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Exceptional standards of care. Every time.

National Standards:

Knowing Your Role and Responsibilities: Medical Officers

Clinical Governance Standard

Key Messages:

- Clinical Governance is about providing a strong framework that brings all of the pieces of safety and quality in every part of our service together so that our patients receive safe, high-quality healthcare.
- It means every one of our Mater People … at every level … is focused on improving the safety and quality of the healthcare experience and outcomes for the patients that we serve.
- It means we have systems in place to actively manage, monitor and continuously focus on improving care for patients.
- It means ensuring our people have the skills, support and supervision they need to consistently provide exceptional healthcare.
- It means our environments are safe and encourage the best possible care so that we deliver on what matters to our patients.
- Clinical Governance guides everything we do … from the bedside to the boardroom and in every part of our support and corporate services.
- It's how we ensure that every part of Mater fits together and is consistently focused on what matters for our patients.

Questions to Consider:

- Are you familiar with the Mater Clinical Governance Framework? Do you know how to access this document?
- Do you consider the safety and quality implications for patients and staff when participating in improvement decisions in your department / service?
- Can you explain a quality improvement activity that your team has undertaken?
- How does the leadership team provide you with support to fulfill your safety and quality roles and responsibilities?
- How do you find a policy, procedure, guideline or clinical pathway at Mater?
- Do you have access to safety and quality reports within your department and are these regularly discussed?
- Do you know how to report a hazard or risk?
- Do you know how to respond to an incident and report it on ERIC (SEQ) or RiskMan (CNQ)?
- Do you know who can assist with providing open disclosure to the patient, carer or family members after an event?
- Do you know how to respond if a patient or family member would like to raise a concern (complaint) or provide feedback about their care?
- Are you familiar with the Mater's Charter of Health Care Rights and how do you provide and explain this to your patients?
- How do you actively involve patients in decision-making about their care and ensure they have signed the appropriate consent forms?
- How do you identify high-risk patients and what steps do you put in place to ensure harm does not occur to them whilst in our care?
- Do you know the minimum medico-legal requirements for accurate and complete medical record documentation?
- Do you know how to comply with security and privacy regulations in relation to patient information?
- Do you know what mandatory training and competencies you are required to complete, and have you completed this?
- Do you know how to support Aboriginal and/or Torres Strait Islander patients, particularly in the context of cultural awareness?
- Do you have a current copy of your position description that includes your safety and quality responsibilities?
- When was your last performance review? How did you demonstrate compliance with your safety and quality responsibilities during your review? Were your needs for training and development discussed with you during your review?
- How does the organisation monitor clinician practice and ensure they are working within the designated scope of practice?
- Do you know who to speak with if you have concerns with patient or staff safety and quality processes, particularly after hours?
- How do you ensure you are delivering evidence- based care?
- How do you monitor for variation in clinical practice and health outcomes?
- How do you participate in maintaining a safe environment for us to work in?

Action:	Intent:	Key Tasks & Strategies for Improvement:
1.01	Governing Body	• Clinicians, managers and members of governing bodies have individual and collective responsibilities for ensuring the safety and quality of clinical care. As well as being reflected in the NSQHS Standards, many of these are also specified in relevant professional codes of conduct. • Clinical governance relies on well-designed systems that deliver, monitor and account for the safety and quality of patient care. Although it is ultimately the responsibility of a governing body to set up a sound clinical governance system and be accountable for outcomes and performance within this system, implementation involves contributions by individuals and teams at all levels of the organisation.
1.02	Aboriginal & Torres Strait Islander Health	• Monitoring safety and quality for Aboriginal and Torres Strait Islander people; health service organisations should have goals or targets in place for the care of their Aboriginal and Torres Strait Islander patients and should routinely measure and report on specific performance indicators related to those goals and targets. • Interventions are multidisciplinary and operate across services.
1.09	Safety & Quality Reporting	• Collaborate with the workforce, consumers, local communities and other health service organisations to identify the topic areas, format and frequency of reporting to these groups on safety and quality performance, and the effectiveness of the safety and quality systems. • Routinely collecting process and outcome data, monitoring data for trends and reporting clinical alerts enables organisations to understand outcomes from service delivery, and to respond to deviations from the expected outcomes promptly.

		• Monitoring safety and quality performance data should include all clinical areas and cover all locations of service delivery to ensure a comprehensive picture of performance. • Clearly documented processes to ensure the accuracy, validity and comprehensiveness of information will increase the organisation's confidence in data quality. Providing the governing body and the workforce with access to the organisation's most important safety and quality metrics (indicators) will enable regular review of progress and will allow the organisation to respond to issues as they arise. Suitable metrics may include: o Key relevant national priority indicators and regulatory requirements o Those covering safety, clinical effectiveness, patient experience, access and efficiency across the organisation's range of services and service locations o Trends in reported adverse events, incidents and near misses o Compliance with best-practice pathways. Provide the governing body and management with regular, comprehensive safety and quality presentations and reports from managers and clinicians. Schedule data presentations following agreed criteria (for example, significance of risk, patient volume, organisational priority or focus). Effective data presentations should cover: o The design of the systems and processes being used o Evaluation and management of risks o The effectiveness of the risk management system o Compliance with evidence-based practice o Safety and quality outcomes, including consumer experience and patient-reported outcome measures o Plans to improve safety and quality and reduce risk. • The workforce, who should review the data to identify emerging safety and quality issues or assess the impact of safety and quality initiatives.
1.10	Risk Management	• Demonstrate ability to identify and manage risk effectively.
1.11	Incident Management	• Workforce responsibilities for managing reported incidents, including grading their severity and leading further investigations. • Ensure that each incident is reviewed by the clinicians involved and the manager responsible for the operational area in which the incident occurred. This enables lessons to be learned and local improvements to be implemented. A system to verify that managers follow up incidents appropriately will ensure integrity of the risk management system. • The workforce and consumers can be involved in the review of clinical incidents through: o Regular review of reports or data analysis on clinical incidents o Periodic review of incident management and investigation systems to ensure that they are effective in improving safety.
1.12	Open Disclosure	• An open disclosure process is used to enable the health service and clinicians to communicate openly with patients following unexpected healthcare outcomes and harm.
1.13	Feedback	• Feedback from the workforce, patients and carers is used to improve safety and quality. • Providing a mechanism to regularly seek feedback from the workforce to test the culture of the organisation o Ensuring that information gained from the feedback system is analysed for safety and quality risks and improvement opportunities, and used to inform the organisation's quality improvement system o Reviewing information about the performance of the patient feedback system o Ensuring that the workforce, patients and carers receive information about what has been learned from the feedback system, and how it has been used to generate improvements in the organisation o Comparing performance with similar services and any nationally available benchmark
1.14	Complaints Management	• The workforce, patients and carers are to report complaints, and that support the analysis of the complaints process. • Roles and responsibilities of those overseeing the complaints management system (including data analysis) should be clearly defined including: o Initiating an open disclosure process o Following up complaints to ensure that improvements have been made, if appropriate.
1.16	Healthcare Record Systems	• Maintain accurate and complete healthcare record. • Review the processes for maintaining confidentiality and privacy of patient information. • A number of standards, guidelines and policies apply to healthcare record documentation – for example, medical record–keeping requirements for good medical practice of the Medical Board of Australia, and state or territory health department standards for healthcare record documentation and data capture. • An effective healthcare records system should incorporate: o A workforce that is appropriately qualified and experienced in the management of healthcare records systems, with appropriate leadership skills and authority o Orientation and training of the clinical workforce in the organisation's requirements for healthcare record documentation, including the safety and quality rationale for those requirements o Clearly documented accountabilities and terms of reference for the individual or committee responsible for governance of the healthcare records system o Accountability for healthcare record documentation in performance development processes for the clinical workforce.
1.17	My Health Record	• Health service organisations securely share a patient's clinical information with authorised clinicians in other settings, including the My Health Record system. • The My Health Record system allows secure collection, storage and exchange of health information between consumers and providers. It uses information from general practitioners, pharmacies, pathology laboratories, imaging services and hospitals to improve the safety and quality of care by supporting clinical handover and making clinical information accessible in different settings.

