

## Delivering comprehensive care

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

Item	Action
Using the comprehensive care plan	5.14 The workforce, patients, carers and families work in partnership to: <ol style="list-style-type: none"> <li>Use the comprehensive care plan to deliver care</li> <li>Monitor the effectiveness of the comprehensive care plan in meeting the goals of care</li> <li>Review and update the comprehensive care plan if it is not effective</li> <li>Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur</li> </ol>
Comprehensive care at the end of life	5.15 The health service organisation has processes to identify patients who are at the end of life that are consistent with the <i>National Consensus Statement: Essential elements for safe and high-quality end-of-life care</i> <sup>46</sup>
	5.16 The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice
	5.17 The health service organisation has processes to ensure that current advance care plans: <ol style="list-style-type: none"> <li>Can be received from patients</li> <li>Are documented in the patient's healthcare record</li> </ol>
	5.18 The health service organisation provides access to supervision and support for the workforce providing end-of-life care
	5.19 The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care
	5.20 Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the <i>National Consensus Statement: Essential elements for safe and high-quality end-of-life care</i> <sup>46</sup>

## Minimising patient harm

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

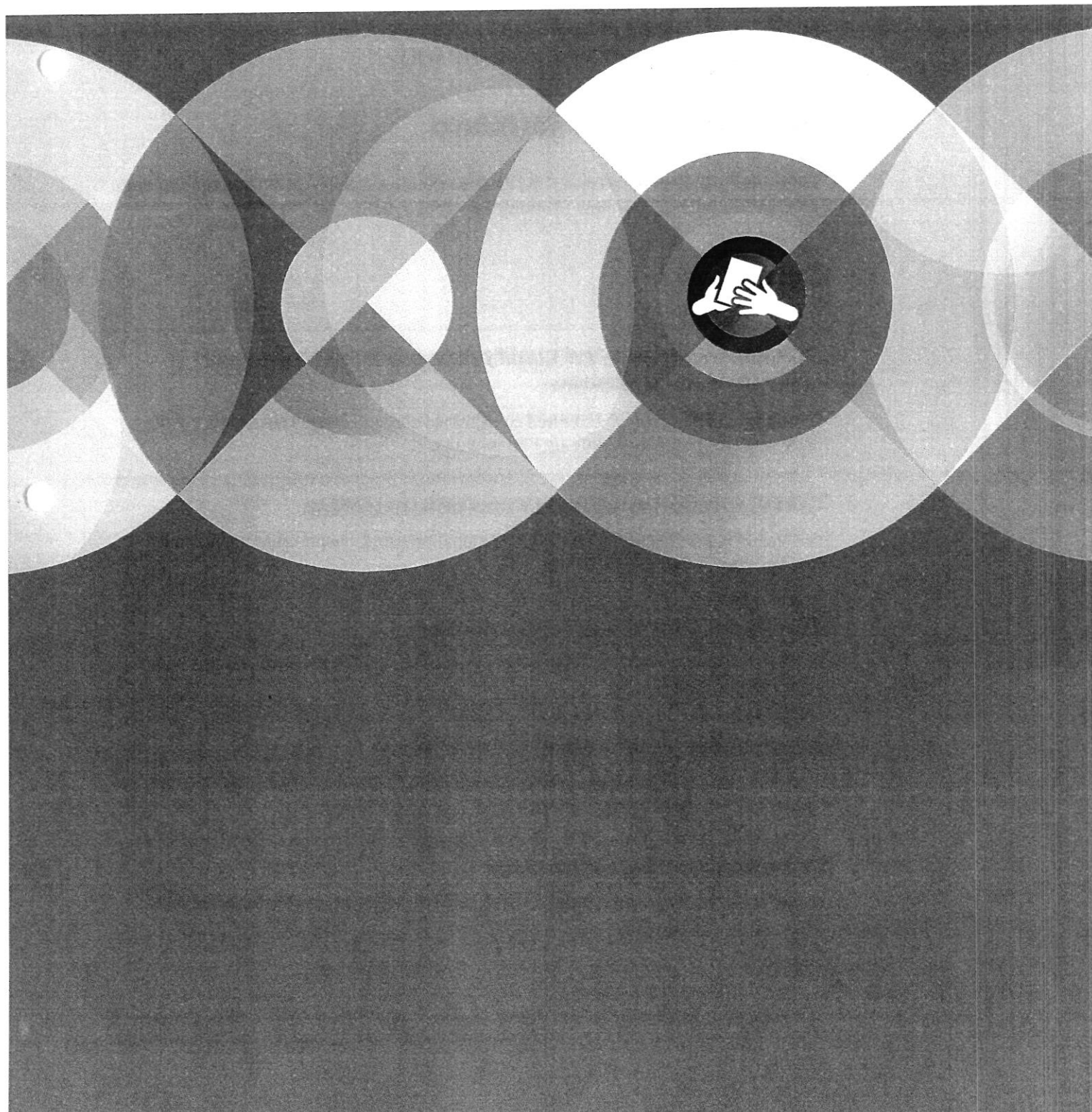
Item	Action
Preventing and managing pressure injuries	5.21 The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines
	5.22 Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency
	5.23 The health service organisation providing services to patients at risk of pressure injuries ensures that: <ol style="list-style-type: none"> <li>Patients, carers and families are provided with information about preventing pressure injuries</li> <li>Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries</li> </ol>
Preventing falls and harm from falls	5.24 The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: <ol style="list-style-type: none"> <li>Falls prevention</li> <li>Minimising harm from falls</li> <li>Post-fall management</li> </ol>
	5.25 The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls
	5.26 Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies
Nutrition and hydration	5.27 The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice
	5.28 The workforce uses the systems for preparation and distribution of food and fluids to: <ol style="list-style-type: none"> <li>Meet patients' nutritional needs and requirements</li> <li>Monitor the nutritional care of patients at risk</li> <li>Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone</li> <li>Support patients who require assistance with eating and drinking</li> </ol>

Item	Action
Preventing delirium and managing cognitive impairment	<p>5.29 The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to:</p> <ul style="list-style-type: none"> <li>a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard<sup>47</sup>, where relevant</li> <li>b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation</li> </ul>
	<p>5.30 Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to:</p> <ul style="list-style-type: none"> <li>a. Recognise, prevent, treat and manage cognitive impairment</li> <li>b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care</li> </ul>
Predicting, preventing and managing self-harm and suicide	<p>5.31 The health service organisation has systems to support collaboration with patients, carers and families to:</p> <ul style="list-style-type: none"> <li>a. Identify when a patient is at risk of self-harm</li> <li>b. Identify when a patient is at risk of suicide</li> <li>c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed</li> </ul>
	<p>5.32 The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts</p>
Predicting, preventing and managing aggression and violence	<p>5.33 The health service organisation has processes to identify and mitigate situations that may precipitate aggression</p>
	<p>5.34 The health service organisation has processes to support collaboration with patients, carers and families to:</p> <ul style="list-style-type: none"> <li>a. Identify patients at risk of becoming aggressive or violent</li> <li>b. Implement de-escalation strategies</li> <li>c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce</li> </ul>

Item	Action
Minimising restrictive practices: restraint	5.35 Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: <ul style="list-style-type: none"> <li>a. Minimise and, where possible, eliminate the use of restraint</li> <li>b. Govern the use of restraint in accordance with legislation</li> <li>c. Report use of restraint to the governing body</li> </ul>
Minimising restrictive practices: seclusion	5.36 Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: <ul style="list-style-type: none"> <li>a. Minimise and, where possible, eliminate the use of seclusion</li> <li>b. Govern the use of seclusion in accordance with legislation</li> <li>c. Report use of seclusion to the governing body</li> </ul>



# Communicating for Safety Standard





## Communicating for Safety Standard

Leaders of a health service organisation set up and maintain systems and processes to support effective communication with patients, carers and families; between multidisciplinary teams and clinicians; and across health service organisations. The workforce uses these systems to effectively communicate to ensure safety.

### Intention of this standard

To ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for patients.

### Criteria

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#### Clinical governance and quality improvement to support effective communication

Systems are in place for effective and coordinated communication that supports the delivery of continuous and safe care for patients.

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#### Correct identification and procedure matching

Systems to maintain the identity of the patient are used to ensure that the patient receives the care intended for them.

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#### Communication at clinical handover

Processes for structured clinical handover are used to effectively communicate about the health care of patients.

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#### Communication of critical information

Systems to effectively communicate critical information and risks when they emerge or change are used to ensure safe patient care.

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#### Documentation of information

Essential information is documented in the healthcare record to ensure patient safety.

## Explanatory notes

Communication is a key safety and quality issue. This standard recognises the importance of effective communication and its role in supporting continuous, coordinated and safe patient care.

Actions in this standard outline the high-risk situations in which effective communication and documentation are required. They include transitions of care (clinical handover), when critical information about a patient's care emerges or changes, and when it is important to ensure that a patient is correctly identified and matched to their intended care.

To meet this standard, health service organisations are required to have systems and processes in place to support effective communication and documentation at these high-risk times. Recognising that communication is a variable process, organisations will need to develop, describe and adapt these systems to their service context to ensure that communication processes are flexible, and appropriate for the nature of the organisation and the consumers who use their service.

Communication is inherent to patient care, and informal communications will occur throughout care delivery. It is not intended that this standard will apply to all communications within an organisation. Rather, the intention is to ensure that systems and processes are in place at key times when effective communication and documentation are critical to patient safety.

Communication is relevant across all of the NSQHS Standards, and many of the actions in this standard rely on, and are linked to, actions in the other NSQHS Standards. In particular, this standard should be applied in conjunction with the Clinical Governance, Partnering with Consumers, Medication Safety, Comprehensive Care, and Recognising and Responding to Acute Deterioration standards.

The review of the NSQHS Standards found that Standard 6: Clinical Handover was often interpreted narrowly as only referring to shift-to-shift handover. However, because effective communication is critical at other key times throughout the delivery of health care, changes have been made to this standard to deal with clinical communications more broadly.

## Clinical governance and quality improvement to support effective communication

Systems are in place for effective and coordinated communication that supports the delivery of continuous and safe care for patients.

