine-related problems per resident in aged care facilities²⁴, and 40–50% of residents being prescribed potentially inappropriate medicines.^{25,26}

In general practice, 8.5–12% of patients are reported to have experienced an adverse medicine event within the previous six months^{27–29}, consistent with previous estimates of 10% of patients.³⁰

Errors affect both health outcomes for consumers and healthcare costs. The cost of such adverse events to individual patients and the healthcare system is significant. A study published in 2009 reported that medication-related hospital admissions in Australia were estimated to cost \$660 million.²¹ Estimates, with an average cost per separation of \$5,204 in 2011–12, place this figure closer to \$1.2 billion.²¹ The effects on patients' quality of life are more difficult to quantify.

Standardising and systemising processes can improve medication safety by preventing medication incidents. Other recognised solutions for reducing common causes of medication incidents include:

- Improving governance and quality measures relating to medication safety
- Improving clinician–workforce communication and clinical handover
- Improving clinician–patient communication and partnership
- Using technology to support information recording and transfer
- Providing better access to patient information and clinical decision support.

Clinical governance and quality improvement to support medication management

Organisation-wide systems are used to support and promote safety for procuring, supplying, storing, compounding, manufacturing, prescribing, dispensing, administering and monitoring the effects of medicines.

Item	Action
Integrating clinical governance	4.1 Clinicians use the safety and quality systems from the Clinical Governance Standard when: <ol style="list-style-type: none"> Implementing policies and procedures for medication management Managing risks associated with medication management Identifying training requirements for medication management
Applying quality improvement systems	4.2 The health service organisation applies the quality improvement system from the Clinical Governance Standard when: <ol style="list-style-type: none"> Monitoring the effectiveness and performance of medication management Implementing strategies to improve medication management outcomes and associated processes Reporting on outcomes for medication management
Partnering with consumers	4.3 Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: <ol style="list-style-type: none"> Actively involve patients in their own care Meet the patient's information needs Share decision-making
Medicines scope of clinical practice	4.4 The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians

Documentation of patient information

A patient's best possible medication history is recorded when commencing an episode of care. The best possible medication history, and information relating to medicine allergies and adverse drug reactions are available to clinicians.

Item	Action
Medication reconciliation	4.5 Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care
	4.6 Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care
Adverse drug reactions	4.7 The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation
	4.8 The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system
	4.9 The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements

Continuity of medication management

A patient's medicines are reviewed, and information is provided to them about their medicines needs and risks. A medicines list is provided to the patient and the receiving clinician when handing over care.

Item	Action
Medication review	4.10 The health service organisation has processes: <ol style="list-style-type: none"> To perform medication reviews for patients, in line with evidence and best practice To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems That specify the requirements for documentation of medication reviews, including actions taken as a result
Information for patients	4.11 The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks
Provision of a medicines list	4.12 The health service organisation has processes to: <ol style="list-style-type: none"> Generate a current medicines list and the reasons for any changes Distribute the current medicines list to receiving clinicians at transitions of care Provide patients on discharge with a current medicines list and the reasons for any changes