		• Clinicians to ensure secure access to healthcare records.
1.20	Training Systems – competency; training needs; mandatory training; access to training and monitoring training	• Visiting medical practitioners or locum members of the workforce have the required qualifications, training and skills. • Provide training to locum or agency members of the workforce at orientation and induction. • Remain up to date with mandatory training and competency.
1.22	Performance Review	• For clinicians, performance review processes support reflective practice and provide opportunities to identify practice improvements. Reflective practice is effective when accurate and timely data are available that describe and benchmark a clinician's practice outcomes. Organisations should seek to collect and present clinician-specific data that can be used to support practice improvement and encourage clinicians to participate regularly in performance appraisals. • Formal performance review processes may not be in place for members of the workforce who are employed indirectly (for example, through contract or locum arrangements). In these cases, performance management may be addressed by: o Using the processes for credentialing and scope of clinical practice outlined in Actions 1.23 and 1.24 o Reviewing clinical performance data when contracts are due for renewal o Addressing feedback or issues identified by the medical advisory committee.
1.23	Scope of Clinical Practice	• The health service organisation has processes to: o Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan o Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice o Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered. • Clinicians are appropriately skilled and experienced to perform their roles safely, and to provide services within agreed scope of clinical practice.
1.24	Credentialing	• The health service organisation: o Conducts processes to ensure that clinicians are credentialed, where relevant o Monitors and improves the effectiveness of the credentialing process. • A formal process is used to ensure that clinicians have the appropriate qualifications, experience and skills to fulfil their delegated roles and responsibilities.
1.25	Safety & Quality Roles & Responsibilities	• Every member of the workforce understands and enacts their safety and quality roles and responsibilities
1.26	Clinician Supervision	• The clinical workforce is appropriately supervised as and when required to ensure the provision of safe, high-quality care. • Ensure that clinicians who supervise other clinicians o Have the qualifications and skills necessary to supervise in the nominated area of clinical practice o Have experience at the appropriate level of practice o Have the training and experience necessary to provide supervision o Are located appropriately to provide adequate supervision o Participate in the process of reviewing the supervised clinicians' scope of clinical practice.
1.27	Evidenced-based Care	• The clinical workforce is supported to use the best available evidence.
1.28	Variation in Clinical Practice & Health Outcomes	• Clinical practice levels of activity, processes of care and outcomes are reviewed regularly and compared with data on performance from external sources and other similar health service organisations.
1.30	High Risk Behaviour Management	• Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce. • Provides access to a calm and quiet environment when it is clinically required.

Partnering with Consumers Standard

Key Messages:

- Partnering with consumers is essential to patient-centred care.
- Encourage patients and carers to ask questions about their care and participate in care planning and treatment decisions.
- We need to make sure patients and carers know how to provide feedback

Questions to Consider:

- When should a patient be provided with the Charter of Healthcare Rights?

- What do you do if a patient is at risk of not understanding their Rights?
- When is a patient provided a copy of the patient information handbook?
- When is the most appropriate time to identify the cultural and language needs of a patient?
- If a patient is dissatisfied with any aspect of their care, how should you proceed?
- If a patient would like to see a copy of their care plan, what do you do?
- If a patient would like to have a member of their family participate in an interdisciplinary case conference or 'round' to discuss their discharge plan, what do you do?
- How do you work in partnership with patients and carers in care planning and treatment decisions?

Action:	Intent:	Key Tasks & Strategies for Improvement:

2.01	Process, risk management, training requirements	• Safety and quality systems support clinicians in partnering with consumers in the delivery of care.
		• Organisational policies and procedures are in place that cover:
		  ○ Healthcare rights
		  ○ Informed consent, including financial consent
		  ○ Shared decision making and planning care
		  ○ Health literacy and effective communication with patients, carers, families and consumers
		  ○ Partnering with consumers in governance.
		• Understanding and awareness of the value of partnerships with consumers including person-centred care, shared decision making, communication techniques and health literacy.
		• The workforce effectively use the incident management and investigation system to inform risk management, and to plan and implement quality improvement processes to mitigate risks.

2.03	Charter of Healthcare Rights	• Provide ready access to copies of the Mater Charter of Healthcare Rights, in appropriate languages or formats, to all patients, and their carers and families.

2.04	Informed consent	• Informed consent is a person's voluntary decision about their health care that is made with knowledge and understanding of the benefits and risks involved. Ensure that the organisation has effective processes in place to:
		  ○ Inform patients (and, if applicable, their carers and substitute decision-makers) about the risks, benefits and alternatives of a treatment, including any fees and charges associated with treatment and referrals
		  ○ Determine patient preferences for treatment
		  ○ Document patient consent to treatment.
		• This includes processes for consent relating to transfusions of blood or blood products (Action 7.3), and specific situations that require informed consent for treatment with a medicine (Action 4.11).
		• The following are best-practice principles for informed consent systems
		  ○ Provide information to patients in a way that they can understand before asking for their consent – for example, provide an accredited interpreter to help with communication, or adapt information into accessible formats (such as translation into community languages, or providing audio or visual information); other strategies for tailoring communications to the diverse needs of the patient population are provided in Action 2.8
		  ○ Obtain informed consent or other valid authority before undertaking any examination or investigation, or providing treatment (except in an emergency)
		  ○ Document consent appropriately, and provide guidance on what to do if there are concerns about a patient's capacity to provide consent
		  ○ Meet the common law and legal requirements of the relevant state or territory relating to – providing information about treatment – obtaining consent to treatment, including the requirement to disclose all risks.

2.05	Substitute decision makers	• Clinicians to assess patients for their capacity to make health decisions.
		• Clinicians are to:
		  ○ Assess fluctuations in decision-making capacity
		  ○ Consider special populations, such as children
		  ○ Understand requirements for recording and documenting decisions.

2.06	Plan, communicate, set goals and make decisions about care	• Clinicians to partner with patients or their substitute decision-maker in the planning, communication, goal-setting and decision-making relating to their current and future care. • Provide consumers with access to information and resources in a format that meets their needs; this may include – general information about their health, condition and healthcare arrangements – information and tools about how they can be involved in their own care – information that has been developed specifically for them. • Create an environment in which patients feel confident asking questions, and in which clinicians respond positively to patient needs; this may involve speaking with patients in a neutral environment, away from the clinical setting. • Strategies for involving patients in care planning may include systematically discussing patient preferences for care during admission consultations, and at regular times during their care. This may be facilitated by including patients in bedside rounding and clinical handovers.
2.07	Forming partnerships with patients to involve them in own care	• Clinicians work with patients to enable them to be partners in their own care.