Item	Action
Integrating clinical governance	6.1 Clinicians use the safety and quality systems from the Clinical Governance Standard when: <ol style="list-style-type: none"> <li>Implementing policies and procedures to support effective clinical communication</li> <li>Managing risks associated with clinical communication</li> <li>Identifying training requirements for effective and coordinated clinical communication</li> </ol>
Applying quality improvement systems	6.2 The health service organisation applies the quality improvement system from the Clinical Governance Standard when: <ol style="list-style-type: none"> <li>Monitoring the effectiveness of clinical communication and associated processes</li> <li>Implementing strategies to improve clinical communication and associated processes</li> <li>Reporting on the effectiveness and outcomes of clinical communication processes</li> </ol>
Partnering with consumers	6.3 Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: <ol style="list-style-type: none"> <li>Actively involve patients in their own care</li> <li>Meet the patient's information needs</li> <li>Share decision-making</li> </ol>
Organisational processes to support effective communication	6.4 The health service organisation has clinical communications processes to support effective communication when: <ol style="list-style-type: none"> <li>Identification and procedure matching should occur</li> <li>All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge</li> <li>Critical information about a patient's care, including information on risks, emerges or changes</li> </ol>

## Correct identification and procedure matching

Systems to maintain the identity of the patient are used to ensure that the patient receives the care intended for them.

Item	Action
Correct identification and procedure matching	6.5 The health service organisation: <ul style="list-style-type: none"><li>a. Defines approved identifiers for patients according to best-practice guidelines</li><li>b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated</li></ul>
	6.6 The health service organisation specifies the: <ul style="list-style-type: none"><li>a. Processes to correctly match patients to their care</li><li>b. Information that should be documented about the process of correctly matching patients to their intended care</li></ul>

## Communication at clinical handover

Processes for structured clinical handover are used to effectively communicate about the health care of patients.

Item	Action
Clinical handover	<p>6.7 The health service organisation, in collaboration with clinicians, defines the:</p> <ul style="list-style-type: none"> <li>a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines</li> <li>b. Risks relevant to the service context and the particular needs of patients, carers and families</li> <li>c. Clinicians who are involved in the clinical handover</li> </ul> <hr/> <p>6.8 Clinicians use structured clinical handover processes that include:</p> <ul style="list-style-type: none"> <li>a. Preparing and scheduling clinical handover</li> <li>b. Having the relevant information at clinical handover</li> <li>c. Organising relevant clinicians and others to participate in clinical handover</li> <li>d. Being aware of the patient's goals and preferences</li> <li>e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient</li> <li>f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care</li> </ul>

## Communication of critical information

Systems to effectively communicate critical information and risks when they emerge or change are used to ensure safe patient care.

Item	Action
Communicating critical information	6.9 Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: <ul style="list-style-type: none"><li>a. Clinicians who can make decisions about care</li><li>b. Patients, carers and families, in accordance with the wishes of the patient</li></ul>
	6.10 The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians

## Documentation of information

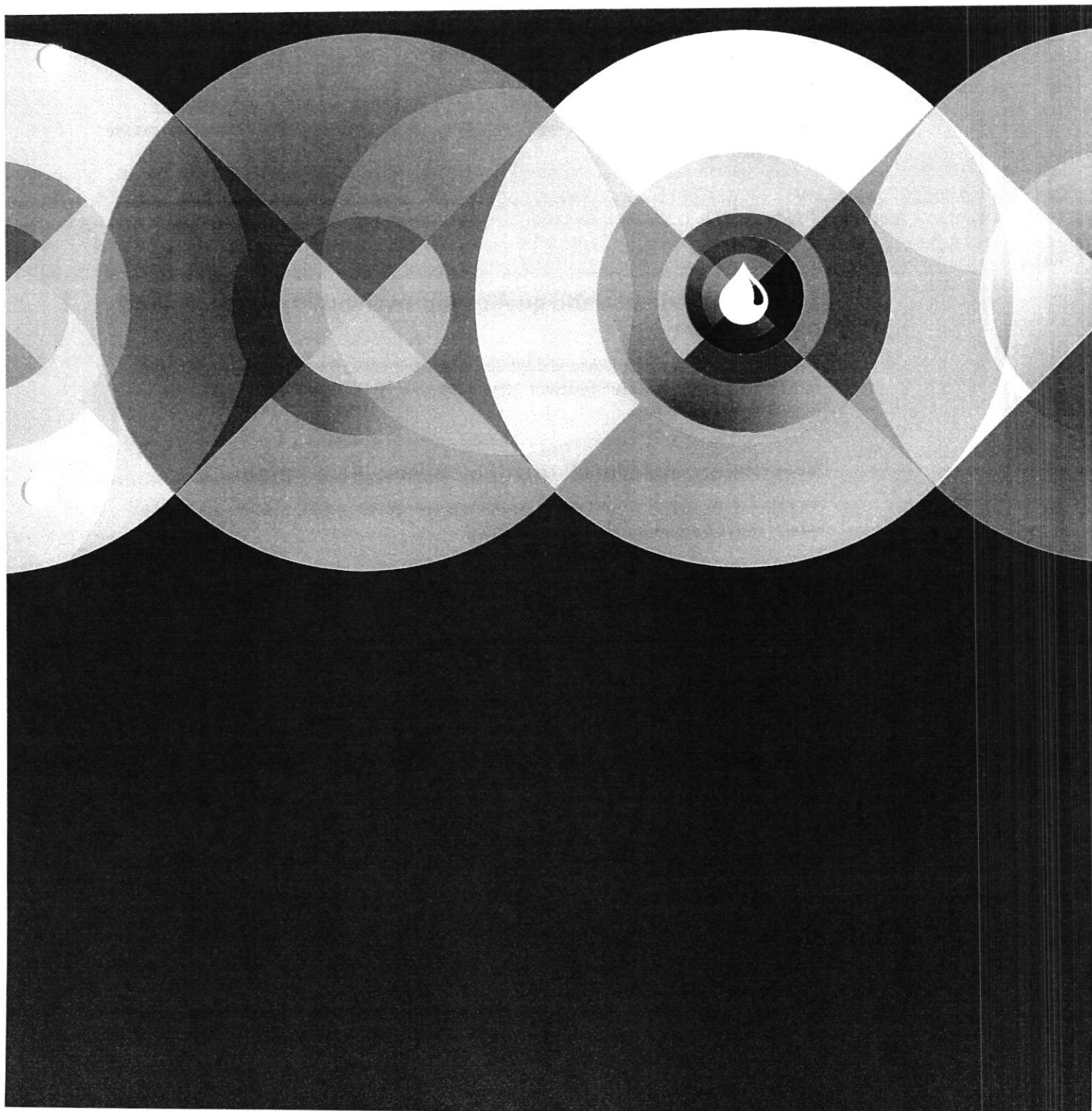
Essential information is documented in the healthcare record to ensure patient safety.

Item	Action
Documentation of information	6.11 The health service organisation has processes to contemporaneously document information in the healthcare record, including: <ul style="list-style-type: none"><li>a. Critical information, alerts and risks</li><li>b. Reassessment processes and outcomes</li><li>c. Changes to the care plan</li></ul>



7

# Blood Management Standard





## Blood Management Standard

Leaders of a health service organisation describe, implement and monitor systems to ensure the safe, appropriate, efficient and effective care of patients' own blood, as well as other blood and blood products. The workforce uses the blood product safety systems.

### Intention of this standard

To identify risks, and put in place strategies, to ensure that a patient's own blood is optimised and conserved, and that any blood and blood products the patient receives are appropriate and safe.

### Criteria

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#### Clinical governance and quality improvement to support blood management

Organisation-wide governance and quality improvement systems are used to ensure safe and high-quality care of patients' own blood, and to ensure that blood product requirements are met.

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#### Prescribing and clinical use of blood and blood products

The clinical use of blood and blood products is appropriate, and strategies are used to reduce the risks associated with transfusion.

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#### Managing the availability and safety of blood and blood products

Strategies are used to effectively manage the availability and safety of blood and blood products.

## Explanatory notes

This standard is a revision of Standard 7: Blood and Blood Products in the NSQHS Standards (1st ed.). The actions in this standard have been refined to:

- Focus on the patient receiving blood and blood products, rather than only on the blood and blood products
- Focus on effectively optimising and conserving a patient's own blood, reducing the unnecessary risk of exposure to blood products and associated adverse events
- More explicitly consider identified gaps in practice
- Remove duplications in the standard
- More specifically reflect national policy agreements about blood and blood products.

Treatment with blood and blood products can be lifesaving. However, using biological materials, blood and blood products has some inherent risks. Actions to minimise these risks include screening and testing donors and donated blood; and ensuring that all treatment options, and their risks and benefits, are considered before deciding to transfuse.

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

- Making clinical decisions
- Obtaining recipient samples and assessing compatibility with donated products
- Safely administering the products to the intended recipient
- Storing and disposing of blood and blood products
- Reporting and investigating any adverse reactions or incidents.

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

The standard supports the principles of good patient blood management that provide for clinically appropriate and safe management of patients while avoiding transfusion of blood and blood products, and its associated risks.

Research and practice show that the dual approach of implementing governance structures and evidence-based clinical guidelines is the most effective way to ensure the appropriate and safe use of blood and blood products.

## Clinical governance and quality improvement to support blood management

Organisation-wide governance and quality improvement systems are used to ensure safe and high-quality care of patients' own blood, and to ensure that blood product requirements are met.

Item	Action
Integrating clinical governance	7.1 Clinicians use the safety and quality systems from the Clinical Governance Standard when: <ol style="list-style-type: none"> <li>Implementing policies and procedures for blood management</li> <li>Managing risks associated with blood management</li> <li>Identifying training requirements for blood management</li> </ol>
Applying quality improvement systems	7.2 The health service organisation applies the quality improvement system from the Clinical Governance Standard when: <ol style="list-style-type: none"> <li>Monitoring the performance of the blood management system</li> <li>Implementing strategies to improve blood management and associated processes</li> <li>Reporting on the outcomes of blood management</li> </ol>
Partnering with consumers	7.3 Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: <ol style="list-style-type: none"> <li>Actively involve patients in their own care</li> <li>Meet the patient's information needs</li> <li>Share decision-making</li> </ol>

## Prescribing and clinical use of blood and blood products

The clinical use of blood and blood products is appropriate, and strategies are used to reduce the risks associated with transfusion.