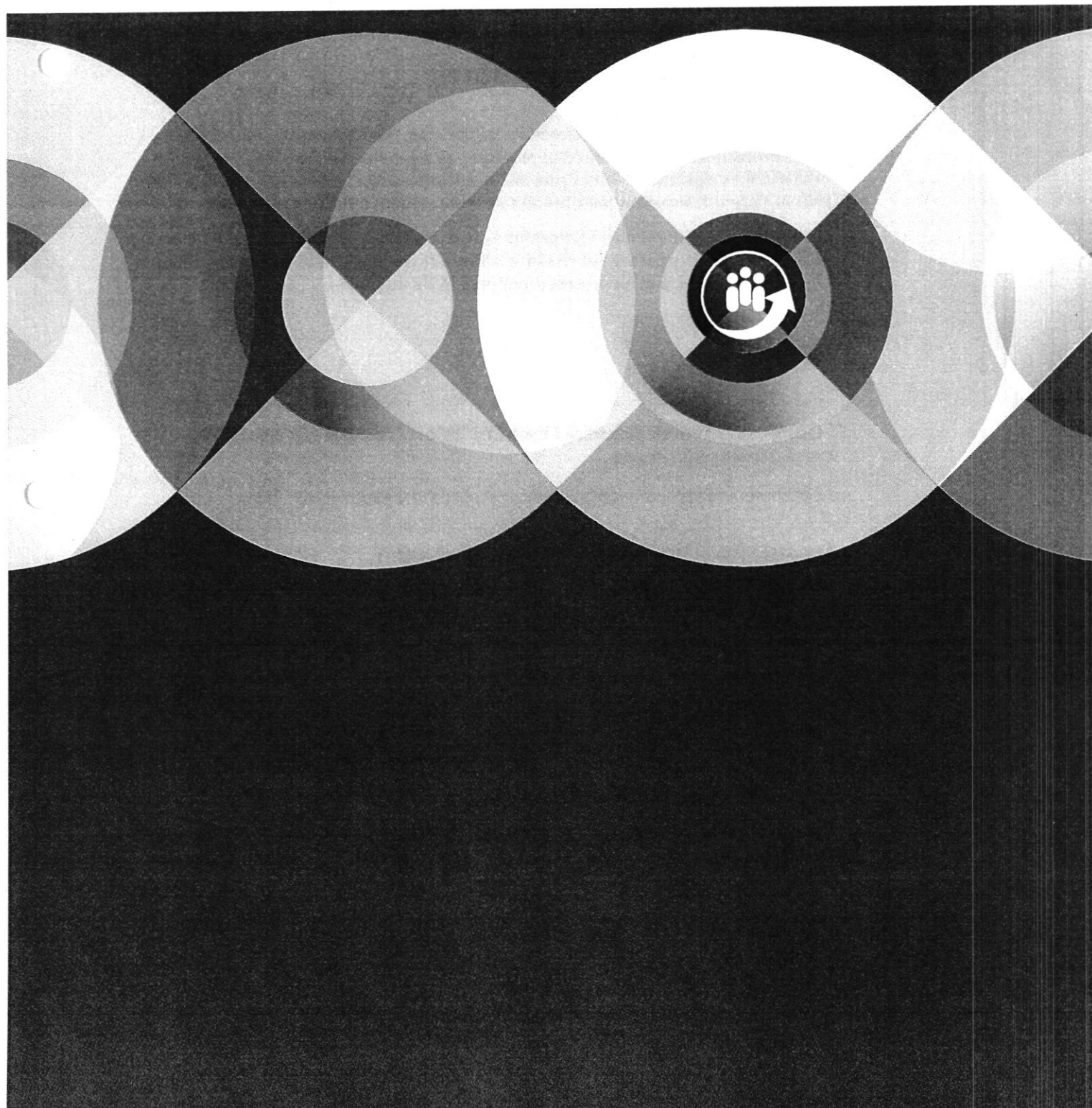
Medication management processes

Health service organisations procure medicines for safety. Clinicians are supported to supply, store, compound, manufacture, prescribe, dispense, administer, monitor and safely dispose of medicines.

Item	Action
Information and decision support tools for medicines	4.13 The health service organisation ensures that information and decision support tools for medicines are available to clinicians
Safe and secure storage and distribution of medicines	4.14 The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: <ul style="list-style-type: none"> a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines
High-risk medicines	4.15 The health service organisation: <ul style="list-style-type: none"> a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely

5

Comprehensive Care Standard





Comprehensive Care Standard

Leaders of a health service organisation set up and maintain systems and processes to support clinicians to deliver comprehensive care. They also set up and maintain systems to prevent and manage specific risks of harm to patients during the delivery of health care. The workforce uses the systems to deliver comprehensive care and manage risk.

Intention of this standard

To ensure that patients receive comprehensive care – that is, coordinated delivery of the total health care required or requested by a patient. This care is aligned with the patient's expressed goals of care and healthcare needs, considers the effect of the patient's health issues on their life and wellbeing, and is clinically appropriate.

To ensure that risks of harm for patients during health care are prevented and managed. Clinicians identify patients at risk of specific harm during health care by applying the screening and assessment processes required in this standard.