2.08	Communication mechanisms for diverse consumer group (interpreter services)	• Implement communication mechanisms that meet the needs of specific populations:
		  ○ Adapting existing consumer information into culturally appropriate formats
		  ○ Using techniques to check a consumer's understanding of information, such as a 'teach back' method
		  ○ Using symbols or cue cards for communicating with patients during care, such as instructions for the correct use of medicines

		○ Using technology, mobile apps or social media to help communication, if appropriate.
2.10	Communication - information meets needs, is easy to understand, meets clinical needs in facility and ongoing care at discharge	• Clinicians to communicate effectively with consumers about their health and healthcare needs. • Clear and open communication between consumers and clinicians is vital for the delivery of effective, efficient and ethical health care. It also facilitates good clinical decision-making, protects the legal rights of consumers to be informed and involved in decision-making, and assists when supported decision-making is required. • Processes to support clinicians to communicate effectively with patients and their carers about all aspects of their care involve obtaining informed consent and determining a patient's treatment preferences and goals of care.

Preventing and Controlling Infections Standard

Key Messages:

- The intent of this standard is to reduce the risk to patients, consumers and members of the workforce of acquiring preventable infections. This will be achieved by:
  - Effectively manage infections, if they occur;
  - Prevent and contain antimicrobial resistance;
  - Promote appropriate prescribing and use of antimicrobials as part of antimicrobial stewardship; and
  - Promote appropriate and sustainable use of infection prevention and control resources
- All patients are potentially at risk of hospital acquired infections
- Follow the five moments of hand hygiene.
- Involve patients and their families in reducing the risk of infection.
- Follow the principles of 'Clean between' (clean shared patient equipment between use)
- Practice the principles of aseptic technique
- Know your immunisation status

Action:	Intent:	Key Tasks & Strategies for Improvement:
3.01	Policies, Procedures & Risks	• Please refer to local policies and procedures and ongoing updates regarding COVID-19 management. • Familiarisation with specific policies and local work processes relating to this standard for all clinicians include: ○ Standard and transmission-based precautions ○ Environmental cleaning and disinfection ○ Reprocessing of reusable medical devices ○ Single-use items ○ Insertion and maintenance of invasive devices ○ Outbreaks or unusual clusters of infection or communicable disease ○ Reporting requirements for communicable and notifiable diseases ○ Antimicrobial prescribing and use ○ Safe work practices for: ▪ use, handling and disposal of sharps ▪ waste and linen management ▪ workforce immunisation ▪ exposure-prone procedures ▪ prevention and management of occupational exposures to blood and body substances.
3.02	Governance Activities	• Understand where you can access the relevant equipment and personal protective equipment (PPE) i.e. masks, gloves, gowns to prevent and control infections. • Establish multidisciplinary teams to identify and manage risks associated with infections and antimicrobial stewardship. • Understand organisational plans for public health and pandemic risks as required.
3.03	Quality Improvement	• Have access to updates, communication and reports regarding infection prevention and control processes e.g. COVID-19 update emails. • Support and monitor the safe and sustainable use of infection prevention and control resources.
3.04	Partnering with Consumers	• Clinicians partner with patients to prevent and manage healthcare-associated infections and implement an antimicrobial stewardship program by: ○ Actively involving the patients in their own care ○ Meeting the patient's information needs ○ Ensuring shared decision-making.
3.05	Surveillance	• Monitor, assess and use surveillance data to reduce the risks associated with infections relevant to facility and service. • Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing. • Surveillance strategies should support infection prevention and control activities and be used to identify gaps and set priorities for action to minimise the risk of preventable healthcare-associated infections. • Surveillance activities may be used to monitor: ○ Staphylococcus aureus bacteraemia

		○ Clostridium difficile infection ○ Central line-associated bloodstream infection ○ Catheter-associated urinary tract infection ○ Surgical site infection (for example, joint replacement, cardiac and maternity) ○ Ventilator-associated complications ○ Multidrug-resistant organisms of significance ○ Compliance with outbreak management processes in the health service organisation ○ Intravascular devices removed because of complications compared with those removed at the end of treatment ○ Consistency of antimicrobial prescribing with evidence-based Australian therapeutic guidelines ○ Post-discharge infection data from other health service organisations, clinicians or general practitioners.
3.06	Standard & Transmission-based Precautions	• The risk of infection to patients, the workforce and visitors is minimised by the routine application of basic infection prevention and control strategies. • Understand the local policies and processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare
3.07		• Understand how to apply and remove PPE safely and if required, ensuring that you have undergone the required training and fit testing process.
3.08		• Understand what might make patients at increased risk of infection. • Know what infection prevention strategies are in place where you work. • Understand what actions need to be put in place if a patient develops an infection / becomes colonised. • Clinicians assess infection risks and use transmission-based precautions based on the risk of transmission of infectious agents, and consider: ○ Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated when clinically required during care ○ Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance ○ Accommodation needs to manage infection risks ○ The need to control the environment ○ Precautions required when the patient is moved within the facility or to external services ○ The need for additional environmental cleaning or disinfection ○ Equipment requirements
3.09		• A patient's known or suspected colonisation or infection risks are communicated to an admitting, transferring or referring facility to minimise exposure of patients, the workforce and visitors to infectious agents. • Understand local systems and processes used by managers and the workforce on admission, at entry points or when care is transitioning, including: ○ pre-admission information ○ alerts, flags or risk identification processes ○ protocols for clinics, day surgery, emergency departments, community services and clinicians' rooms on how to assess patients for colonisation, infections or communicable diseases ○ processes for transporting patients within or outside the health service organisation. • Understand processes to communicate relevant information relating to a patient's infection status whenever responsibility for care is transferred. This includes: ○ Between members of the workforce ▪ on admission ▪ at every clinical handover ▪ at any transition or transfer of care, including to other departments in the health service organisation (for example, radiology, operating theatre, rehabilitation) ▪ during clinical review or consultation ▪ during transport both within and outside the health service organisation ○ To other relevant clinicians or care providers, including ▪ general practitioners ▪ community nurse services ▪ allied health clinicians ▪ carers and family on discharge ○ To other heath service organisations, including rehabilitation and aged care services. • Keep up to date with communication about infections. • Improvement strategies should be implemented to address areas of concern.
3.10	Hand Hygiene	• All members of the Mater community must adhere to hand hygiene protocols at all times and particularly when working in designated clinical areas. • Hand hygiene data should be regularly shared and discussed. • Improvement strategies should be implemented to address areas of concern.
3.11	Aseptic Technique	• A risk-based process is implemented that will prevent or minimise the risk of introducing infectious agents during clinical procedures and activities. • Know which clinical procedures and activities for which aseptic technique needs to be assessed, such as: ○ Surgical procedures, including invasive procedures performed in the operating room, procedure room or clinical areas ○ Venepuncture