Item	Action
Optimising and conserving patients' own blood	7.4 Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: <ol style="list-style-type: none"> <li>Optimising patients' own red cell mass, haemoglobin and iron stores</li> <li>Identifying and managing patients with, or at risk of, bleeding</li> <li>Determining the clinical need for blood and blood products, and related risks</li> </ol>
Documenting	7.5 Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record
Prescribing and administering blood and blood products	7.6 The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria
Reporting adverse events	7.7 The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria 7.8 The health service organisation participates in haemovigilance activities, in accordance with the national framework

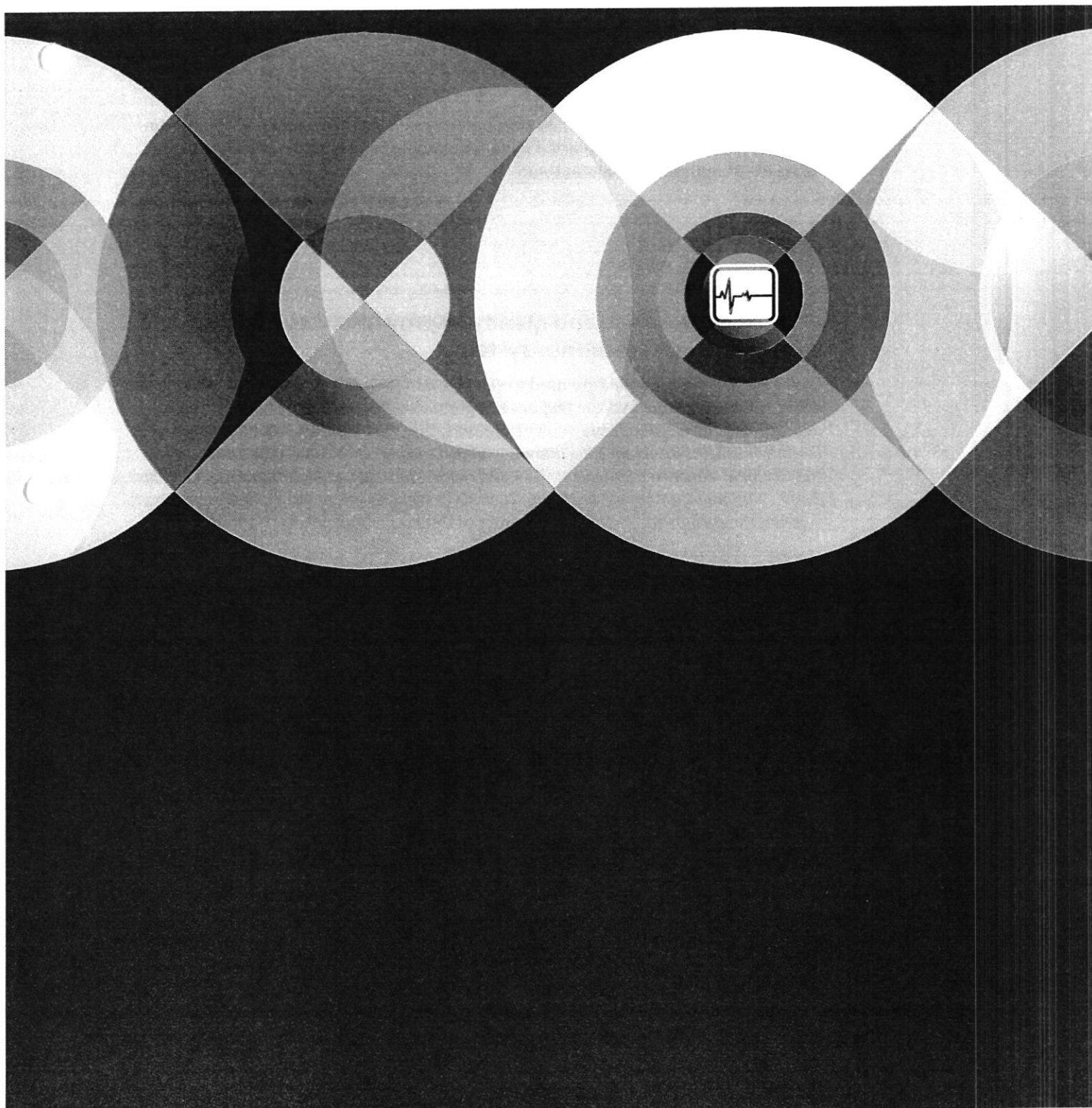
## Managing the availability and safety of blood and blood products

Strategies are used to effectively manage the availability and safety of blood and blood products.

Item	Action
Storing, distributing and tracing blood and blood products	<p>7.9 The health service organisation has processes:</p> <ul style="list-style-type: none"> <li>a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely</li> <li>b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer</li> </ul>
Availability of blood	<p>7.10 The health service organisation has processes to:</p> <ul style="list-style-type: none"> <li>a. Manage the availability of blood and blood products to meet clinical need</li> <li>b. Eliminate avoidable wastage</li> <li>c. Respond in times of shortage</li> </ul>



# Recognising and Responding to Acute Deterioration Standard





# Recognising and Responding to Acute Deterioration Standard

Leaders of a health service organisation set up and maintain systems for recognising and responding to acute deterioration. The workforce uses the recognition and response systems.

## Intention of this standard

To ensure that a person's acute deterioration is recognised promptly and appropriate action is taken. Acute deterioration includes physiological changes, as well as acute changes in cognition and mental state.

## Criteria

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### Clinical governance and quality improvement to support recognition and response systems

Organisation-wide systems are used to support and promote detection and recognition of acute deterioration, and the response to patients whose condition acutely deteriorates. These systems are consistent with the *National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration*<sup>48</sup>, the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*<sup>46</sup>, *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state*, and the Delirium Clinical Care Standard.<sup>47</sup>

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### Detecting and recognising acute deterioration, and escalating care

Acute deterioration is detected and recognised, and action is taken to escalate care.

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### Responding to acute deterioration

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



## Explanatory notes

Serious adverse events such as unexpected death and cardiac arrest are often preceded by observable physiological and clinical abnormalities.<sup>49</sup> Other serious events such as suicide or aggression are also often preceded by observed or reported changes in a person's behaviour or mood that can indicate a deterioration in their mental state.

Early identification of deterioration may improve outcomes and lessen the intervention required to stabilise patients whose condition deteriorates in hospital.<sup>50</sup>

There is evidence that the warning signs of clinical deterioration are not always identified or acted on appropriately.<sup>51</sup> The organisation and workforce factors that contribute to a failure to recognise and respond to a deteriorating patient are complex and overlapping. They include<sup>52-54</sup>:

- Not monitoring physiological observations consistently or not understanding observed changes in physiological observations
- Lack of knowledge of signs and symptoms that could signal deterioration
- Lack of awareness of the potential for a person's mental state to deteriorate
- Lack of awareness of delirium, and the benefits of early recognition and treatment<sup>55</sup>
- Lack of formal systems for responding to deterioration
- Lack of skills to manage patients who are deteriorating
- Failure to communicate clinical concerns, including during clinical handover
- Attributing physical or mental symptoms to an existing condition, such as dementia or a mental health condition.<sup>56,57</sup>

Systems to recognise deterioration early and respond to it appropriately need to deal with all of these factors, and need to be applied across a healthcare facility. The *National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration*<sup>48</sup>, which was developed by the Australian Commission on Safety and Quality in Health Care (the Commission), has been endorsed by Australian health ministers as the national approach for recognising and responding to clinical deterioration in acute care facilities in Australia. It provides a consistent national model to support clinical, organisational and strategic efforts to improve recognition and response systems. This standard builds on the national consensus statement to drive implementation in acute care facilities.

The Commission's *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state* outlines the principles that underpin safe and effective responses to deterioration in a person's mental state, and provides information about the interrelated components that a health service organisation can implement to provide this care.

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

The Commission's Delirium Clinical Care Standard<sup>47</sup> highlights the importance of being alert to, and assessing, delirium with any reported or observed changes in a person's mental state.

## Clinical governance and quality improvement to support recognition and response systems

Organisation-wide systems are used to support and promote detection and recognition of acute deterioration, and the response to patients whose condition acutely deteriorates. These systems are consistent with the *National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration*<sup>48</sup>, the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*<sup>46</sup>, the *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state*, and the Delirium Clinical Care Standard.<sup>47</sup>

Item	Action
Integrating clinical governance	8.1 Clinicians use the safety and quality systems from the Clinical Governance Standard when: <ol style="list-style-type: none"> <li>Implementing policies and procedures for recognising and responding to acute deterioration</li> <li>Managing risks associated with recognising and responding to acute deterioration</li> <li>Identifying training requirements for recognising and responding to acute deterioration</li> </ol>
Applying quality improvement systems	8.2 The health service organisation applies the quality improvement system from the Clinical Governance Standard when: <ol style="list-style-type: none"> <li>Monitoring recognition and response systems</li> <li>Implementing strategies to improve recognition and response systems</li> <li>Reporting on effectiveness and outcomes of recognition and response systems</li> </ol>
Partnering with consumers	8.3 Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: <ol style="list-style-type: none"> <li>Actively involve patients in their own care</li> <li>Meet the patient's information needs</li> <li>Share decision-making</li> </ol>

## Detecting and recognising acute deterioration, and escalating care

Acute deterioration is detected and recognised, and action is taken to escalate care.

