

Explanatory notes

Serious adverse events such as unexpected death and cardiac arrest are often preceded by observable physiological and clinical abnormalities.⁴⁹ 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.⁵⁰

There is evidence that the warning signs of clinical deterioration are not always identified or acted on appropriately.⁵¹ The organisation and workforce factors that contribute to a failure to recognise and respond to a deteriorating patient are complex and overlapping. They include⁵²⁻⁵⁴:

- 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 treatment⁵⁵
- 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.^{56,57}

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*⁴⁸, 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*⁴⁷ 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*⁴⁸, the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*⁴⁶, the *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state*, and the Delirium Clinical Care Standard.⁴⁷

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

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"> Document individualised vital sign monitoring plans Monitor patients as required by their individualised monitoring plan Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient
	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"> Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan 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 Determine the required level of observation Document and communicate observed or reported changes in mental state
Escalating care	8.6 The health service organisation has protocols that specify criteria for escalating care, including: <ol style="list-style-type: none"> Agreed vital sign parameters and other indicators of physiological deterioration Agreed indicators of deterioration in mental state Agreed parameters and other indicators for calling emergency assistance Patient pain or distress that is not able to be managed using available treatment Worry or concern in members of the workforce, patients, carers and families about acute deterioration
	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.⁵⁸

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.⁴⁸

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.⁵⁹ 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.⁶⁰ An allergen may be encountered through inhalation, ingestion, injection or skin contact.⁶¹ 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.⁶²

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

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.⁶²

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.⁶³

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.⁴¹

audit (clinical): a systematic review of clinical care against a predetermined set of criteria.⁶⁴

Australian Charter of Healthcare Rights: specifies the key rights of patients when seeking or receiving healthcare services. It was endorsed by health ministers in 2008.¹⁶

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.⁶

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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.⁶⁵

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.⁶⁶

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.⁶⁷

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.⁶⁸

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.⁶⁹ 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.⁷⁰

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.⁷¹

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.⁴¹ 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.⁷²

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

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.⁷⁴

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.¹⁸

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).⁷⁵ 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.⁷⁶

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.⁷⁷

delirium: an acute disturbance of consciousness, attention, cognition and perception that tends to fluctuate during the day.⁷⁸ 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).⁷⁹

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.⁴⁸

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.⁸⁰

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.⁸¹

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.⁴⁸

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

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.⁸³

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.⁸⁴

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.⁶

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.¹⁸

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.⁸⁵

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.^{86,87} 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.⁸⁸

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.⁸⁹ 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.⁹⁰

injury: damage to tissues caused by an agent or circumstance.⁹¹

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.⁸³ 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.⁹²

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.⁹³

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.⁹⁴

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.⁹⁵ 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.⁹⁶

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.^{97,98}

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 included⁹⁴
- 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).⁹⁹

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.¹⁰⁰

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.¹⁰¹ Multidisciplinary care includes interdisciplinary care. (A discipline is a branch of knowledge within the health system.¹⁰²)

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.¹⁰³

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).¹⁰³

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).¹⁰³

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

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.¹⁰⁵

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.⁹¹

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.¹⁰⁶ 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.⁹ 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.¹⁰⁷

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.¹⁰⁸ 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.¹⁰⁹

restraint: the restriction of an individual's freedom of movement by physical or mechanical means.¹¹⁰

reusable device: a medical device that is designated by its manufacturer as suitable for reprocessing and reuse.¹¹¹

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.¹¹²

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.¹¹³

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.⁷⁴

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.¹¹⁴

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.¹¹⁰

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.¹¹⁵

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.¹⁸

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.¹¹⁶

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.⁷⁵

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

• • • • •

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.¹¹⁷ 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.¹¹¹