		○ Insertion of vascular access devices such as peripheral or central lines ○ Maintenance of vascular access devices, including line or dressing changes, or medicine administration through these devices ○ Urinary catheterisation ○ Simple dressings ○ Complex or large dressings ○ Gowning and gloving ○ Collecting of swabs and other specimens.
3.12	Invasive Medical Devices	• Infections are minimised by the appropriate selection, safe insertion and maintenance, and timely removal of invasive medical devices. • As part of the organisational risk assessment, determine: ○ Which invasive medical devices are used in your local facility ○ Where they are used ○ Which clinicians are using them ○ Escalation pathways to manage difficult insertion of invasive devices ○ Whether clinicians have been trained and assessed in appropriate selection, management and removal of the invasive medical devices they use ○ Consistency with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare ○ Compliance with relevant regulations, guidelines and state or territory requirements covering invasive medical devices. • Understand the recommendations and principles from the new Management of Peripheral Intravenous Catheters Clinical Care Standard.
3.13	Clean & Safe Environment	• Know how to arrange for additional environmental cleaning if required. • Maintain a clean and clutter free area of work.
3.15	Workforce Screening & Immunisation	• Keep your immunisation status up to date. • Partake in the workforce immunisation campaigns provided to all staff e.g. influenza and COVID-19 vaccines.
3.16	Infections in the Workforce	• Promote non-attendance at work and avoid visiting or volunteering when infection is suspected or confirmed. • Arrange for support if you are required to isolate or quarantine following exposure to or confirmation of infection. • Assist in planning for, and managing, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection.
3.17	Reprocessing of Reusable Equipment & Devices	• When reusable equipment and devices are used, understand: ○ Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines ○ The traceability process for critical and semi-critical equipment, instruments and devices that can identify ▪ the patient ▪ the procedure ▪ the reusable equipment, instruments and devices that were used for the procedure ○ Processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections.
3.18	Antimicrobial Stewardship	• Understand and be familiar with the Mater Antimicrobial Stewardship Policy and antimicrobial formulary. • Have access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing. • Understand the recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard. • Act on the results of antimicrobial use and appropriateness audits to promote continuous quality improvement.
3.19		• Use surveillance data on antimicrobial resistance and use to support appropriate prescribing. • Identify areas for improvement and take action to improve the appropriateness of antimicrobial prescribing and use. • Know your: ○ Compliance with the antimicrobial stewardship policy and guidance ○ Areas of action for antimicrobial resistance ○ Areas of action to improve appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or local resources on antimicrobial prescribing ○ The organisation's performance over time for use and appropriateness of use of antimicrobials.

Medication Safety Standard

Key Messages:

- The intent of this standard is to ensure clinicians are competent to safely prescribe, dispense and administer appropriate medicines and to monitor medicine use. To ensure consumers are informed about medicines and understand their individual medicine needs and risks.
- Safe medication management is essential to patient care.
- Follow the six rights of medication administration.
- Monitoring medication errors allows us to take action to reduce risk.

Action:	Intent:	Key Tasks & Strategies for Improvement:
4.01	Clinical governance	• Safety and quality systems support clinicians in the safe and effective use of medicines and reduce medicine-related risk. • Familiarise yourself with local policies and procedures for medication management particularly procedures related to: o Medicine evaluation and list of approved medicines (formulary) o Procedures for managing high-risk medicines (for example, administration of medicines in high-risk domains such as paediatrics, anaesthetics and chemotherapy) o Recording of a best possible medication history (BPMH) o Using standard forms such as the national inpatient medication chart (NIMC) or Pharmaceutical Benefits Scheme hospital medication chart (PBS HMC) o Provision of information about medicines to patients o Liaison with the pharmaceutical industry o Use of oral dispensers for administering oral medicines o User-applied labelling o Avoiding use of abbreviations o Safe implementation and use of electronic medication management o Use of standardised electronic display of clinical medicines information o Management and reporting of medication incidents and suspected adverse drug reactions (ADRs). • Ensure regular assessment of qualifications and competence of clinicians to safely prescribe, dispense and administer medicines.
4.02	Quality improvement	• Implement quality improvement strategies for medication management based on the outcomes of monitoring activities. • Monitoring the occurrence of, analysing the frequency and causes of, and reporting on, medicine-related incidents, including ADRs (related to Actions 4.7–4.9).
4.03	Partnering with consumers	• Clinicians partner with patients to minimise medicine-related risks by: o Actively involve patients in their own care o Meeting the patient's information needs o Ensuring shared decision-making • Shared decision making can only occur when a patient understands what medicines are being proposed, the need for a new medicine, or why a change to therapy (including a dose change or ceasing a medicine) is being recommended. • Patients need to be involved in setting treatment goals and supported to understand the proposed outcomes of treatment. • Discussion about medicines should include: o Duration of treatment o Whether the medicine will cure their illness, or is required to control the symptoms of their chronic illness o Untoward effects (for example, side effects, pain on administration) that the medicine may have. • Use the strategies outlined in Action 2.5 to identify and support patients who do not have the capacity to understand the risks of medicine use or make decisions about their care.
4.04	Medicines scope of clinical practice	• Clinicians work within their scope of clinical practice, and have the knowledge, skills, competence.
4.05	Medication reconciliation	• Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care. • Complete a Best Possible Medication History (BPMH) as early as possible on admission – this is the key first step of a formal process of medication reconciliation. At least two sources of information are needed to obtain and then confirm the patient's BPMH – for example, the patient and their nominated general practitioner or community pharmacist. • Use a systematic approach to obtain and record an accurate and complete history of the medicines taken by patients at home. • The BPMH and associated information should be easily accessible to all clinicians involved in managing the patient's medicines, and used to reconcile against medication orders on admission, at transfers of care and on discharge. At the end of an episode of care, verified information should be transferred and communicated effectively to the next health service organisation to ensure continuity of medication management. • Only clinicians with the requisite knowledge, skills and expertise should conduct medication reconciliation. These clinicians should be able to show competence in each of the steps of the medication reconciliation process.
4.06		• Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care • A formal, structured, multidisciplinary and timely process is in place for reconciling medicines against the BPMH and treatment plan, which involves patients and carers. • Although specific aspects of medication reconciliation may be attributable to one professional group, medication reconciliation is everybody's business, and a multidisciplinary approach is crucial to success. • Medication reconciliation may occur: o On admission – matching the current medicine orders with the BPMH, ideally within 24 hours of admission o During the episode of care – verifying that the current list of medicines is accurately communicated each time care is transferred and when medicines are recharted