Item	Action
Recognising acute deterioration	8.4 The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: <ol style="list-style-type: none"> <li>Document individualised vital sign monitoring plans</li> <li>Monitor patients as required by their individualised monitoring plan</li> <li>Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient</li> </ol>
	8.5 The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: <ol style="list-style-type: none"> <li>Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium</li> <li>Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan</li> <li>Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported</li> <li>Determine the required level of observation</li> <li>Document and communicate observed or reported changes in mental state</li> </ol>
Escalating care	8.6 The health service organisation has protocols that specify criteria for escalating care, including: <ol style="list-style-type: none"> <li>Agreed vital sign parameters and other indicators of physiological deterioration</li> <li>Agreed indicators of deterioration in mental state</li> <li>Agreed parameters and other indicators for calling emergency assistance</li> <li>Patient pain or distress that is not able to be managed using available treatment</li> <li>Worry or concern in members of the workforce, patients, carers and families about acute deterioration</li> </ol>
	8.7 The health service organisation has processes for patients, carers or families to directly escalate care
	8.8 The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance
	8.9 The workforce uses the recognition and response systems to escalate care

## Responding to acute deterioration

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

Item	Action
Responding to deterioration	8.10 The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration
	8.11 The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support
	8.12 The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated
	8.13 The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration

# Glossary

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

**acute deterioration:** physiological, psychological or cognitive changes that may indicate a worsening of the patient's health status; this may occur across hours or days.

**advance care plan:** a plan that states preferences about health and personal care, and preferred health outcomes. An advance care planning discussion will often result in an advance care plan. Plans should be made on the person's behalf and prepared from the person's perspective to guide decisions about care.<sup>58</sup>

**advanced life support:** the preservation or restoration of life by the establishment and/or maintenance of airway, breathing and circulation using invasive techniques such as defibrillation, advanced airway management, intravenous access and drug therapy.<sup>48</sup>

**adverse drug reaction:** a response to a medicine that is noxious and unintended, and occurs at doses normally used or tested in humans for the prophylaxis, diagnosis or therapy of disease, or for the modification of physiological function.<sup>59</sup> An allergy is a type of adverse drug reaction.

**adverse event:** an incident that results, or could have resulted, in harm to a patient or consumer. A near miss is a type of adverse event. *See also* near miss

**alert:** warning of a potential risk to a patient.

**allergy:** occurs when a person's immune system reacts to allergens in the environment that are harmless for most people. Typical allergens include some medicines, foods and latex.<sup>60</sup> An allergen may be encountered through inhalation, ingestion, injection or skin contact.<sup>61</sup> A medicine allergy is one type of adverse drug reaction.

**antimicrobial:** a chemical substance that inhibits or destroys bacteria, viruses or fungi, and can be safely administered to humans and animals.<sup>62</sup>

**antimicrobial resistance:** failure of an antimicrobial to inhibit a microorganism at the antimicrobial concentrations usually achieved over time with standard dosing regimens.<sup>62</sup>

**antimicrobial stewardship:** an ongoing effort by a health service organisation to reduce the risks associated with increasing antimicrobial resistance and to extend the effectiveness of antimicrobial treatments. It may incorporate several strategies, including monitoring and review of antimicrobial use.<sup>62</sup>

**approved identifiers:** items of information accepted for use in identification, including family and given names, date of birth, sex, address, healthcare record number and Individual Healthcare Identifier. Health service organisations and clinicians are responsible for specifying the approved items for identification and procedure matching. Identifiers such as room or bed number should not be used.

**aseptic technique:** a technique that aims to prevent microorganisms on hands, surfaces and equipment from being introduced to susceptible sites. Unlike sterile techniques, aseptic techniques can be achieved in typical ward and home settings.<sup>63</sup>

**assessment:** a clinician's evaluation of a disease or condition based on the patient's subjective report of the symptoms and course of the illness or condition, and the clinician's objective findings. These findings include data obtained through laboratory tests, physical examination and medical history; and information reported by carers, family members and other members of the healthcare team. The assessment is an essential element of a comprehensive care plan.<sup>41</sup>

**audit (clinical):** a systematic review of clinical care against a predetermined set of criteria.<sup>64</sup>

**Australian Charter of Healthcare Rights:** specifies the key rights of patients when seeking or receiving healthcare services. It was endorsed by health ministers in 2008.<sup>16</sup>

**Australian Open Disclosure Framework:** endorsed by health ministers in 2013, it provides a framework for health service organisations and clinicians to communicate openly with patients when health care does not go to plan.<sup>6</sup>

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**best possible medication history:** a list of all the medicines a patient is using at presentation. The list includes the name, dose, route and frequency of the medicine, and is documented on a specific form or in a specific place. All prescribed, over-the-counter and complementary medicines should be included. This history is obtained by a trained clinician interviewing the patient (and/or their carer) and is confirmed, where appropriate, by using other sources of medicines information.<sup>65</sup>

**best practice:** when the diagnosis, treatment or care provided is based on the best available evidence, which is used to achieve the best possible outcomes for patients.

**best-practice guidelines:** a set of recommended actions that are developed using the best available evidence. They provide clinicians with evidence-informed recommendations that support clinical practice, and guide clinician and patient decisions about appropriate health care in specific clinical practice settings and circumstances.<sup>66</sup>

**blood management:** a process that improves outcomes for patients by improving their medical and surgical management in ways that boost and conserve their own blood, and ensure that any blood and blood products patients receive are appropriate and safe.

**blood products:** the products derived from fresh blood – red blood cells and platelets, fresh frozen plasma, cryoprecipitate and cryodepleted plasma, plasma-derived blood products, and recombinant blood products.

**business decision-making:** decision-making regarding service planning and management for a health service organisation. It covers the purchase of building finishes, equipment and plant; program maintenance; workforce training for safe handling of equipment and plant; and all issues for which business decisions are taken that might affect the safety and wellbeing of patients, visitors and the workforce.

**care pathway:** a complex intervention that supports mutual decision-making and organisation of care processes for a well-defined group of patients during a well-defined period.<sup>67</sup>

**carer:** a person who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail or aged. An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are paid, a volunteer for an organisation, or caring as part of a training or education program.<sup>68</sup>

**clinical care standards:** nationally relevant standards developed by the Australian Commission on Safety and Quality in Health Care, and agreed by health ministers, that identify and define the care people should expect to be offered or receive for specific conditions.

**clinical communication:** the exchange of information about a person's care that occurs between treating clinicians, patients, carers and families, and other members of a multidisciplinary team. Communication can be through several different channels, including face-to-face meetings, telephone, written notes or other documentation, and electronic means. *See also* effective clinical communication, clinical communication process

**clinical communication process:** the method of exchanging information about a person's care. It involves several components, and includes the sender (the person who is communicating the information), the receiver (the person receiving the information), the message (the information that is communicated) and the channel of communication. Various channels of communication can be used, including verbal (face to face, over the phone, through Skype), written and electronic.<sup>69</sup> Sending and receipt of the information can occur at the same time, such as verbal communication between two clinicians, or at different times, such as non-verbal communication during which a clinician documents a patient's goals, assessments and comprehensive care plan in the healthcare record, which is later read by another clinician.



**clinical governance:** 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 safe, effective and high-quality services. Clinical governance systems provide confidence to the community and the healthcare organisation that systems are in place to deliver safe and high-quality health care.

**clinical handover:** the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.<sup>70</sup>

**clinical information system:** a computerised healthcare record and management system that is used by clinicians in healthcare settings. Clinical information systems are typically organisation-wide, have high levels of security and access, and have roles and rights (for example, prescribing medicines, reviewing laboratory results, administering intravenous fluids) specified for each clinical and administrative user. Clinical information systems enable electronic data entry and data retrieval by clinicians.<sup>71</sup>

**clinical leaders:** clinicians with management or leadership roles in a health service organisation who can use their position or influence to change behaviour, practice or performance. Examples are directors of clinical services, heads of units and clinical supervisors.

**clinician:** a healthcare provider, trained as a health professional, including registered and non-registered practitioners. Clinicians may provide care within a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They include nurses, midwives, medical practitioners, allied health practitioners, technicians, scientists and other clinicians who provide health care, and students who provide health care under supervision.

**cognitive impairment:** deficits in one or more of the areas of memory, communication, attention, thinking and judgement. This can be temporary or permanent. It can affect a person's understanding, their ability to carry out tasks or follow instructions, their recognition of people or objects, how they relate to others and how they interpret the

environment. Dementia and delirium are common forms of cognitive impairment seen in hospitalised older patients.<sup>41</sup> Cognitive impairment can also be a result of several other conditions, such as acquired brain injury, a stroke, intellectual disability, licit or illicit drug use, or medicines.

**cold chain management:** the system of transporting and storing temperature-sensitive medicines and other therapies, such as blood and blood products, within their defined temperature range at all times, from point of origin (manufacture) to point of administration, to ensure that the integrity of the product is maintained.

**communicable:** an infection that can be transferred from one person or host to another.

**comprehensive care:** health care that is based on identified goals for the episode of care. These goals are aligned with the patient's expressed preferences and healthcare needs, consider the impact of the patient's health issues on their life and wellbeing, and are clinically appropriate.

**comprehensive care plan:** a document describing agreed goals of care, and outlining planned medical, nursing and allied health activities for a patient. Comprehensive care plans reflect shared decisions made with patients, carers and families about the tests, interventions, treatments and other activities needed to achieve the goals of care. The content of comprehensive care plans will depend on the setting and the service that is being provided, and may be called different things in different health service organisations. For example, a care or clinical pathway for a specific intervention may be considered a comprehensive care plan.

**consumer:** a person who has used, or may potentially use, health services, or is a carer for a patient using health services. A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision-making processes.<sup>72</sup>

**contemporaneously (documenting information):** recording information in the healthcare record as soon as possible after the event that is being documented.<sup>73</sup>

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**credentialing:** the formal process used by a health service organisation to verify the qualifications, experience, professional standing, competencies and other relevant professional attributes of clinicians, so that the organisation can form a view about the clinician's competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments.<sup>74</sup>

**critical equipment:** items that confer a high risk for infection if they are contaminated with any microorganism, and must be sterile at the time of use. They include any objects that enter sterile tissue or the vascular system, because any microbial contamination could transmit disease.<sup>18</sup>

**critical information:** information that has a considerable impact on a patient's health, wellbeing or ongoing care (physical or psychological). The availability of critical information may require a clinician to reassess or change a patient's comprehensive care plan.