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.⁶⁴

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.⁴¹

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.⁸⁸

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.¹¹¹

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.¹¹⁸

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.¹⁸

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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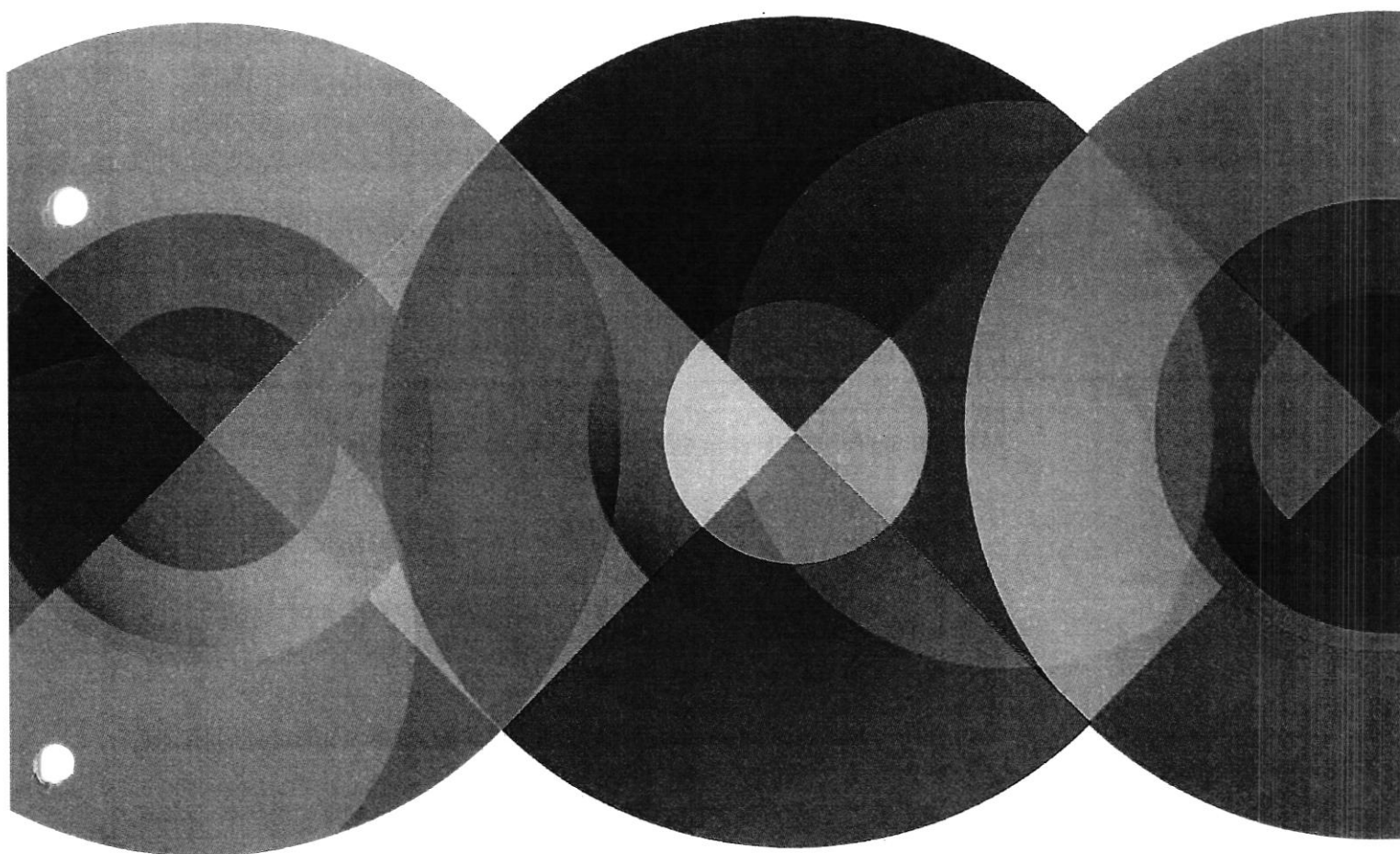
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TERMS OF REFERENCE

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

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

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



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.

<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	1 of 6

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DGD15-005

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,

<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	2 of 6

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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/carers 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/carers 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.

<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	3 of 6

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DGD15-005

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

Doc Number	Version	Issued	Review Date	Area Responsible	Page
DGD15-005	1	01/02/2015	01/12/2018	PGS - Policy and Stakeholder Relations	4 of 6

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DGD15-005

- ACT Health, Language Services Policy (Interpreters, Multilingual Staff and Translated Materials)
- ACT Health, 2013, Toolkit for Chairs and Secretariats with Consumer Representatives.
- Australian Commission on Safety and Quality in Healthcare, Australian Charter of Healthcare Rights.
- Australian Commission on Safety and Quality in Healthcare, 2014, Australian Safety and Quality Goals for Health Care.
- ACT Health, 2003, Listening and Learning Standards.
- ACT Health, 2014, Towards Culturally Appropriate and Inclusive Services, a Co-ordinating Framework: ACT Health (2014-2018).
- Department of Health, 2010, National standards for mental health services 2010, Standard 3. Consumer and carer participation, National Safety and Quality Health Service (NSQHS) Standards, 10 National Standards

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.

References

1. Austin Health, 2013, *Consumer Engagement Framework*. Melbourne
2. Australian Capital Territory Government, 2011, *Engaging Canberrans: A guide to community engagement*, Canberra.
3. Australian Commission on Safety and Quality in Health Care, 2011, *National Safety and Quality Health Service Standards*, ACSQHC, Sydney.
4. Carers ACT, 2014, *Who are carers?*, Canberra. <http://carersact.org.au/facts/who-are-carers>, accessed 10 October 2017.