		○ On discharge – checking that medicines ordered on the discharge prescription match those on the discharge plan and the medicines list, and confirming that changes have been documented. • Prioritise medication reconciliation in patients who have a higher risk of experiencing medicinerelated problems or ADRs, in a similar manner to prioritising or risk assessing patients for medication review (see Actions 4.10 and 4.12).
4.07	Adverse drug reactions (ADR)	• Medicine-related risks for patients are minimised by documenting and referring to the patient's history of medicine allergies and ADRs. • As part of a BPMH, clinicians must elicit and document known medicine allergies and ADRs experienced by a patient before their current admission (see Actions 4.4 and 4.6). • Clinicians are to challenge and verify the diagnosis of true allergies. • To minimise the risk of preventable harm from adverse drug events, it is critical to ensure that clinicians understand their responsibility to refer to a patient's medicine allergy and ADR history before, or at the point of, decision-making when prescribing, dispensing or administering medicines. • Ensure that known medicine allergies and ADRs are recorded: ○ In the medication history (paper or electronic) ○ On all forms on which medicines are ordered, such as national standard medication charts, ancillary charts and the anaesthesia record ○ In electronic medication management and dispensing systems ○ On ADR summary sheets or similar ○ By using an alert sticker on hard-copy healthcare records ○ By using electronic allergy/ADR alerts in digital healthcare records.
4.08		• Document and report medicine allergies and ADRs experienced by patients during their episode of care (see Actions 4.1 and 4.2). • Collate and review trends in reported medicine allergies and audit results, and provide information to clinicians through medication safety bulletins, in-service orientation sessions, case reports or grand rounds.
4.09		• Understand local processes to report all new suspected ADRs experienced by patients to the TGA. • This should include the importance of providing comprehensive information about the patient, the medicine that is suspected of causing the reaction, the patient's concurrent medicines, the reaction they experienced and the organisation at which it was experienced. • Health service organisations can use online learning modules developed by the TGA for health professionals on reporting adverse events with medicines and vaccines.
4.10	Medication review	• Medicines use is optimised and medicine-related problems are minimised by conducting medication reviews and documenting the outcomes in partnership with patients. • Conducted or supervised by a clinician with the appropriate skills and expertise, acting as part of a multidisciplinary team. • Although medication review is considered an inherent role of a pharmacist, medicines should also be reviewed by clinicians whenever decisions are being made about prescribing, dispensing and administering medicines. • For each medicine being reviewed, consider the clarity, validity and appropriateness of the medicine order, as well as the expected treatment outcomes. A patient's experience of using medicines and their needs may change over time, especially during an admission to a health service organisation. This means that medicines may be reviewed more than once during an episode of care. • Use medication reviews to understand the patient's experience with their current medicines and any newly prescribed medicines and ensure that their medicine use is as safe as possible. This might include discussion of: ○ When, how and whether the patient has been taking their prescribed medicines before admission to the health service organisation ○ The patient's satisfaction with the outcomes from their medicines (including those newly prescribed), as well as a positive care experience – for example, no avoidable medicine-related problems ○ The patient's quality of life and life expectancy (for patients with long-term conditions). • Medication review should include assessment of current (existing and newly prescribed) medicines; the history of all medicine-related orders and administration records, including oral and parenteral, and multiple- and single-dose medicines; anaesthetic and operative records; and ceased medicine orders. • When conducting a medication review, consider the following: ○ Is there a documented reason or evidence base for use of a medicine? ○ Does the patient still need the medicine? ○ Is the medicine still working? ○ What risks are associated with use of the medicine, and what monitoring is required? ○ Are there any patient-specific issues that will affect use of the medicine? • Medication review should be conducted in partnership with the patient, carer or family member, and in collaboration with relevant clinicians involved in the patient's care. • Guidance on conducting structured medication review: ○ National Institute for Health and Care Excellence Medicines Optimisation: The safe and effective use of medicines to enable the best possible outcomes
4.11	Information for patients	• Clinicians are supported to provide information to their patients about medicines options, benefits and risks. • Providing medicine-related information is a multidisciplinary responsibility. Provide medicine-related information in a form that can be used and understood by patients, and is sensitive to individual patients' needs (for example, culturally appropriate). • This includes providing a package to patients and carers on discharge that contains relevant medicine-related information (Action 4.12). Discuss the benefits and associated risks of any medicines, and use patient-specific written information (such as CMI) to help inform the patient about the medicine.

		• Include a section on medicines in patient information brochures about general health service organisation care and services, and in patient charter documents. This will help to inform patients that medicine-related treatment options will be discussed and information will be provided about medicines prescribed.
		• Refer patients and carers to education programs that include medicine-related information, such as cardiac rehabilitation programs, or chemotherapy education sessions for oncology or haematology patients and carers.
		• Ensure that clinicians have access to relevant, up-to-date medicine-related information (including reference materials and information tailored for patients) that is evidence based, at all stages of the medication management pathway (Action 4.13). This includes:
		  o When clinicians discuss associated risks of any medicines, as well as treatment options, with patients (for example, before making a decision to prescribe or deprescribe)
		  o When clinicians are counselling patients on the use of their prescribed medicines (for example, on discharge)
		  o When medicines are being dispensed (for example, provide patients with CMI)
		  o When medicines are being administered (for example, to educate patients on self-administration techniques, such as for inhalers or subcutaneous injections).
		• Use medicine-related information that has been tailored for patients, which has either been developed locally or sourced from reliable sites. Medicine-related information and materials that have been developed locally to meet a specific need must be endorsed by the organisation's medication safety governance group.
		• Patient-specific medicine-related information can be accessed from:
		  o Medicines.org.au, which provides access to up-to-date CMI, as well as product information for medicines available in Australia
		  o NPS MedicineWise Consumer medicine information (CMI) explained, which includes information about how to use CMI.
		• Guidance for producing locally developed information includes:
		  o The Australian Self-Medication Industry Writing About Medicines for People: Usability guidelines for consumer product information, 3rd edition
		  o The Australian Commission on Safety and Quality in Health Care (the Commission) Tip Sheet 5: Preparing written information for consumers that is clear, understandable and easy to use
		  o Medline Plus How to write easy-to-read health materials.

4.12	Provision of a medicines list	• Medicine-related problems and risk of patient harm are minimised by maintaining a current medicines list with reasons for any changes and providing it in a suitable format for clinicians at transfer of care and patients on discharge.
		• Establish a set of key elements relating to medication management in clinical handover, such as identifying high-risk patients, high-risk medicines, and the priorities for maintaining treatment and achieving patient treatment goals (see Action 4.3).
		• Continuity of medication management includes generating, maintaining and communicating a current list of medicines and the reasons for changes at clinical handover (including shift changes and movement between clinical areas/ wards; see Actions 6.7 and 6.8).
		• It is critical to communicate the patient's current medicines list, along with any medicine-related problems or adverse drug events that have occurred during a shift or episode of care (see Action 4.6). A medicine-related problem may include a patient refusing or missing a dose of medicine or withholding a medicine.
		• Ensure that clinical handover training includes the principles of continuity of medication management, and the construction of a current medicines list and the reasons for changes, tailored for communicating to the intended audience (for example, clinicians or patients).
		• To improve communication about medicines and continuity of medication management, minimise delays, and reduce the risk of medicine-related problems after transfer or discharge:
		  o Provide a current reconciled medicines list, in a standard format (discharge summary, either paper or electronic), that includes the essential elements of the medicines list and an explanation of any changes made to therapy during the episode of care
		  o Prepare the medicines list in partnership with the patient
		  o Provide clear instructions for ongoing care and follow-up requirements, if relevant
		  o Ensure consistency between medicines lists that are:
		  ▪ provided to the patient
		  ▪ in the discharge summary
		  ▪ in the patient healthcare record
		  o Resolve any discrepancies with prescriptions written on discharge before finalising the discharge medicines list
		  o If possible, transfer the medicines list electronically along with other discharge information to the patient's general practitioner and community pharmacy, and to the patient's digital healthcare record
		  o Incorporate the process of obtaining informed consent for transfer of medicines information to general practitioners and community pharmacists into standard work practices.
		• When transferring patients to other organisations, implement a standard procedure for transferring an updated medicines list and reasons for any changes. This could be an electronic transfer summary, or a copy of the current NIMC and MMP (or equivalent record).
		• Tailor the discharge format of the medicines list to the needs of the recipient (for example, the general practitioner, community pharmacist or other clinicians, as well as any organisation that the patient is being transferred to).
		• Extra documentation may be provided in specific situations, such as transfer to residential care facilities. This should be outlined in the relevant policies, procedures and guidelines.
		• Provide information for patients and carers that explains the medicines list and its purpose as leaflets, brochures, posters or the health service organisation's patient information handbook (see Action 4.11 for other medicine-related information that would be expected to be provided on discharge). Tailor the discharge format of the medicines list to the needs of the patient.