Criteria

Clinical governance and quality improvement to support comprehensive care

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

Developing the comprehensive care plan

Integrated screening and assessment processes are used in collaboration with patients, carers and families to develop a goal-directed comprehensive care plan.

Delivering comprehensive care

Safe care is delivered based on the comprehensive care plan, and in partnership with patients, carers and family. Comprehensive care is delivered to patients at the end of life.

Minimising patient harm

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

Explanatory notes

Comprehensive care

Safety and quality gaps are often reported as failures to provide adequate care for specific conditions, or in specific situations or settings, or to achieve expected outcomes in certain populations. The purpose of the Comprehensive Care Standard is to address the cross-cutting issues underlying many adverse events. These issues often include failures to:

- Provide continuous and collaborative care
- Work in partnership with patients, carers and families to adequately identify, assess and manage patients' clinical risks, and find out their preferences for care
- Communicate and work as a team (that is, between members of the healthcare team).

Processes for delivering comprehensive care will vary, even within a health service organisation. Take a flexible approach to standardisation so that safety and quality systems support local implementation and innovation. Target screening, assessment, comprehensive care planning and delivery processes to improve the safety and quality of care delivered to the population that the organisation serves.

Although this standard refers to actions needed within a single episode of patient care, it is fundamental that each single episode or period of care is considered as part of the continuum of care for a patient. Meaningful implementation of this standard requires attention to the processes for partnering with patients in their own care, and for safely managing transitions between episodes of care. This requires that the systems and processes necessary to meet the requirements of this standard also meet the requirements of the Partnering with Consumers Standard and the Communicating for Safety Standard.

Minimising patient harm

Implement targeted, best-practice strategies to prevent and minimise the risk of specific harms identified in this standard.

Pressure injuries

Pressure injuries can occur to patients of any age who have one or more of the following risk factors: immobility, older age, lack of sensory perception, poor nutrition or hydration, excess moisture or dryness, poor skin integrity, reduced blood flow, limited alertness or muscle spasms. Evidence-based strategies to prevent pressure injuries exist and should be applied if screening identifies that a patient is at risk.

Falls

Falls also occur in all age groups. However, the risk of falls and the harm from falls vary between individuals as a result of differences in factors such as eyesight, balance, cognitive impairment, muscle strength, bone density and medicine use. The Australian Commission on Safety and Quality in Health Care has developed evidence-based guidelines for older people.³¹⁻³³ Policies and procedures for other age groups need to be based on available evidence and best practice.

Poor nutrition and malnutrition

Patients with poor nutrition, including malnutrition, are at greater risk of pressure injuries and their pressure injuries are more severe.^{8,34} They are also at greater risk of healthcare-associated infections and mortality in hospital, and for up to three years following discharge.³⁵⁻³⁹ Malnutrition significantly increases length of hospital stay and unplanned readmissions.^{37,38,40} Ensure that patients at risk of poor nutrition are identified and that strategies are put in place to reduce these risks.

Cognitive impairment

People with cognitive impairment who are admitted to hospital are at a significantly increased risk of preventable complications such as falls, pressure injuries, delirium and failure to return to premorbid function, as well as adverse outcomes such as unexpected death, or early and unplanned entry into residential care.⁴¹ People with cognitive impairment may also experience distress in unfamiliar and busy environments. Although cognitive impairment is a common condition experienced by people in health service organisations, it is often not detected, or is dismissed or misdiagnosed. Delirium can be prevented with the right care⁴², and harm can be minimised if systems are in place to identify cognitive impairment and the risk of delirium, so that strategies can be incorporated in the comprehensive care plan and implemented.

Unpredictable behaviours

People in healthcare settings can exhibit unpredictable behaviours that may lead to harm. Health service organisations need systems to identify situations where there is higher risk of harm, and strategies to mitigate or prevent these risks. They also need systems to manage situations in which harm relating to unpredictable behaviour occurs. For the purpose of this standard, unpredictable behaviours include self-harm, suicide, aggression and violence. It is important that systems designed to respond to the risks of unpredictable behaviour minimise further trauma to patients and others. This relates to both the material practices and the attitude with which care is delivered.