**current medicines list:** See medicines list

**decision support tools:** tools that can help clinicians and consumers to draw on available evidence when making clinical decisions. The tools have a number of formats. Some are explicitly designed to enable shared decision making (for example, decision aids). Others provide some of the information needed for some components of the shared decision-making process (for example, risk calculators, evidence summaries), or provide ways of initiating and structuring conversations about health decisions (for example, communication frameworks, question prompt lists).<sup>75</sup> See also shared decision making

**de-escalation strategies:** psychosocial techniques that aim to reduce violent or disruptive behaviour. They are intended to reduce or eliminate the risk of violence during the escalation phase, using verbal and non-verbal communication skills. De-escalation is about establishing rapport to gain the patient's trust, minimising restriction to protect their self-esteem, appearing externally calm and self-aware in the face of aggressive behaviour, and intuitively identifying creative and flexible interventions that will reduce the need for aggression.<sup>76</sup>

**definitive management:** the treatment plan for a disease or disorder that has been chosen as the best one for the patient after all other choices have been considered.<sup>77</sup>

**delirium:** an acute disturbance of consciousness, attention, cognition and perception that tends to fluctuate during the day.<sup>78</sup> It is a serious condition that can be prevented in 30–40% of cases, and should be treated promptly and appropriately. Hospitalised older people with existing dementia are at the greatest risk of developing delirium. Delirium can be hyperactive (the person has heightened arousal; or can be restless, agitated and aggressive) or hypoactive (the person is withdrawn, quiet and sleepy).<sup>79</sup>

**deterioration in mental state:** a negative change in a person's mood or thinking, marked by a change in behaviour, cognitive function, perception or emotional state. Changes can be gradual or acute; they can be observed by members of the workforce, or reported by the person themselves, or their family or carers. Deterioration in a person's mental state can be related to several predisposing or precipitating factors, including mental illness, psychological or existential stress, physiological changes, cognitive impairment (including delirium), intoxication, withdrawal from substances, and responses to social context and environment.

**diversity:** the varying social, economic and geographic circumstances of consumers who use, or may use, the services of a health service organisation, as well as their cultural backgrounds, religions, beliefs, practices, languages spoken and sexualities (diversity in sexualities is currently referred to as lesbian, gay, bisexual, transgender and intersex, or LGBTI).

**effective clinical communication:** two-way, coordinated and continuous communication that results in the timely, accurate and appropriate transfer of information. Effective communication is critical to, and supports, the delivery of safe patient care.

**emergency assistance:** clinical advice or assistance provided when a patient's condition has deteriorated severely. This assistance is provided as part of the rapid response system, and is additional to the care provided by the attending clinician or team.<sup>48</sup>

**end of life:** the period when a patient is living with, and impaired by, a fatal condition, even if the



trajectory is ambiguous or unknown. This period may be years in the case of patients with chronic or malignant disease, or very brief in the case of patients who suffer acute and unexpected illnesses or events, such as sepsis, stroke or trauma.<sup>80</sup>

**environment:** the physical surroundings in which health care is delivered, including the building, fixtures, fittings, and services such as air and water supply. Environment can also include other patients, consumers, visitors and the workforce.

**episode of care:** a phase of treatment. There may be more than one episode of care within the one hospital stay. An episode of care ends when the principal clinical intent changes or when the patient is formally separated from the facility.<sup>81</sup>

**escalation protocol:** the protocol that sets out the organisational response required for different levels of abnormal physiological measurements or other observed deterioration. The protocol applies to the care of all patients at all times.<sup>48</sup>

**fall:** an event that results in a person coming to rest inadvertently on the ground or floor, or another lower level.<sup>82</sup>

**goals of care:** clinical and other goals for a patient's episode of care that are determined in the context of a shared decision-making process.

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

**governing body:** a board, chief executive officer, organisation owner, partnership or other highest level of governance (individual or group of individuals) that has ultimate responsibility for

strategic and operational decisions affecting safety and quality in a health service organisation.

**guidelines:** clinical practice guidelines are systematically developed statements to assist clinician and consumer decisions about appropriate health care for specific circumstances.<sup>83</sup>

**haemovigilance:** a set of surveillance procedures covering the entire blood transfusion chain, from the donation and processing of blood and its components, to their provision and transfusion to patients, to their follow-up. It includes monitoring, reporting, investigating and analysing adverse events related to the donation, processing and transfusion of blood, as well as development and implementation of recommendations to prevent the occurrence or recurrence of adverse events.<sup>84</sup>

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

**health care:** the prevention, treatment and management of illness and injury, and the preservation of mental and physical wellbeing through the services offered by clinicians, such as medical, nursing and allied health professionals.<sup>6</sup>

**healthcare-associated infections:** infections that are acquired in healthcare facilities (nosocomial infections) or that occur as a result of healthcare interventions (iatrogenic infections). Healthcare-associated infections may manifest after people leave the healthcare facility.<sup>18</sup>

**healthcare record:** includes a record of the patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care.

**health literacy:** the Australian Commission on Safety and Quality in Health Care separates health literacy into two components – individual health literacy and the health literacy environment.

Individual health literacy is the skills, knowledge, motivation and capacity of a consumer to access, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action.

The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the healthcare system, which affect the ways in which consumers

access, understand, appraise and apply health-related information and services.<sup>85</sup>

**health service organisation:** a separately constituted health service that is responsible for implementing clinical governance, administration and financial management of a service unit or service units providing health care at the direction of the governing body. A service unit involves a group of clinicians and others working in a systematic way to deliver health care to patients. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.

**higher risk (patients at higher risk of harm):** a patient with multiple factors or a few specific factors that result in their being more vulnerable to harm from health care or the healthcare system. Risk factors may include having chronic clinical conditions; having language barriers; being of Aboriginal or Torres Strait Islander background; having low health literacy; being homeless; or being of diverse gender identities and experiences, bodies, relationships and sexualities (currently referred to as lesbian, gay, bisexual, transgender and intersex, or LGBTI).

**high-risk medicines:** medicines that have an increased risk of causing significant patient harm or death if they are misused or used in error. High-risk medicines may vary between hospitals and other healthcare settings, depending on the types of medicines used and patients treated. Errors with these medicines are not necessarily more common than with other medicines. Because they have a low margin of safety, the consequences of errors with high-risk medicines can be more devastating.<sup>86,87</sup> At a minimum, the following classes of high-risk medicines should be considered:

- Medicines with a narrow therapeutic index
- Medicines that present a high risk when other system errors occur, such as administration via the wrong route.

**hygienic environment:** an environment in which practical prevention and control measures are used to reduce the risk of infection from contamination by microbes.

**incident (clinical):** an event or circumstance that resulted, or could have resulted, in unintended or unnecessary harm to a patient or consumer; or a

complaint, loss or damage. An incident may also be a near miss. *See also* near miss

**infection:** the invasion and reproduction of pathogenic (disease-causing) organisms inside the body. This may cause tissue injury and disease.<sup>88</sup>

**informed consent:** a process of communication between a patient and clinician about options for treatment, care processes or potential outcomes. This communication results in the patient's authorisation or agreement to undergo a specific intervention or participate in planned care.<sup>89</sup> The communication should ensure that the patient has an understanding of the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.<sup>90</sup>

**injury:** damage to tissues caused by an agent or circumstance.<sup>91</sup>

**invasive medical devices:** devices inserted through skin, mucosal barrier or internal cavity, including central lines, peripheral lines, urinary catheters, chest drains, peripherally inserted central catheters and endotracheal tubes.

**jurisdictional requirements:** systematically developed statements from state and territory governments about appropriate healthcare or service delivery for specific circumstances.<sup>83</sup> Jurisdictional requirements encompass a number of types of documents from state and territory governments, including legislation, regulations, guidelines, policies, directives and circulars. Terms used for each document may vary by state and territory.

**leadership:** having a vision of what can be achieved, and then communicating this to others and evolving strategies for realising the vision. Leaders motivate people, and can negotiate for resources and other support to achieve goals.<sup>92</sup>

**local community:** the people living in a defined geographic region or from a specific group who receive services from a health service organisation.

**mandatory:** required by law or mandate in regulation, policy or other directive; compulsory.<sup>93</sup>

**medication management:** practices used to manage the provision of medicines. Medication management has also been described as a cycle, pathway or system, which is complex and involves a number of different clinicians. The patient is the central focus. The system includes manufacturing, compounding, procuring, dispensing, prescribing, storing, administering, supplying and monitoring the effects of medicines. It also includes decision-making, and rules, guidelines, support tools, policies and procedures that are in place to direct the use of medicines.<sup>94</sup>

**medication reconciliation:** a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines, and matching the medicines the patient should be prescribed to those they are actually prescribed. Any discrepancies are discussed with the prescriber, and reasons for changes to therapy are documented and communicated when care is transferred. Medication review may form part of the medication reconciliation process.

**medication review:** a systematic assessment of medication management for an individual patient that aims to optimise the patient's medicines and outcomes of therapy by providing a recommendation or making a change.<sup>95</sup> Medication review may be part of medication reconciliation.

**medicine:** a chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental wellbeing of people. These include prescription, non-prescription, investigational, clinical trial and complementary medicines, irrespective of how they are administered.<sup>96</sup>

**medicine-related problem:** any event involving treatment with a medicine that has a negative effect on a patient's health or prevents a positive outcome. Consideration should be given to disease-specific, laboratory test-specific and patient-specific information. Medicine-related problems include issues with medicines such as:

- Underuse
- Overuse
- Use of inappropriate medicines (including therapeutic duplication)
- Adverse drug reactions, including interactions (medicine-medicine, medicine-disease, medicine-nutrient, medicine-laboratory test)
- Noncompliance.<sup>97,98</sup>

**medicines list:** prepared by a clinician, a medicines list contains, at a minimum:

- All medicines a patient is taking, including over-the-counter, complementary, prescription and non-prescription medicines; for each medicine, the medicine name, form, strength and directions for use must be included<sup>94</sup>
- Any medicines that should not be taken by the patient, including those causing allergies and adverse drug reactions; for each allergy or adverse drug reaction, the medicine name, the reaction type and the date on which the reaction was experienced should be included.

Ideally, a medicines list also includes the intended use (indication) for each medicine.