4.13	Information & decision support tools	• Medication management is supported by providing relevant, up-to-date and evidence-based medicine-related information and decision support tools to the clinical workforce. • A minimum standard set of medicine-related reference materials could include current versions of: o Australian Medicines Handbook (AMH) and AMH Children's Dosing Companion o Therapeutic Guidelines o The Australian Immunisation Handbook o Australian product information and CMI, such as MIMS and AusDI o Medicine interactions references, such as Micromedex or Stockley's Drug Interactions o References on complementary and alternative medicines, such as MedlinePlus Drugs, herbs and supplements o Australian Injectable Drugs Handbook or local injectable medicines administration guidelines o Don't Rush to Crush handbook or local guidelines. • Examples of decision support tools are: o Formulary information, prescribing requirements and approval systems o Policy directives, protocols, guidelines and authorised standing orders o Dosing calculators and medicine-interaction databases o Reference texts, and telephone-based medicines information and advice services o Guidelines for safe administration of specific medicines (for example, administering medicines via enteral tubes) o Selection of treatment in specific clinical situations (for example, appropriate choice of antimicrobial).
4.14	Safe & secure storage & distribution of medicines	• Medicines are safely stored and distributed with minimal waste, and disposed of appropriately. • Incorporate factors that reduce opportunity for 'look-alike, sound-alike' selection errors, particularly in relation to high-risk medicines (linked to Action 4.15). • Review incident reports for incidents associated with handling (including procurement), storage and distribution of medicines. • Review the potential for increased risk of error when changes to product labelling, packaging or storage requirements are introduced as a result of changes to procurement arrangements and contracts, product shortages, recalls or substitution. • Review and implement work practices that ensure safe and secure handling (including procurement), storage and distribution of medicines (including high-risk, investigational and clinical trial medicines). • Workforce orientation and training on cold chain management and pharmaceutical waste management. • Review organisational policies, procedures and protocols for disposal of unused, unwanted or expired medicines to ensure: o Minimal risk to the workforce and the environment (for example, cytotoxic chemotherapy, vaccines, hazardous substances) o Consistency with legislative, health and safety, and state or territory requirements (for example, secure disposal of recordable [Schedule 8] medicines only by those with the relevant authority.
4.15	High-risk medicines	• Medicine-related risks are minimised by identifying and safely managing processes relating to high-risk medicines. • Review and implement work practices relating to high-risk medicines that ensure: o Appropriate storage and safe delivery systems for medicines such as anaesthetics, neuromuscular blocking agents, anticoagulants, aminoglycosides, cytotoxic chemotherapy (for example, vincristine), opioids and insulin o Storage of, and access to, high-risk medicines comply with legislative requirements (for example, opioids only available to clinicians with authorised access) o Safe prescribing (for example, standardised or specialised charts, using protocols or standard sets, electronic prescribing, dose-calculating tools) o Accuracy in medicine selection and dispensing (for example, using barcode or similar product scanning technology, using Tall Man lettering) o Appropriate controls are in place for compounding high-risk medicines (for example, using commercially available products or ready-to-administer preloaded syringes, standardised single concentrations for infusions, adhering to good manufacturing practices, using National Association of Testing Authorities–certified cytotoxic containment cabinets or similar, spill containment procedures) o Safe procurement practices (for example, avoiding look-alike packaging for high-risk medicines, especially those used in high-risk procedures such as sedation) o Safe administration (for example, appropriate use of equipment such as infusion pump drug libraries, oral liquid dispensers, line labelling for routes of administration, epidural lines without injection ports, standardised premixed solutions, independent double checks, principles of 'time out'). • Implement high-risk medicine-related policies, procedures, guidelines and safe work practices that are evidence based, have been developed in collaboration with relevant clinicians, and include: o Labelling and storage requirements (for example, implementing the National Standard for User-Applied Labelling of Injectable Medicines, Fluids and Lines, separate storage of highly concentrated electrolyte solutions such as injectable potassium chloride or magnesium) o Patient-specific protocols for monitoring requirements that will ensure a prompt response to adverse events or side effects associated with treatment o Availability of antidotes and reversal agents, and rescue protocols o Work practice restrictions and access authorities, as necessary o Incident reporting requirements o Management of breaches, violations or practice variations. • Investigate incidents involving high-risk medicines, analyse the frequency and causal factors, and implement strategies to mitigate risks associated with high-risk medicine-related incidents.

		• Use recommendations from high-risk medicine-related incident analysis to make relevant system-wide changes within the organisation. • Apply safe and robust design principles to processes. Ensure that recommendations from national, state or territory and local policies, alerts, incident reports and audits are actioned. • Tailor communications on high-risk medicines for patients and carers, which might include instructions on monitoring symptoms or side effects, and when to ask a clinician for assistance.

Comprehensive Care Standard

Key Messages:

- The intent of this standard is to ensure that patients receive comprehensive care – that is, coordinated delivery of the total health care required or requested by a patient.
- This care is aligned with the patient's expressed goals of care and healthcare needs, considers the effect of the patient's health issues on their life and wellbeing, and is clinically appropriate.
- To ensure that risks of harm for patients during health care are prevented and managed, clinicians identify patients at risk of specific harm during health care by applying the screening and assessment processes required in this standard.

Action:	Intent:	Key Tasks & Strategies for Improvement:
5.01	Clinical governance	• Safety and quality systems support clinicians in the delivery of comprehensive care and minimising patient harm. • Using organisation-wide integrated screening and assessment processes. • Ensuring shared decision making in the context of comprehensive care planning, and in making decisions about end-of-life care. • Documenting screening and assessment findings, the outcome of shared decision-making processes, agreed goals of care and comprehensive care plans. • Outlining the roles, responsibilities and accountabilities of multidisciplinary team members in developing, documenting, evaluating and reviewing comprehensive care plans, and delivering comprehensive care. • Using processes for identifying patients with endof-life care needs; receiving, documenting and using advance care plans; accessing supervision and support; and reviewing the safety and quality of end-of-life care. • Using processes relating to the specific harms identified in the 'Minimising patient harm' criterion of this standard.
5.02	Quality improvement	• Quality improvement systems are used to support the delivery of comprehensive care and minimise patient harm.

5.03	Partnering with consumers	• Clinicians partner with patients when providing comprehensive care and minimising patient harm by:
		  o Actively involving the patients in their own care
		  o Meeting the patient's information needs
		  o Ensuring shared decision-making.