<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	5 of 6

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DGD15-005

5. Commonwealth of Australia, 2010, Carer Recognition Act 2010, Canberra.
6. Commonwealth of Australia, 2010, National Standards for Mental Health Services, Canberra.
7. Health Care Consumers' Association of the ACT Inc, 2014, HCCA Strategy Plan 2014-2017, Canberra.
8. Health Care Consumers' Association of the ACT Inc, 2014, Who is a health care consumer? Canberra. <http://www.hcca.org.au/consumers>, accessed 10 October 2017.
9. South Australian Department of Public Health, Flinders University, the South Australian Community Health Research Unit, 2000, Improving Health Services Through Consumer Participation A Resource Guide for Organisations, Canberra.
<http://healthissuescentre.org.au/images/uploads/resources/Improving-health-services-through-cp-resources-guide-for-orgs.pdf>, accessed 10 October 2017.

Search Terms

Consumer, carer, participation, engagement

Disclaimer: *This document has been developed by ACT Health specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at his or her own risk and Health Directorate assumes no responsibility whatsoever.*

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

Do not refer to a paper based copy of this policy document. The most current version can be found on the ACT Health Policy Register

Attwood, Courtney (Health)

From: Harding, Nikki
Sent: Friday, 24 May 2019 2:50 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: RE: SPIRE ESC - Papers [SEC=UNCLASSIFIED]
Attachments: 7.6 SPIRE ESC Updated Project Governance.pdf; 7.8 SPIRE ESC Campus Car Parking.pdf

Good afternoon all

Please find attached further papers for Tuesday's SPIRE ESC.

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

Please consider the environment before printing this email - or if printing is necessary, please print double-sided.

From: Harding, Nikki

Sent: Thursday, 23 May 2019 4:09 PM

To: Lopa, Liz (Health) <Liz.Lopa@act.gov.au>; De'Ath, Michael (Health) <Michael.De'Ath@act.gov.au>; Doran, Karen (Health) <Karen.Doran@act.gov.au>; McDonald, Bernadette (Health) <Bernadette.McDonald@act.gov.au>; Mooney, Colm (Health) <Colm.Mooney@act.gov.au>; Burch, Brad (Health) <Brad.Burch@act.gov.au>; Esau, Lloyd <Lloyd.Esau@act.gov.au>; Whybrow, Mark <Mark.Whybrow@act.gov.au>; Lindemann, Monica (Health) <Monica.Lindemann@act.gov.au>; Culver, Jakob (Health) <Jakob.J.Culver@act.gov.au>; Chatham, Elizabeth (Health) <Elizabeth.Chatham@act.gov.au>

Cc: Hayne, Casey (Health) <Casey.Hayne@act.gov.au>; Building Health Services Program <BuildingHealthServicesProgram@act.gov.au>; Finlay, India (Health) <India.Finlay@act.gov.au>; Chicco, Dee (Health) <Dee.Chicco@act.gov.au>; Douglas, Nerida (Health) <Nerida.Douglas@act.gov.au>; Tzavalas, Olivia (Health) <Olivia.Tzavalas@act.gov.au>; Gray, Sophie <Sophie.Gray@act.gov.au>; Elfving, Regan <Regan.Elfving@act.gov.au>; DDGCorporate <DDGCorporate@act.gov.au>; IFCW Governance <IFCWGovernance@act.gov.au>

Subject: SPIRE ESC - Papers [SEC=UNCLASSIFIED]

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

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GPO Box 158 Canberra ACT 2601 | www.act.gov.au

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Submission Paper Project Governance

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

Meeting Date: 28 May 2019

Agenda Item No: 7.6

Subject: Updated Project Governance for SPIRE Moving Forward

Author: Strategic Infrastructure

Purpose: Noting

Ivansson, Zoe (Health)

From: Esau, Lloyd
Sent: Monday, 27 May 2019 3:25 PM
To: Lopa, Liz (Health); Culver, Jakob (Health)
Cc: Harding, Nikki
Subject: SPIRE ESC Papers
Attachments: 7.1 SPIRE ESC Programme & Next Steps.pdf; 7.4 SPIRE ESC Legal Adviser Appointment.pdf; 7.1 SPIRE ESC Programme & Next Steps.docx; 7.1a SPIRE ESC-Attachment A.pdf; 7.4 SPIRE ESC Legal Adviser Appointment.docx; 7.4A SPIRE ESC - Attachment A.docx

UNCLASSIFIED

Liz,

Attached are the my two ESC papers. I have attached the word versions and separate attachments in case you want edit – but have also provided the full pdf version (first two attachments) if you want to just send them out.

Sorry for the delay – my Friday got out of control.

Regards

Lloyd Esau

Executive Director, Major Projects
Infrastructure Finance and Capital Works, CMTEDD

A: GPO Box 158, Canberra, ACT 2601

T: +61 (0)2 6205 3552 | M: [REDACTED]

This email, and any attachments, may be confidential and also privileged. If you are not the intended recipient please notify the sender and delete all copies of this transmission along with any attachments immediately. You should not copy or use it for any purpose, nor disclose its contents to any other person.