Processes to manage people who have thoughts of harming themselves, with or without suicidal intent, or who have actually harmed themselves are needed. These processes need to provide physical safety, and support to deal with psychological and other issues contributing to self-harm. The health service organisation is responsible for ensuring that follow-up services are arranged before the person leaves the health service, because of the known risks of self-harm after discharge.⁴³

Some people are at higher risk of aggressive behaviour as a result of impaired coping skills relating to intoxication, acute physical deterioration or mental illness. Healthcare-related situations, such as waiting times, crowded or high-stimulus environments, and conflicts regarding treatment decisions, can precipitate aggression. Members of the workforce need skills to identify the risk of aggression, and strategies to safely manage aggression and violence when they do occur.

Restrictive practices

Minimising and, where possible, eliminating the use of restrictive practices (including restraint and seclusion) are key parts of national mental health policy.^{44,45} Minimising the use of restraint in other healthcare settings besides mental health has also been identified as a clinical priority. Identifying risks relating to unpredictable behaviour early and using tailored response strategies can reduce the use of restrictive practices. Restrictive practices must only be implemented by members of the workforce who have been trained in their safe use. The health service organisation needs processes to benchmark and review the use of restrictive practices.

Key links with other standards

To implement systems that meet the requirements of the Comprehensive Care Standard, identify where there are synergies with the other NSQHS Standards. This will help ensure that the organisation's safety and quality systems, policies and processes are integrated, and will reduce the risk of duplication of effort arising from attempts to implement the eight standards separately.

Clinical governance and quality improvement to support comprehensive care

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

Item	Action
Integrating clinical governance	5.1 Clinicians use the safety and quality systems from the Clinical Governance Standard when: <ol style="list-style-type: none"> Implementing policies and procedures for comprehensive care Managing risks associated with comprehensive care Identifying training requirements to deliver comprehensive care
Applying quality improvement systems	5.2 The health service organisation applies the quality improvement system from the Clinical Governance Standard when: <ol style="list-style-type: none"> Monitoring the delivery of comprehensive care Implementing strategies to improve the outcomes from comprehensive care and associated processes Reporting on delivery of comprehensive care
Partnering with consumers	5.3 Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: <ol style="list-style-type: none"> Actively involve patients in their own care Meet the patient's information needs Share decision-making
Designing systems to deliver comprehensive care	5.4 The health service organisation has systems for comprehensive care that: <ol style="list-style-type: none"> Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment Provide care to patients in the setting that best meets their clinical needs Ensure timely referral of patients with specialist healthcare needs to relevant services Identify, at all times, the clinician with overall accountability for a patient's care
Collaboration and teamwork	5.5 The health service organisation has processes to: <ol style="list-style-type: none"> Support multidisciplinary collaboration and teamwork Define the roles and responsibilities of each clinician working in a team
	5.6 Clinicians work collaboratively to plan and deliver comprehensive care

Developing the comprehensive care plan

Integrated screening and assessment processes are used in collaboration with patients, carers and families to develop a goal-directed comprehensive care plan.

Item	Action
Planning for comprehensive care	5.7 The health service organisation has processes relevant to the patients using the service and the services provided: <ol style="list-style-type: none"> For integrated and timely screening and assessment That identify the risks of harm in the 'Minimising patient harm' criterion
	5.8 The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems
	5.9 Patients are supported to document clear advance care plans
Screening of risk	5.10 Clinicians use relevant screening processes: <ol style="list-style-type: none"> On presentation, during clinical examination and history taking, and when required during care To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm To identify social and other circumstances that may compound these risks
Clinical assessment	5.11 Clinicians comprehensively assess the conditions and risks identified through the screening process
Developing the comprehensive care plan	5.12 Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record
	5.13 Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: <ol style="list-style-type: none"> Addresses the significance and complexity of the patient's health issues and risks of harm Identifies agreed goals and actions for the patient's treatment and care Identifies the support people a patient wants involved in communications and decision-making about their care Commences discharge planning at the beginning of the episode of care Includes a plan for referral to follow-up services, if appropriate and available Is consistent with best practice and evidence