It is expected that the medicines list is updated and correct at the time of transfer (including clinical handover) or when services cease, and that it is tailored to the audience for whom it is intended (that is, patient or clinician).<sup>99</sup>

**mental state:** See deterioration in mental state

**minimum information content:** the content of information that must be contained and transferred in a particular type of clinical handover. What is included as part of the minimum information content will depend on the context and reason for the handover or communication.<sup>100</sup>

**multidisciplinary team:** a team including clinicians from multiple disciplines who work together to deliver comprehensive care that deals with as many of the patient's health and other needs as possible. The team may operate under one organisational umbrella or may be from several organisations brought together as a unique team. As a patient's condition changes, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient.<sup>101</sup> Multidisciplinary care includes interdisciplinary care. (A discipline is a branch of knowledge within the health system.<sup>102</sup>)

**My Health Record (formerly known as a personally controlled electronic device):** the secure online summary of a consumer's health information, managed by the System Operator of the national My Health Record system (the Australian Digital Health Agency). Clinicians are able to share health clinical documents to a consumer's My Health Record, according to the consumer's access controls. These may include information on medical history and treatments, diagnoses, medicines and allergies.<sup>103</sup>

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**national patient identifier:** a unique 16-digit number that is used to identify individuals who receive or may receive health care in the Australian healthcare system. Also known as an Individual Healthcare Identifier (IHI).<sup>103</sup>

**national provider identifier:** a unique 16-digit number that is used to identify individual clinicians or organisations that deliver health care in the Australian healthcare setting. For individuals, it is also known as a Healthcare Provider Identifier – Individual (HPI-I); for organisations, it is also known as a Healthcare Provider Identifier – Organisation (HPI-O).<sup>103</sup>

**near miss:** an incident or potential incident that was averted and did not cause harm, but had the potential to do so.<sup>104</sup>

**nutrition care plan:** a plan to meet the nutrition and hydration needs of a patient. The nutrition care plan is developed for the patient after their nutrition and hydration needs have been assessed.

**open disclosure:** an open discussion with a patient and carer about an incident that resulted in harm to the patient while receiving health care. The criteria of open disclosure are an expression of regret, and a factual explanation of what happened, the potential consequences, and the steps taken to manage the event and prevent recurrence.<sup>105</sup>

**organisation-wide:** intended for use throughout the health service organisation.

**orientation:** a formal process of informing and training a worker starting in a new position or beginning work for an organisation, which covers the policies, processes and procedures applicable to the organisation.

**outcome:** the status of an individual, group of people or population that is wholly or partially attributable to an action, agent or circumstance.<sup>91</sup>

**partnership:** a situation that develops when patients and consumers are treated with dignity and respect, when information is shared with them, and when participation and collaboration in healthcare processes are encouraged and supported to the extent that patients and consumers choose. Partnerships can exist in different ways in a health service organisation, including at the level of individual interactions; at the level of a service, department or program; and at the level of the organisation. They can also exist with

consumers and groups in the community. Generally, partnerships at all levels are necessary to ensure that the health service organisation is responsive to patient and consumer input and needs, although the nature of the activities for these different types of partnership will depend on the context of the health service organisation.

**patient:** a person who is receiving care in a health service organisation.

**person-centred care:** an approach to the planning, delivery and evaluation of health care that is founded on mutually beneficial partnerships among clinicians and patients.<sup>106</sup> Person-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of person-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care.<sup>9</sup> Also known as patient-centred care or consumer-centred care.

**point of care:** the time and location of an interaction between a patient and a clinician for the purpose of delivering care.

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

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

**procedure:** the set of instructions to make policies and protocols operational, which are specific to an organisation.

**procedure matching:** the processes of correctly matching patients to their intended care.

**process:** a series of actions or steps taken to achieve a particular goal.<sup>107</sup>

**program:** an initiative, or series of initiatives, designed to deal with a particular issue, with resources, a time frame, objectives and deliverables allocated to it.

**protocol:** an established set of rules used to complete tasks or a set of tasks.



**purpose-driven communication:** communication in which all the parties involved in the communication process have a shared understanding of why the communication is taking place (for example, to gather, share, receive or check information), what action needs to be taken and who is responsible for taking that action.

**quality improvement:** the combined efforts of the workforce and others – including consumers, patients and their families, researchers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development.<sup>108</sup> Quality improvement activities may be undertaken in sequence, intermittently or continually.

**regularly:** occurring at recurring intervals. The specific interval for regular review, evaluation, audit or monitoring needs to be determined for each case. In the NSQHS Standards (2nd ed.), the interval should be consistent with best practice, risk based, and determined by the subject and nature of the activity.

**responsibility and accountability for care:** accountability includes the obligation to report and be answerable for consequences. Responsibility is the acknowledgement that a person has to take action that is appropriate to a patient's care needs and the health service organisation.<sup>109</sup>

**restraint:** the restriction of an individual's freedom of movement by physical or mechanical means.<sup>110</sup>

**reusable device:** a medical device that is designated by its manufacturer as suitable for reprocessing and reuse.<sup>111</sup>

**risk:** the chance of something happening that will have a negative impact. Risk is measured by the consequences of an event and its likelihood.

**risk assessment:** assessment, analysis and management of risks. It involves recognising which events may lead to harm in the future, and minimising their likelihood and consequences.<sup>112</sup>

**risk management:** the design and implementation of a program to identify and avoid or minimise risks to patients, employees, volunteers, visitors and the organisation.

**safety culture:** a commitment to safety that permeates all levels of an organisation, from the clinical workforce to executive management.

Features commonly include acknowledgement of the high-risk, error-prone nature of an organisation's activities; a blame-free environment in which individuals are able to report errors or near misses without fear of reprimand or punishment; an expectation of collaboration across all areas and levels of an organisation to seek solutions to vulnerabilities; and a willingness of the organisation to direct resources to deal with safety concerns.<sup>113</sup>

**scope of clinical practice:** the extent of an individual clinician's approved clinical practice within a particular organisation, based on the clinician's skills, knowledge, performance and professional suitability, and the needs and service capability of the organisation.<sup>74</sup>

**screening:** a process of identifying patients who are at risk, or already have a disease or injury. Screening requires enough knowledge to make a clinical judgement.<sup>114</sup>

**seclusion:** the confinement of a patient, at any time of the day or night, alone in a room or area from which free exit is prevented.<sup>110</sup>

**self-harm:** includes self-poisoning, overdoses and minor injury, as well as potentially dangerous and life-threatening forms of injury. Self-harm is a behaviour and not an illness. People self-harm to cope with distress or to communicate that they are distressed.<sup>115</sup>

**semi-critical equipment:** items that come into contact with mucous membranes or non-intact skin, and should be single use or sterilised after each use. If this is not possible, high-level disinfection is the minimum level of reprocessing that is acceptable.<sup>18</sup>

**service context:** the particular context in which care is delivered. Health service delivery occurs in many different ways, and the service context will depend on the organisation's function, size and organisation of care regarding service delivery mode, location and workforce.<sup>116</sup>

**shared decision making:** a consultation process in which a clinician and a patient jointly participate in making a health decision, having discussed the options, and their benefits and harms, and having considered the patient's values, preferences and circumstances.<sup>75</sup>

**standard:** agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.<sup>91</sup>

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**standard national terminologies:** a structured vocabulary used in clinical practice to accurately describe the care and treatment of patients. Healthcare providers around the world use specialised vocabulary to describe diseases, operations, clinical procedures, findings, treatments and medicines. In Australia, terminologies include SNOMED CT-AU and Australian Medicines Terminology.<sup>117</sup> Standard national terminologies are also referred to as clinical terminologies.

**standard precautions:** work practices that provide a first-line approach to infection prevention and control, and are used for the care and treatment of all patients.<sup>111</sup>

**structured clinical handover:** a structured format used to deliver information (the minimum information content), enabling all participants to know the purpose of the handover, and the information that they are required to know and communicate.<sup>64</sup>

**substitute decision-maker:** a person appointed or identified by law to make health, medical, residential and other personal (but not financial or legal) decisions on behalf of a patient whose decision-making capacity is impaired. A substitute decision-maker may be appointed by the patient, appointed for (on behalf of) the person, or identified as the default decision-maker by legislation, which varies by state and territory.<sup>41</sup>

**surveillance:** an epidemiological practice that involves monitoring the spread of disease to establish progression patterns. The main roles of surveillance are to predict and observe spread; to provide a measure for strategies that may minimise the harm caused by outbreak, epidemic and pandemic situations; and to increase knowledge of the factors that might contribute to such circumstances.<sup>88</sup>

**system:** the resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish a stated goal. A system:

- Brings together risk management, governance, and operational processes and procedures, including education, training and orientation
- Deploys an active implementation plan; feedback mechanisms include agreed protocols and guidelines, decision support tools and other resource materials

- Uses several incentives and sanctions to influence behaviour and encourage compliance with policy, protocol, regulation and procedures.

The workforce is both a resource in the system and involved in all elements of systems development, implementation, monitoring, improvement and evaluation.

**timely (communication):** communication of information within a reasonable time frame. This will depend on how important or time critical the information is to a patient's ongoing care or wellbeing, the context in which the service is provided and the clinical acuity of the patient.

**traceability:** the ability to trace the history, application or location of reusable medical devices. Some professional groups may refer to traceability as tracking.<sup>111</sup>

**training:** the development of knowledge and skills.

**transfusion history:** a list of transfusions a patient has had before presentation, including details of any adverse reactions to the transfusion and any special transfusion requirements. The completeness of the history will depend on the availability of information. It is expected that information will be obtained by reviewing any available referral information and interviewing the patient or their carer.