5.04	Designing systems	• The health service organisation provides systems to enable and support the delivery of comprehensive care to patients.
		• Identify, at all times, the clinician with overall accountability for a patient's care.
		• Comprehensive care plans are different from traditional nursing care plans or medical treatment plans because they require the expertise of each clinician group to be brought together to coordinate and progress a patient's care and reach agreed goals.
		• This means that clinical and consumer groups should be involved in agreements about:
		  o The minimum expectations for the content of comprehensive care plans
		  o Further expectations for comprehensive care planning in specific settings or services, or for specific patient populations (for example, children, older adults, elective and emergency admissions, Aboriginal and Torres Strait Islander people)
		  o Triggers for review of comprehensive care plans
		  o Roles and responsibilities for developing comprehensive care plans
		  o Processes for supporting shared decision making with patients, carers and families (see Actions 2.6 and 2.7)
		  o Templates for documenting comprehensive care plans
		  o Processes for communicating the content of the plan (see Actions 6.4, and 6.7–6.10).
		• Design processes to develop, document and communicate comprehensive care plans:
		  o Comprehensive care plans should be developed in partnership with patients, carers and families, and with input from all the clinicians involved in a patient's care (for example, doctors, nurses, pharmacists, allied health clinicians).
		  o Develop processes to ensure that patients receive care in the setting that best meets their needs: Although patient flow affects clinical care, clinical care also affects patient flow. Poorly coordinated, disconnected and reactive care planning can compromise patient flow through the hospital and timely hospital discharge.
		• Establish referral processes:
		  o Referring clinicians, and specialist clinicians and services need to work collaboratively to set clear referral criteria.
		• Set up processes for identifying the clinician with overall accountability:
		  o Although all clinicians are accountable for the care they provide to patients, the clinician carrying overall accountability for an individual patient's care should have the seniority to make time-sensitive or complex clinical decisions. The clinician who has overall accountability should also be accessible and available so that

		they can lead and coordinate comprehensive care planning and delivery. Confusion about which clinician has overall accountability for a patient's care can lead to communication issues and delays in clinical decision-making. o It is a requirement in the Medical Board of Australia's Code of Conduct that doctors ensure 'that it is clear to the patient, the family and colleagues who has ultimate responsibility for coordinating the care of the patient'. This can be challenging in the hospital context, and identifying which clinician has overall accountability for a patient's care at any given time can be complex. o Overall accountability for a patient's care may be handed over between several clinicians (including doctors, nurse practitioners, midwives and allied health clinicians) during a 24-hour period, and during the course of a patient's admission. On-call or locum clinicians may carry overall accountability for a patient's care at different times. Further complexity can be added when care is shared between teams (for example, in orthogeriatrics) or when multiple teams are involved in a patient's care (for example, patients with multiple chronic organ diseases, maternity patients with pre-existing medical conditions, children with complex medical conditions). o Develop consistent and up-to-date processes for identifying the clinician with accountability for individual patients' care at any time of the day or night.
5.05	Collaboration & MDT teamwork	• Clinicians are supported to work in collaborative multidisciplinary teams, and they understand their own roles and responsibilities, and those of other team members. • To deliver comprehensive care that is safe and continuous, effective communication and teamwork are critical. Implement this action with consideration of the requirements of the Communicating for Safety Standard. • A substantial proportion of potentially preventable adverse events are underpinned by failures in communication and teamwork. Given the complexity of health care, teams and clinicians may change regularly or over time, depending on the needs of the patient. Improvements in multidisciplinary collaboration and teamwork have been associated with outcomes such as reduced length of stay , reduced risk of complications of medical care and reduced risk of surgical complications or death. • Demonstrate compliance with 'Speaking with Good Judgement' training.
5.06		• Clinicians work together to plan and deliver comprehensive care in partnership with patients, carers and families. • Collaborate with patients, carers and families: o Collaborating with patients, carers and family members can ensure that essential baseline information about a patient's condition is established so that deterioration, improvement and strategies for ongoing care can be identified. o As well as being experts in care needs, information providers and part of shared decision making, carers and other family members may also choose to be actively involved in a person's care. • Implement shared decision making: o Shared decision making is a critical strategy for effectively collaborating with patients, carers and families. Shared decision making is a process of incorporating the best available clinical evidence into a discussion about a patient's values and preferences to make decisions about care. o Shared decision making offers a framework for working jointly with patients (and carers and families, if the patient chooses to have them involved) to make decisions about the comprehensive care plan that are based on a shared understanding of the patient's goals of care, and the risks and benefits of clinically appropriate options for diagnostic tests, treatments, interventions and care. o One model for shared decision making describes five questions that clinicians can use to guide the process: 1. What will happen if the patient waits and watches? 2. What are the test or treatment options? 3. What are the benefits and harms of each option? 4. How do the benefits and harms weigh up for the patient? 5. Does the patient have enough information to make a choice? o Another model, framed from the patient perspective, is Ask Share Know, which encourages patients to ask three questions about their care. o The Commission has also developed a Question Builder tool to help patients, carers and families consider questions to ask their doctor and prepare for a clinical consultation. • Use decision support tools: o Decision aids are a type of decision support tool that clinicians, patients, carers and families can work through together. Specific decision aids have been developed for some health topics, and an online inventory of existing tools is available. o A generic decision aid tool has also been developed to help clinicians, patients, carers and families work together to make decisions if no specific decision aid is available. • Strengthen teamwork processes: o No single clinician can deliver all aspects of the care that a patient needs. Different clinician groups bring specific expertise and need to work together to provide the complete health care that a patient requires. Effective teamwork and collaboration rely on establishing and communicating clear and shared goals. These goals should have meaning for each team member who contributes to the effort to achieve them
5.07	Screening & assessment	• Processes are in place for integrated and timely screening, assessment and risk identification. • Link screening activities to clinical decision-making and action when clinical risks are identified. This might mean ensuring that screening tools direct clinicians to the relevant assessments and interventions for managing an identified risk. • In some cases, different emphasis will be placed on screening versus comprehensive assessment. For example, in the anaesthetic assessment service, a detailed preoperative screening process may be needed to identify anaesthetic

		and surgical risks. In the geriatric section, screening processes may be minimal because patients routinely receive a thorough clinical assessment of the common conditions, issues and risks associated with older hospitalised patients.
5.08	A&TSI identification & care planning	• People who identify as being of Aboriginal and/or Torres Strait Islander origin are provided with tailored and culturally appropriate comprehensive care. • Further strategies are available in NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health

5.09	Advance care plans	• Patients are supported to document clear advance care plans.
		• Ensure that the advance care planning process includes discussion of a patient's values, preferences, and personal and family circumstances, and occurs in the context of their medical history and condition.
		  o When undertaking advance care planning, patients need to consider many issues, including: How their previous experiences of health care influence their preferences for future care
		  o The quality of life that would be acceptable to them
		  o Who they would want to speak for them if they lack the capacity to take part in decision-making
		  o How they will maintain the relevance and currency of their advance care plan.
		• Outcomes of advance care planning may include nomination of a substitute decision-maker, or documentation of an advance care plan or directive. Patients may want to consider a number of different scenarios through advance care planning, such as their wishes and preferences for future care when:
		  o An episode of acute deterioration in mental state occurs
		  o Progressive cognitive decline associated with dementia occurs
		  o Decisions about end-of-life care are needed.
		• Advance care planning is an iterative process, and multiple discussions may be needed. Documented advance care plans need to be updated over time.