Ivansson, Zoe (Health)

From: Harding, Nikki
Sent: Tuesday, 28 May 2019 9:23 AM
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: 7.1 SPIRE ESC Programme & Next Steps inc Attachment A.pdf; 7.4 SPIRE ESC Legal Adviser Appointment.pdf
Importance: High

Good morning all

Please find attached final SPIRE ESC papers, 7.1 and 7.4.

Regards,

Nikki Harding | Governance Officer

Phone: (02) 6205 1757

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

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Cc: Hayne, Casey (Health) <Casey.Hayne@act.gov.au>; Building Health Services Program <BuildingHealthServicesProgram@act.gov.au>; Finlay, India (Health) <India.Finlay@act.gov.au>; Chicco, Dee (Health) <Dee.Chicco@act.gov.au>; Douglas, Nerida (Health) <Nerida.Douglas@act.gov.au>; Tzavalas, Olivia (Health) <Olivia.Tzavalas@act.gov.au>; Gray, Sophie <Sophie.Gray@act.gov.au>; Elfving, Regan <Regan.Elfving@act.gov.au>; DDGCorporate <DDGCorporate@act.gov.au>; IFCW Governance <IFCWGovernance@act.gov.au>
Subject: RE: SPIRE ESC - Papers [SEC=UNCLASSIFIED]

Good afternoon all

Please find attached further papers for Tuesday's SPIRE ESC.

Regards,

Nikki Harding | Governance Officer

Phone: (02) 6205 1757

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Sent: Thursday, 23 May 2019 4:09 PM

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Cc: Hayne, Casey (Health) <Casey.Hayne@act.gov.au>; Building Health Services Program <BuildingHealthServicesProgram@act.gov.au>; Finlay, India (Health) <India.Finlay@act.gov.au>; Chicco, Dee (Health) <Dee.Chicco@act.gov.au>; Douglas, Nerida (Health) <Nerida.Douglas@act.gov.au>; Tzavalas, Olivia (Health) <Olivia.Tzavalas@act.gov.au>; Gray, Sophie <Sophie.Gray@act.gov.au>; Elfving, Regan <Regan.Elfving@act.gov.au>; DDGCorporate <DDGCorporate@act.gov.au>; IFCW Governance <IFCWGovernance@act.gov.au>

Subject: SPIRE ESC - Papers [SEC=UNCLASSIFIED]

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

Please consider the environment before printing this email - or if printing is necessary, please print double-sided.

Ivansson, Zoe (Health)

From: Johnston, ClaireV
Sent: Tuesday, 28 May 2019 9:38 AM
To: Pulli, Tracey (Health)
Cc: Dal Molin, Vanessa (Health); Lopa, Liz (Health); ACT Health DLO; Health Ministerial Liaison Officer; Phillips, Georgia; Nock, Thomas; Canberra Health Services Media
Subject: RE: Event brief for SPIRE pre-budget announcement [IN CONFIDENCE]

Can we please leave this for today actually? I think we want to avoid talking too much about how it has all changed between the original commitment and what we are now going to deliver. So if we did redraft this, just state what it will have, not how much more it was than "originally planned". Does that make sense?

From: Pulli, Tracey (Health)
Sent: Tuesday, 28 May 2019 9:34 AM
To: Johnston, ClaireV <ClaireV.Johnston@act.gov.au>
Cc: Dal Molin, Vanessa (Health) <Vanessa.DalMolin@act.gov.au>; Lopa, Liz (Health) <Liz.Lopa@act.gov.au>; ACT Health DLO <ACTHealthDLO@act.gov.au>; Health Ministerial Liaison Officer <HealthMinisterialLiaisonOfficer@act.gov.au>; Phillips, Georgia <Georgia.Phillips@act.gov.au>; Nock, Thomas <Thomas.Nock@act.gov.au>; Canberra Health Services Media <CHSmedia@act.gov.au>
Subject: RE: Event brief for SPIRE pre-budget announcement [IN CONFIDENCE]

UNCLASSIFIED

Hi Claire

Just checking up on the fact sheet. Is the office okay with this?

We will need to print the fact sheet prior to the staff briefing, which is at 11am, so if we can have your feedback prior to 10.15 that would be great.

Cheers
 Tracey

From: Pulli, Tracey (Health)
Sent: Friday, 24 May 2019 4:53 PM
To: Johnston, ClaireV <ClaireV.Johnston@act.gov.au>
Cc: Dal Molin, Vanessa (Health) <Vanessa.DalMolin@act.gov.au>; Lopa, Liz (Health) <Liz.Lopa@act.gov.au>; ACT Health DLO <ACTHealthDLO@act.gov.au>; Health Ministerial Liaison Officer <HealthMinisterialLiaisonOfficer@act.gov.au>; Phillips, Georgia <Georgia.Phillips@act.gov.au>; Nock, Thomas <Thomas.Nock@act.gov.au>; Canberra Health Services Media <CHSmedia@act.gov.au>
Subject: Event brief for SPIRE pre-budget announcement [IN CONFIDENCE]
Importance: High

UNCLASSIFIED

Hi Claire

Final package for SPIRE pre-budget announcement on Tuesday next week. Attached includes:

- Arrangements brief (includes talking points)
- Media release (includes quotes from CEO of CHS)
- Media alert
- Fact sheet on new features of SPIRE (pdf)

- Jpeg of SPIRE artist impression (to provide to media with the MR)

Please let us know if you need anything further. I will be available on my mobile over the weekend.