**transitions of care:** situations when all or part of a patient's care is transferred between healthcare locations, providers, or levels of care within the same location, as the patient's conditions and care needs change.<sup>118</sup>

**transmission-based precautions:** extra work practices used in situations when standard precautions alone may not be enough to prevent transmission of infection. Transmission-based precautions are used in conjunction with standard precautions.<sup>18</sup>

**workforce:** all people working in a health service organisation, including clinicians and any other employed or contracted, locum, agency, student, volunteer or peer workers. The workforce can be members of the health service organisation or medical company representatives providing technical support who have assigned roles and responsibilities for care of, administration of, support of, or involvement with patients in the health service organisation. *See also* clinician

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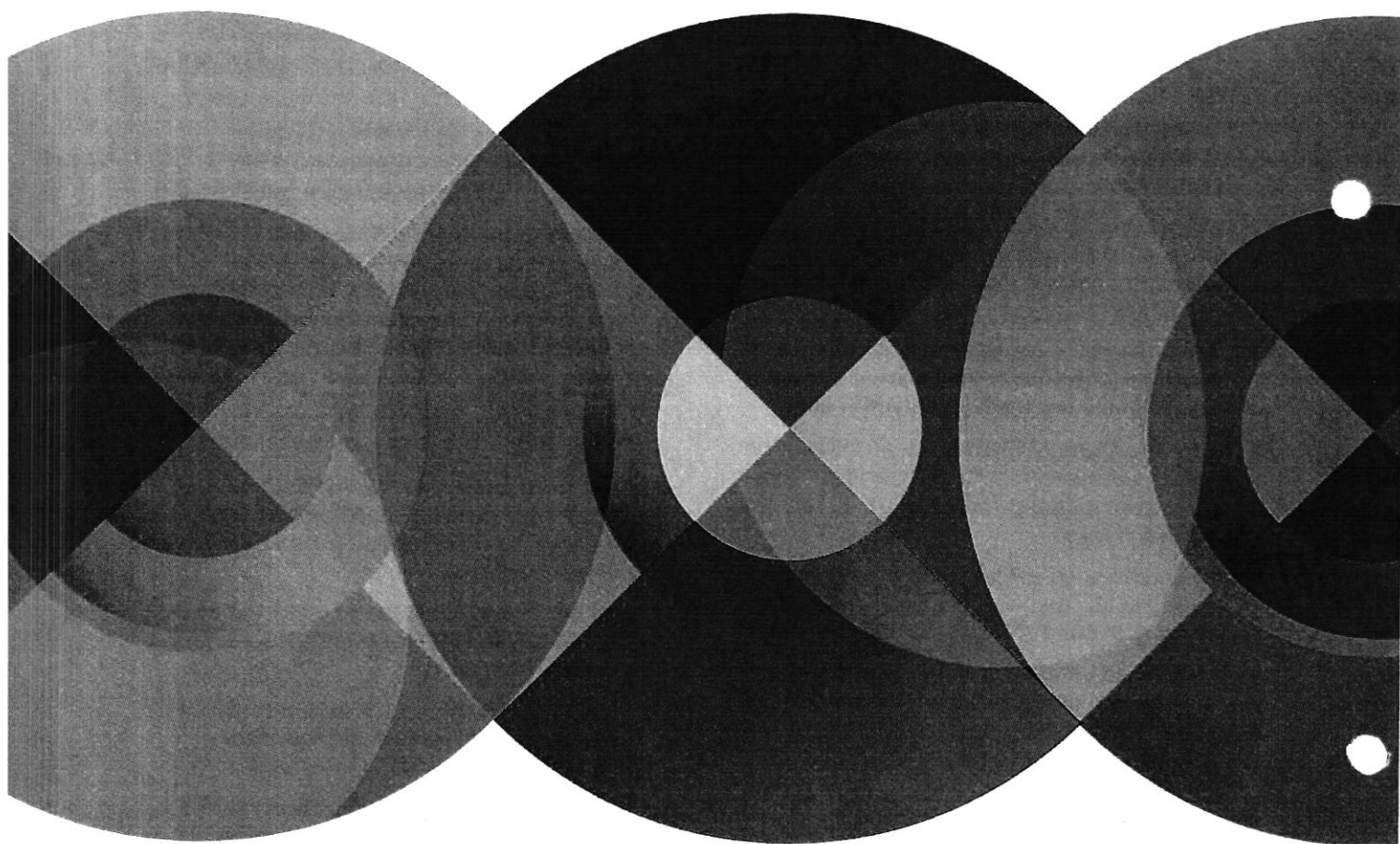
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# ACT Health Policy

## Consumer and Carer Participation in ACT Health

### Policy Statement

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.

ACT Health values the contribution consumers and carers make to improving the quality and safety of the health service and is committed to building engagement and genuine partnership with consumers and carers.

ACT Health is committed to the *National Safety and Quality Health Service (NSQHS) Standards* which provide a nationally consistent statement of the level of care that consumers and carers should be able to expect from health services. Partnering with consumers is one of the three *Australian Safety and Quality Goals for Health Care* identified by the Australian Commission on Safety and Quality in Healthcare. These goals support effective partnerships between consumers and healthcare providers and organisations at levels of healthcare provision, planning and evaluation.

All consumers, their carers and families have the right to provide feedback without compromising their privacy or health care. ACT Health services have a responsibility to invite feedback and to respond in a timely and respectful manner.

ACT Health recognises that consumers and carers come from diverse backgrounds including different age groups, genders, cultural backgrounds, and health needs with differing levels of health literacy and experiences of the health system. Participation strategies need to be tailored to groups within the community who might not ordinarily participate to ensure they are culturally or age appropriate. Effective participation with Aboriginal, Torres Strait Islander, culturally and linguistically diverse (CALD), children, and young consumers and carers in decision making processes will help to ensure appropriate and effective health service delivery to these groups. This policy describes a range of strategies for engaging with consumers and carers however, ACT Health staff are not limited to these strategies.

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Priorities include at:

- Individual care level:
  - Promote patient centred care.
  - Communicate clearly and respectfully in a way and language the consumer or carer can understand.
  - Provide accessible and appropriate information to consumers, carers and the community about the health system, health information, and health care rights.
  - Provide information about treatment options and plans that are developed with consumers and carers.
  - Listen to and act on the decisions made by the consumer and/or carer where appropriate, related to their treatment, including making appropriate referrals.
- Program and department level
  - Involve consumers and carers in all stages of program development from planning to implementation, evaluation and monitoring.
  - Provide access for staff to ongoing training in patient centred care and understanding patient experience.
  - Promote the importance of utilising feedback to inform and improve services.
  - Involve consumer and carers in the development and review of clinical policy, procedures, guidelines, publications, and research.
- Organisational Level:
  - Involve consumers and carers in the safety and quality program.
  - Involve consumers and carers in the review of system level issues which arise from consumer and carer feedback.
  - Include consumers and carers in all aspects of organisational planning and development.
  - Provide information on how to use different models of consumer and carer participation.
  - Ensure selection documentation recognises the applicant's/staff member's role in consumer and/or carer participation.
  - Report publicly on quality and safety and on levels of consumer and/or carer participation.
  - Involve consumer and carers in the development and review of clinical and strategic policy, procedures, guidelines, publications, and research.
  - Ensure consumer and carer feedback is reviewed and action plans are implemented.

## Purpose

The purpose of this policy is to ensure a consistent understanding of consumer and carer participation across ACT Health, and improve and strengthen its application. Additionally,

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this policy outlines the opportunities for consumer and carer partnerships across ACT Health to:

- Improve the quality and safety of our health services.
- Improve health outcomes for consumers and carers.
- Provide access to services.
- Involve consumers and/or carers in decision making at all levels.
- Ensure we understand what is valued by consumers and carers.

## Scope

This document is the overarching policy for all consumer and carer participation within ACT Health. It is to be applied when planning, developing and reviewing **all** policies/guidelines/procedures/publications/training/business rules as all of these have an impact on the consumer/carer experience, and health outcomes.

This policy applies to all staff working within ACT Health, including contractors, and is applicable to adults, young people, and children.

## Roles & Responsibilities

**ACT Health Executive, including managers,** are responsible for integrating consumer and carer participation into the organisation's culture by:

- providing staff with strategic direction and resources to continually improve and increase partnership with consumers and carers;
- ensuring their staff have access to education related to consumer and carer participation and patient experience;
- including consumer and carer participation in division and branch business plans;
- ensuring this policy is implemented in their areas;
- ensuring job descriptions include consumer/carer participation and patient experience; and
- promoting and implementing this policy.

**ACT Health staff** are responsible for:

- adhering to this policy and the attached Consumer and Carer Participation Framework; and
- ensuring there is meaningful consumer and carer participation in their area of work.

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**Policy and Stakeholder Relations Branch** is responsible for:

- Advising staff of the application of the policy; and
- Evaluating the policy.

## Evaluation

### Outcome Measures

- Consumer and carer participation strategies are included in division and branch business plans.
- The actions around *Standard 2: Partnering with Consumers* accreditation are met.
- Patient experience survey results.
- Staff attendance at consumer and carer participation focussed training and education.

### Method

- Annual survey to be completed by all ACT Health divisions regarding how they have implemented this policy.
- Annual survey to be completed by consumer and carer peak bodies regarding participation by their representatives.
- All new selection documentation recognises the applicant's/staff member's role in consumer and/or carer participation.
- Track and analyse results from patient experience surveys.
- Evaluation of Committees with consumer and/or carer representatives.

Evaluation will be undertaken by Policy and Stakeholder Relations Branch, and will be reported to Executive Director's Council.

## Related Policies, Procedures, Guidelines and Legislation

### Legislation

- Carer Recognition Act 2010 (Cwlth)
- Human Rights Act 2004 (ACT)

### Policies

- ACT Government, Engaging Canberrans: A guide to community engagement
- ACT Health, 2014, ACT Health Business Plan 2014-15.
- ACT Health, Consumer and Carer Participation Framework
- ACT Health, Health Directorate Corporate Plan 2012-2017

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- ACT Health, Language Services Policy (Interpreters, Multilingual Staff and Translated Materials)
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### Definition of Terms (only use this section if needed, delete if not needed)

**Consumer:** In ACT Health, the word 'consumer' describes people who use, have previously used, or may use in the future, any health service. It is not limited to those currently using a service.

**Carer:** The word 'carer' describes people who provide unpaid care and support to family members and friends who have a disability, medical condition, mental illness, an alcohol or other drug issue, or who are frail and/or aged.