I will also provide this to CMTEDD so treasury can look at it, noting no figures will be released as part of this Budget announcement.

Cheers

Tracey

Tracey Pulli

Director of Media | ACT Health Directorate

P | (02) 5124 9444 M [REDACTED]

E | tracey.pulli@act.gov.au

URL | www.health.act.gov.au

Lowes, Shannon (Health)

Subject: FW: Clinician briefing - SPIRE Announcement
Location: Meeting room 1, Level 1, Building 24 TCH

Start: Tue 28/05/2019 11:00 AM
End: Tue 28/05/2019 11:45 AM
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Organizer: McDonald, Bernadette (Health)

Hi Guys

Clinician briefing which you are welcome to attend.

Liz

-----Original Appointment-----

From: McDonald, Bernadette (Health)

Sent: Thursday, 23 May 2019 3:33 PM

To: McDonald, Bernadette (Health); Lopa, Liz (Health); Chandler, Rodney (Health); Mossman, Wendy (Health); Beckingham, Wendy (Health); Wong, Chin (Health); Ngu, Charles (Health); Mitchell, Anne (Health); Saunder, Kate (Health); Dahlstrom, Jane (Health); Laloo, Shivendra (Health); Smallbane, Suzanne (Health); Scanlan, Samuel (Health); Slater, Nicole (Health); Avar, Bronwyn (Health); Robertson, SimonJ (TCH) (Health); Harrigan, Genevieve (Health); Grove, Kelvin (Health); Fitzgerald, Ailene (Health); Silberberg, Carly (Health); Brussel, Thomas (Health); Piscioneri, Frank (Health); Davis, Jillian (Health); Lepper, Margaret (Health); Tan, Ren (Health); Baldwin, Alison (Health); Reeves, Kerri (Health); Lim, Boon (Health); Wood, Daniel (Health); Gilmore, Lisa (Health); Dugdale, Paul (Health); Boyd, Narelle (Health); Mooney, Colm (Health); O'Neill, Cathie (Health); Kohlhagen, Linda (Health); Bracher, Katrina (Health); Chatham, Elizabeth (Health); Grace, Karen (Health); Boyd, Kerry (Health); Gay, AndrewD (Health); Hammat, Janine (Health); Burns, Cathy (Health); Taylor, Jacqui (Health); Lamb, Denise (Health)

Cc: Riordan, Denise (Health); Chief Psychiatrist; ACT Health, ACTPathologyED; Noffke, Kellie (Health)

Subject: Clinician briefing - SPIRE Announcement

When: Tuesday, 28 May 2019 11:00 AM-11:45 AM (UTC+10:00) Canberra, Melbourne, Sydney.

Where: Meeting room 1, Level 1, Building 24 TCH

Nicole Stevenson

Business Manager to the Chief Executive Officer

Phone: 02 5124 4702 | **Mobile:** [REDACTED] **Email:** nicole.stevenson@act.gov.au
 Building 24, Level 2, Canberra Hospital, Yamba Drive, Garran ACT 2605

Care | Excellence | Collaboration | Integrity

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
Committee Members	
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)
Attendees / Other Invitees	
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 (CMTED)

No.	Item	Paper	Outcome	Lead
1	Welcome and Apologies			Chair
2	Review of Previous Minutes	2.1	Decision	Chair
3	Review of Actions List	3.1	Discussion	Chair
4	Review of Decisions Register	4.1	Noting	Chair
5	ACT Health Directorate Project Update	Verbal	Discussion	ACTHD
6	Project Status Update	6.1	Noting	IFCW
7	Submissions for Noting, Discussion and Decision			
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	Other Business			Chair
9	Meeting Close 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

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

Author: Secretariat, IFCW

Purpose: For Noting

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

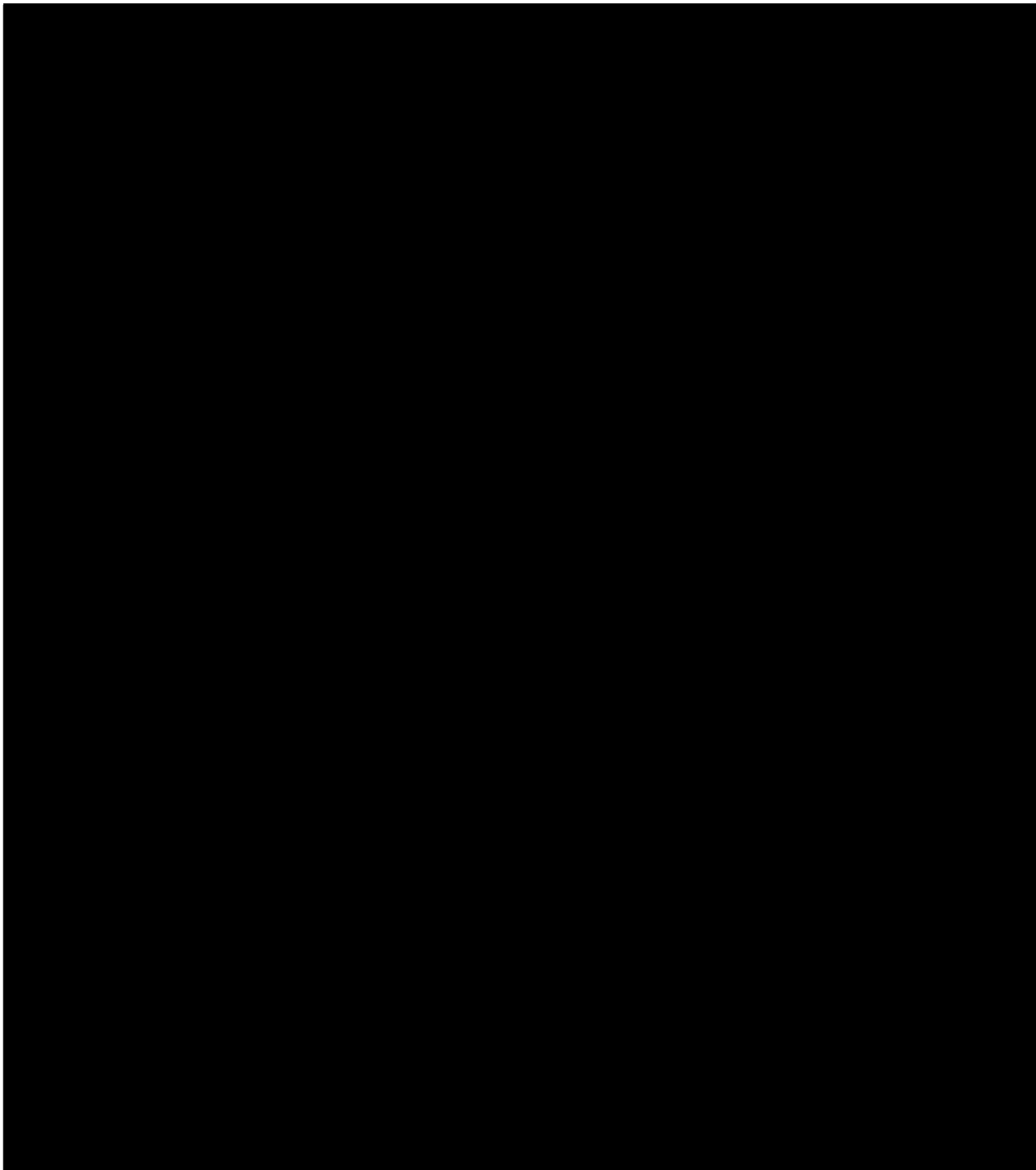
Monday 8 April 2019

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

Name	Position
Executive Steering Committee Members	
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)
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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