**Participation:** The term 'participation' is described as a consumer and/or carer being meaningfully involved in the delivery of a person's own care, and/or in decision making about service design, planning and delivery, education delivery, and quality improvement activities, broader strategic and policy development, and evaluation.

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## Search Terms

*Consumer, carer, participation, engagement*

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*Policy Team ONLY to complete the following:*

<i>Date Amended</i>	<i>Section Amended</i>	<i>Divisional Approval</i>	<i>Final Approval</i>

*This document supersedes the following:*

<i>Document Number</i>	<i>Document Name</i>

<i>Doc Number</i>	<i>Version</i>	<i>Issued</i>	<i>Review Date</i>	<i>Area Responsible</i>	<i>Page</i>
DGD15-005	1	01/02/2015	01/12/2018	PGS - Policy and Stakeholder Relations	6 of 6

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**Attwood, Courtney (Health)**

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**From:** Harding, Nikki  
**Sent:** Thursday, 23 May 2019 4:09 PM  
**To:** Lopa, Liz (Health); De'Ath, Michael (Health); Doran, Karen (Health); McDonald, Bernadette (Health); Mooney, Colm (Health); Burch, Brad (Health); Esau, Lloyd; Whybrow, Mark; Lindemann, Monica (Health); Culver, Jakob (Health); Chatham, Elizabeth (Health)  
**Cc:** Hayne, Casey (Health); Building Health Services Program; Finlay, India (Health); Chicco, Dee (Health); Douglas, Nerida (Health); Tzavalas, Olivia (Health); Gray, Sophie; Elfving, Regan; DDGCorporate; IFCW Governance  
**Subject:** SPIRE ESC - Papers [SEC=UNCLASSIFIED]  
**Attachments:** Agenda - SPIRE Executive Steering Committee 28 May 2019.pdf; 2.1 SPIRE ESC and joint ESC PCG minutes.pdf; 3.1 SPIRE ESC Outstanding Actions Register.pdf; 4.1 SPIRE ESC Decisions Register.pdf; 6.1 SPIRE ESC April Project Status Update.pdf; 7.2 SPIRE ESC ANU Campus Project.pdf; 7.3 SPIRE ESC Stage and Decanting Update.pdf; 7.5 SPIRE ESC Models of Care for the Project.pdf; 7.7 SPIRE ESC Consumer Representation for Project.pdf

Good afternoon all

Please find attached papers for next Tuesday's SPIRE ESC. Please note a second package of papers will be circulated tomorrow.

Regards,

**Nikki Harding** | Governance Officer

Phone: (02) 6205 1757

**Infrastructure Finance and Capital Works** | Chief Minister, Treasury and Economic Development Directorate | ACT Government

GPO Box 158 Canberra ACT 2601 | [www.act.gov.au](http://www.act.gov.au)

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## AGENDA

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

MEETING NO. 4

DATE / TIME: 1:00pm to 2:30pm, 28 May 2019

VENUE: Executive Conference Room, Level 5, 2-6 Bowes Street Phillip

Name	Position
<b>Committee Members</b>	
Michael De'Ath [Chair]	Director-General, ACT Health Directorate (ACTHD)
Karen Doran	Deputy Director-General, Corporate Services (ACTHD)
Liz Lopa	Executive Group Manager, Strategic Infrastructure (ACTHD)
Brad Burch	Executive Branch Manager, Strategic Infrastructure (ACTHD)
Bernadette McDonald	Chief Executive Officer, Canberra Health Services (CHS)
Chris Bone	Deputy Director-General, Clinical Services (CHS)
Colm Mooney	Executive Director, Infrastructure Management and Maintenance (CHS)
Lloyd Esau	Executive Director, Infrastructure Finance and Capital Works (IFCW) (CMTEDD)
Mark Whybrow	Executive Director, Finance and Budget Division (CMTEDD)
<b>Attendees / Other Invitees</b>	
TBC	<i>SPIRE Program Manager</i>
TBC	<i>SPIRE Clinical Director</i>
Monica Lindemann	Special Advisor, Strategic Infrastructure (ACTHD)
Jakob Culver	Commercial Advisor, Strategic Infrastructure (ACTHD)
Secretariat	Infrastructure, Finance and Capital Works (CMTEDD)

No.	Item	Paper	Outcome	Lead
1	<b>Welcome and Apologies</b>			Chair
2	<b>Review of Previous Minutes</b>	2.1	Decision	Chair
3	<b>Review of Actions List</b>	3.1	Discussion	Chair
4	<b>Review of Decisions Register</b>	4.1	Noting	Chair
5	<b>ACT Health Directorate Project Update</b>	Verbal	Discussion	ACTHD
6	<b>Project Status Update</b>	6.1	Noting	IFCW
7	<b>Submissions for Noting, Discussion and Decision</b>			
7.1	Update on Program and Next Steps	Pending	Discussion	IFCW
7.2	ANU Campus Project	7.2	Decision	ACTHD
7.3	Decanting for SPIRE	7.3	Decision	ACTHD
7.4	Legal Advisor for the Project	Pending	Discussion	IFCW
7.5	Models of Care for the Project	7.5	Decision	ACTHD
7.6	Governance Paper	Pending	Noting	ACTHD
7.7	Consumer Representation for Project	7.7	Decision	ACTHD
7.8	Campus Parking	Pending	Discussion	CHS
8	<b>Other Business</b>			Chair
9	<b>Meeting Close</b> Next meeting: 1:00 – 2:30pm 25 June 2019 Executive Conference Room Level 5, 2-6 Bowes Street Phillip			



## Submission Paper SPIRE ESC Previous Minutes

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

**Meeting Date:** 28 May 2019

**Agenda Item No:** 2.1

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**Subject:** Previous Minutes - Joint SPIRE ESC & PCG 8 April, & SPIRE ESC 21 March 2019

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**Author:** Secretariat, IFCW

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**Purpose:** For Noting

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## Surgical Procedures, Interventional Radiology and Emergency (SPIRE) Centre Project – Joint Executive Steering Committee and Project Control Group

Monday 8 April 2019

Building 24, Level 1, Meeting Room 1, The Canberra Hospital

Name	Position
<b>Executive Steering Committee Members</b>	
Michael De'Ath [Chair]	Director-General, ACT Health Directorate (ACTHD)
Karen Doran	Deputy Director-General, Corporate Services (ACTHD)
Liz Lopa	Executive Group Manager, Strategic Infrastructure (ACTHD)
Brad Burch	Executive Branch Manager, Strategic Infrastructure (ACTHD)
Bernadette McDonald	Chief Executive Officer, Canberra Health Services (CHS)
Elizabeth Chatham	A/g Chief Operating Officer, Clinical Services (CHS)
Colm Mooney	Executive Group Manager, Infrastructure and Health Support Services (CHS)
Lloyd Esau	Executive Director, Infrastructure Finance and Capital Works (IFCW) (CMTEDD)
Mark Whybrow	Executive Director, Finance and Budget Division (CMTEDD)
<b>Project Control Group Members</b>	
Hamish Jeffrey	A/g Executive Director, Nursing and Midwifery Services (CHS)
Paul Dugdale	A/g Executive Director, Medical Services (CHS)
Danial Wood	A/g Executive Director, Surgery and Oral Health (CHS)
Lisa Gilmore	A/g Executive Director, Critical Care (CHS)
Chris Tarbuck	Director, Facilities and Maintenance, Infrastructure and Health Support Services (CHS)
Sophie Gray	Executive Branch Manager, Social Infrastructure Branch, Infrastructure Finance and Capital Works (IFCW) (CMTEDD)
Ben Morris	Executive Branch Manager, Social Policy Branch, Finance and Budgets Division (CMTEDD)
<b>Attendees / Other Invitees</b>	
Monica Lindemann	Special Advisor, Strategic Infrastructure (ACTHD)
Jakob Culver	Commercial Advisor, Strategic Infrastructure (ACTHD)
Kate Evans	Clinical Liaison Officer, Strategic Infrastructure (ACTHD)
John Catanzariti	Project Manager, Social Infrastructure Branch, Infrastructure Finance and Capital Works (CMTEDD)
Jeanne McLauchlan	Director of Business Support, Logistic Support Services (CHS)
Sally-Anne Kinghorne	Senior Health Facility Planner, Strategic Infrastructure (ACTHD)



**ACT**  
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Canberra Health  
Services



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**ACT**  
Government

Chief Minister, Treasury and  
Economic Development

	<i>Representative from Silver Thomas Hanley</i>
	<i>Representatives from Ernst &amp; Young</i>
Nikki Harding	Secretariat, Infrastructure Finance and Capital Works (CMTEDD)



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

Thursday, 21 March 2019  
Conference Room, Level 5, 2-6 Bowes Street Phillip

Name	Position
Committee Members	
Michael De'Ath [Chair] (MD)	Director-General, ACT Health Directorate (ACTHD)
Karen Doran (KD)	Deputy Director-General, Corporate Services (ACTHD)
Liz Lopa (LL)	Executive Group Manager, Strategic Infrastructure (ACTHD)
Brad Burch (BB)	Executive Branch Manager, Strategic Infrastructure (ACTHD)
Bernadette McDonald (BM)	Chief Executive Officer, Canberra Health Services (CHS)
Colm Mooney (CM)	Executive Director, Infrastructure Management and Maintenance (CHS)
Lloyd Esau (LE)	Executive Director, Infrastructure Finance and Capital Works (IFCW) (CMTEDD)
Mark Whybrow (MW)	Executive Director, Finance and Budget Division (CMTEDD)
Attendees	
Monica Lindemann (ML)	Special Advisor, Strategic Infrastructure (ACTHD)
Jakob Culver (JC)	Commercial Advisor, Strategic Infrastructure (ACTHD)
Nikki Harding (NH)	Secretariat, Infrastructure Finance and Capital Works (CMTEDD)
Apologies	
Chris Bone (CB)	Deputy Director-General, Clinical Services (CHS)









































































































## Submission Paper Consumer Reference Group

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

**Meeting Date:** 28 May 2019

**Agenda Item No:** 7.7

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

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**Author:** Strategic Infrastructure Division/Strategic Infrastructure Branch

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**Purpose:** For Decision

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# Consumer Reference Group

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

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### 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.