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

Author: Strategic Infrastructure Division/Strategic Infrastructure Branch

Purpose: For Decision

Consumer Reference Group

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

Background

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

Issues

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

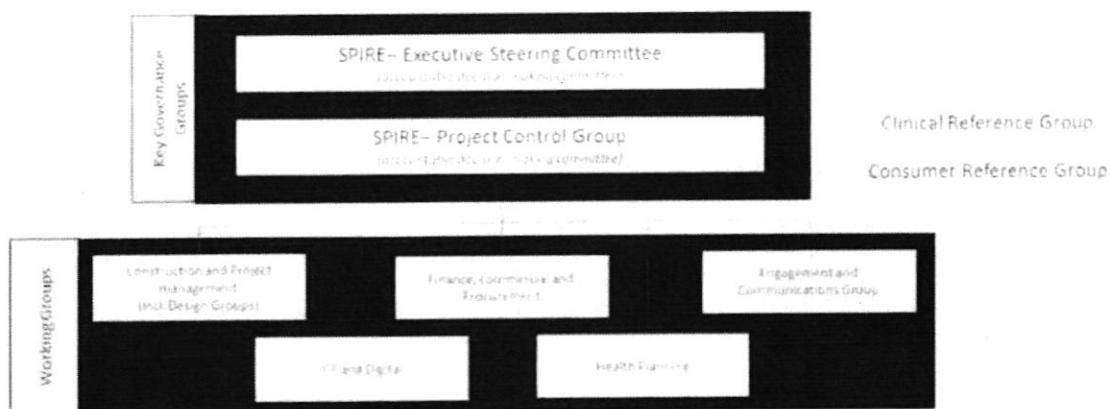


Image: SPIRE Project Governance Structure

Recommendation

10. It is recommended that the Executive Steering Committee approve:

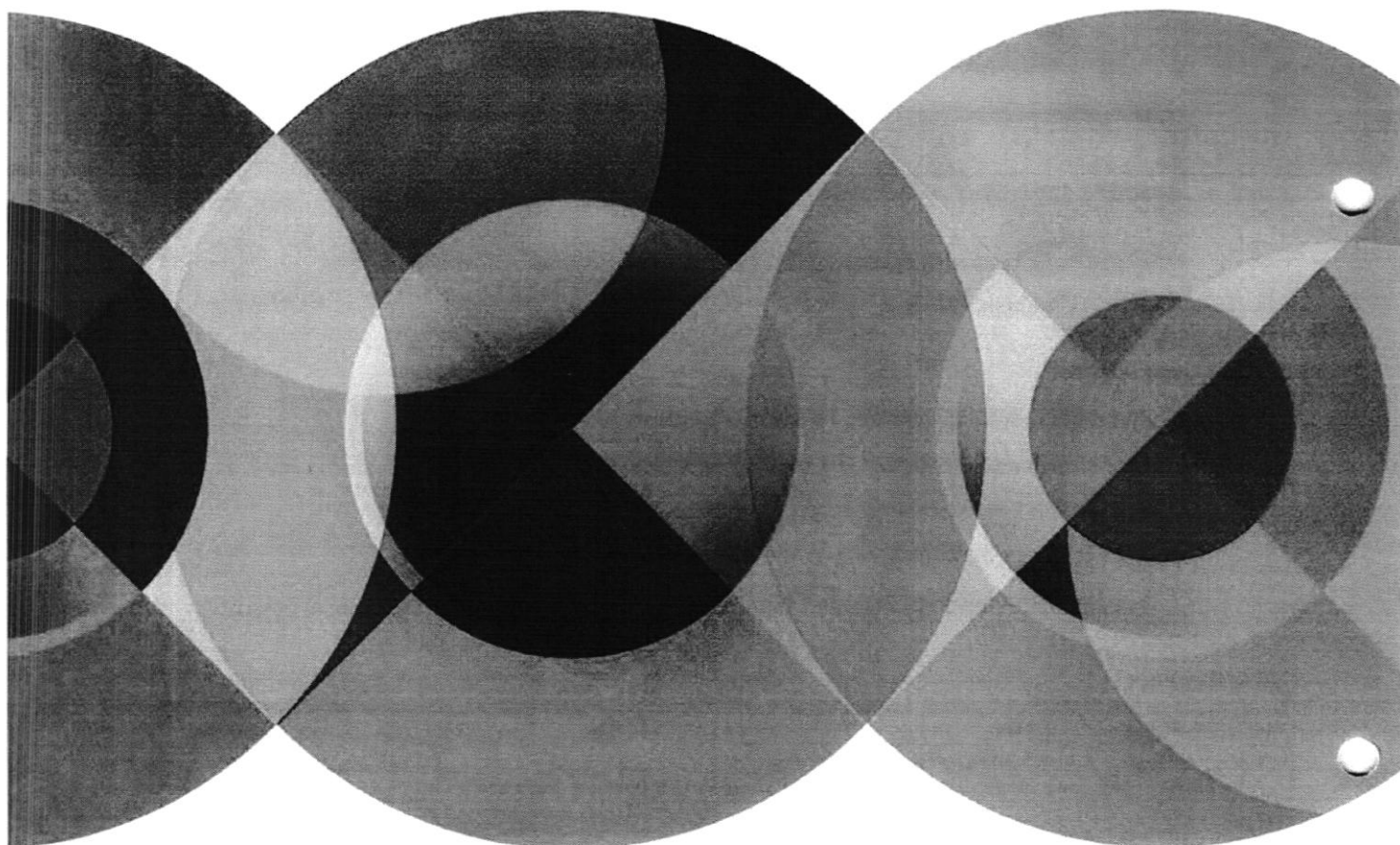
- a. the role and function of the Consumer Reference Group,
- b. the draft Terms of Reference,
- c. Consumer Reference Group membership; and
- d. payment of Reference Group expenses from the SPIRE project budget.

Attachments

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

AUSTRALIAN COMMISSION
ON **SAFETY** AND **QUALITY** IN HEALTH CARE

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NSQHS
STANDARDS



National Safety and Quality Health Service Standards

Second edition



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Acknowledgement

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

This document was released in November 2017.

Contents

Introduction	1
 Clinical Governance Standard	3
 Partnering with Consumers Standard	13
 Preventing and Controlling Healthcare-Associated Infection Standard	21
 Medication Safety Standard	29
 Comprehensive Care Standard	37
 Communicating for Safety Standard	47
 Blood Management Standard	55
 Recognising and Responding to Acute Deterioration Standard	61
Glossary	67
References	77

Introduction

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

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

The eight NSQHS Standards are:



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



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



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



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



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



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



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



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

Each standard contains:

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

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

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

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

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

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

More information

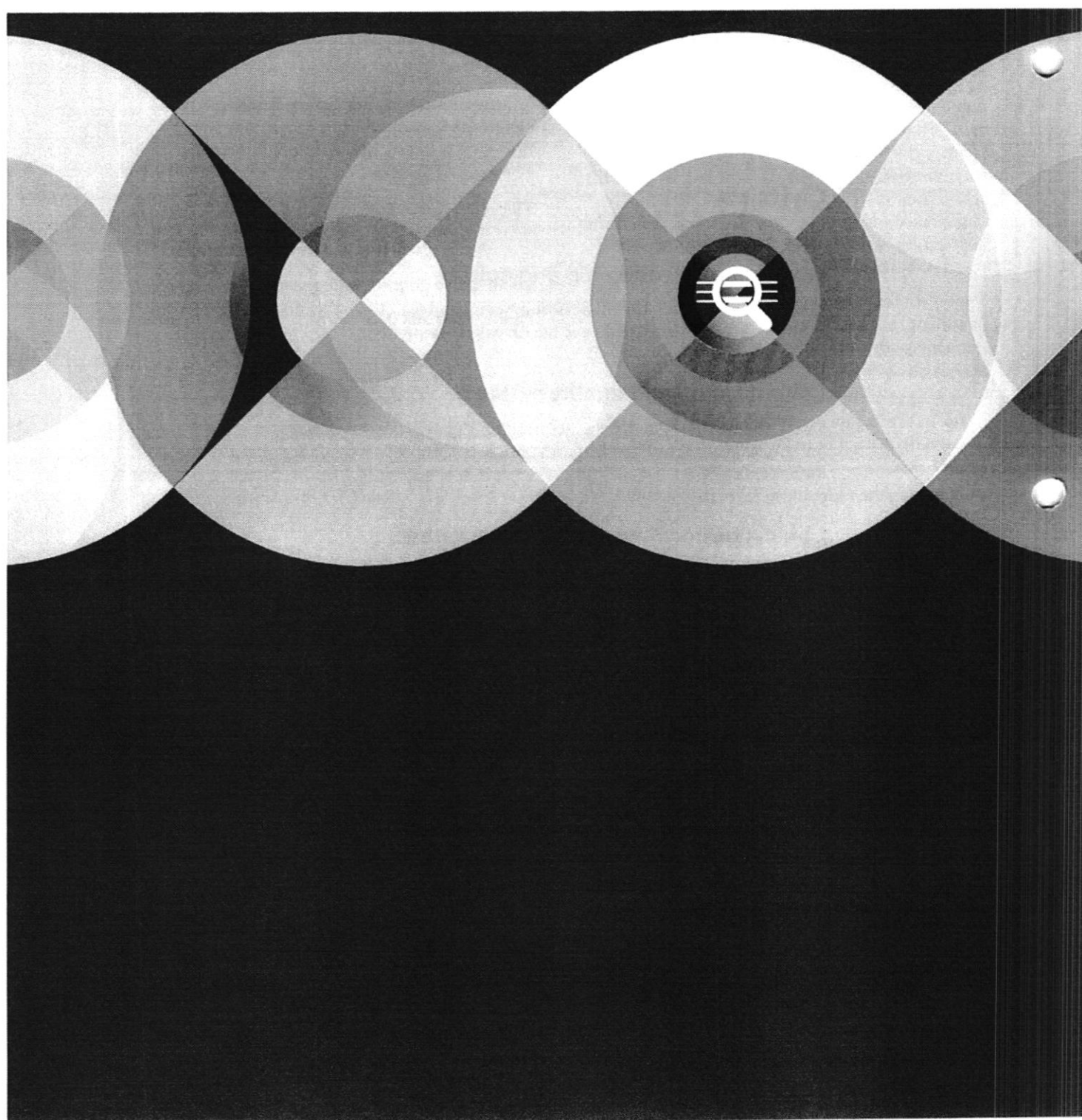
A range of other supporting resources to assist health service organisations to implement the NSQHS Standards are available on the Commission's website.

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

Email: accreditation@safetyandquality.gov.au

Phone: 1800 304 056

Clinical Governance Standard





Clinical Governance Standard

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

Intention of this standard

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

Criteria

Governance, leadership and culture

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

Patient safety and quality systems

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

Clinical performance and effectiveness

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

Safe environment for the delivery of care

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

Explanatory notes

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

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

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

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

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

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

Governance, leadership and culture

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

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

Patient safety and quality systems

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

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

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

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