5.10	Screening of risk	• Patients receive initial and, if necessary, repeated screening for cognitive, behavioural, mental and physical conditions, issues or risks of harm. • Integrate the use of screening processes into clinician workflow. This may include requiring that credentialed medical and other practitioners use screening tools during clinic appointments before a planned episode of care.
5.11	Clinical assessment	• Patients receive comprehensive assessment to determine their healthcare needs and appropriate treatment options. • Comprehensive assessment relies on clinicians working with patients, carers and families to understand a patient's current health status, and its effect on their life and wellbeing. Integrate usual clinical assessment processes (for example, investigation of the presenting condition) with assessments of specific conditions, issues and risks (for example, a pre-existing chronic condition, a behavioural issue relating to cognitive impairment, a social issue such as homelessness). • Clinicians from different professions and in different services may need to work together to develop a full picture of the patient's needs.
5.12	Comprehensive care plan & shared decision-making	• Findings of screening and assessment processes are documented accurately and contemporaneously. • This action should align with the requirements of the Communicating for Safety Standard. Work with clinicians to develop processes for documenting the findings of screening and assessment processes.

5.13		• Clinicians use shared decision-making processes to develop person-centred and goal-directed comprehensive care plans that meet identified patient needs.
		• This action requires clinicians to use the processes described in the Partnering with Consumers Standard to work with patients or substitute decision-makers to reach shared decisions about the comprehensive care plan. It also requires clinicians to use the processes described in the Communicating for Safety Standard to document the comprehensive care plan and communicate its content to relevant members of the workforce.
		• The level of detail in a comprehensive care plan should reflect the significance and complexity of a patient's clinical situation.
		• Ensure that comprehensive care plans include:
		  o Agreed goals of care and actions required to achieve them
		  o Actions required to manage identified risks of harm
		  o Actions required to ensure safe discharge from the health service organisation
		  o Indications for review of the comprehensive care plan.
		• The comprehensive care plan may also identify the individuals who are accountable for the actions required to achieve the goals of care, manage clinical risks and ensure safe discharge from the health service organisation.
		• Identify goals of care:
		  o Ensure that goals of care reflect the input of doctors, nurses, allied health clinicians, consumer liaison officers (for example, Aboriginal liaison officers), the patient, carers and family.
		  o Goals of care may include:
		  ▪ Condition- or disease-specific goals such as 'give maximum three days of antibiotics and fluids; seek specialist palliative care advice regarding symptom control; likely palliation if significant deterioration occurs or if there is no improvement within 72 hours'
		  ▪ Functional goals such as 'maintain ability to independently perform activities of daily living'
		  ▪ Personal goals such as 'attend daughter's wedding in four weeks'.
		  o Ensure that goals of care also identify the overall intent of an episode of care, including whether there are any agreed limitations on medical treatment.
		  o Clinicians who deliver care to people who experience mental illness can work collaboratively to ensure that clinical goals are balanced with the person's own values.
		• A person-centred healthcare system is one that supports patients to make informed decisions, and successfully manage their own health and care. This includes giving patients choice about when to let support people, such as family or carers, be involved in their decision-making or make decisions on their behalf.
		• Plan for discharge:

		○ Part of the comprehensive care planning process is planning for discharge from the health service organisation. This includes identifying any services, equipment and follow-up that may be needed to safely discharge the patient. Develop processes to ensure that follow-up arrangements are made before the patient leaves the health service, and that any required referrals are dealt with promptly. The person, and their family and carers, should be engaged in discharge planning from the beginning of the healthcare episode.
5.14	Using the comprehensive care plan	• The comprehensive care plan is used to direct the delivery of safe and effective care that aligns with the patient's needs and preferences. • Clinicians and other members of the workforce are aware of their obligation to provide care in accordance with the comprehensive care plan, and in collaboration with patients, carers and family members.
5.15	Comprehensive care at the end of life	• Patients with end-of-life care needs are identified as soon as possible to maximise opportunities for appropriate decision-making and care. • The National Consensus Statement: Essential elements for safe and high-quality end-of-life care sets out suggested practice for health service organisations delivering end-of-life care in settings that provide acute health care. It describes 10 essential elements of care. • The fourth essential element in the consensus statement provides detail about the need to use triggers to recognise when patients are approaching the end of life. Considering the likelihood of a patient dying offers opportunities to identify their needs and preferences, review their goals and comprehensive care plan, and consider how best to align care with the individual's expressed values and wishes. Routine use of simple trigger tools and questions can prompt clinicians to use their clinical judgement to make a holistic assessment of whether a patient has end-of-life care needs.
5.16		• Clinicians can access advice from specialist palliative care clinicians when planning and delivering end-of-life care. • Although many clinicians may regularly be involved in providing care to patients approaching the end of their life, this is the core business of specialist palliative care clinicians. If a patient has unmet physical, psychosocial or spiritual care needs at the end of life, specialist palliative care involvement can improve quality of life.
5.17		• Patients with an advance care plan receive care in line with their plan if they lack the capacity to participate in decision-making. • Ensuring that advance care plans are readily accessible to clinicians involved in providing care to patients.
5.18		• The workforce has access to support and supervision to alleviate workplace stress associated with delivering end-of-life care. • Dealing with death and dying can be challenging for clinicians, and for other members of the workforce such as ward clerks, porters and cleaners. It can add considerably to workplace stress. Chronic unmanaged stress can erode empathy, and could contribute to poorer experiences for patients, carers and families. • Understand how you can access assistance through the Employee Assistance Program (EAP).
5.19		• Patients receive safe and high-quality end-of-life care.
5.20		• Clinicians support consumers, carers and families to make shared decisions about end-of-life care.
5.21	Preventing & managing pressure injuries	• Evidence-based guidelines are used for prevention and care for patients at risk of, or with, a pressure injury. • Ensure that assessment of pressure injuries incorporates: ○ The use of a validated risk assessment tool ○ The use of a pressure injury classification system ○ Assessment of pain using validated self-reporting tools such as verbal descriptor, visual analogue or numerical scales ○ Ongoing assessment that evaluates the effectiveness of the wound management plan. • Ensure that treatment addresses: ○ Pain management ○ Wound management ○ Adjunctive treatment options such as heel elevation, prophylactic dressings or electrotherapy ○ Referral to allied health services when indicated, including dietetics or occupational therapy.
5.24	Preventing falls & harm from falls	• Clinical practice for preventing and managing falls is evidence based, and patient risks and harm are minimised.
5.27	Nutrition & hydration	• Patients' nutrition and hydration needs are identified and documented in their comprehensive care plan. • The multidisciplinary team is responsible for implementing a food and nutrition system. To be effective, all members of the workforce involved need to understand their roles and responsibilities, as well as the role of nutrition in clinical care. Identify the clinical and non-clinical members of the workforce who need training for the best operation of the system.
5.28		• The workforce ensures that the nutrition and hydration needs of patients are met. • Monitor patients' food intake and their capacity to independently eat and drink, and help when required.
5.29	Preventing delirium & managing cognitive impairment	• A system for caring for cognitive impairment is implemented that minimises the risk of harm for people with cognitive impairment or at risk of developing delirium. • An initial screen provides a useful baseline for further monitoring. Note that a positive score on a screening tool is not a diagnosis but a prompt for further assessment, early intervention and early family involvement. Document the results and communicate them to patients and family, and the relevant members of the workforce who interact with patients, including primary care clinicians. • The use of antipsychotics and other psychoactive medicines is in line with best practice and legislation.

		• For all patients with cognitive impairment:
		  ○ Assess for delirium and reassess with any changes in behaviour or thinking using validated delirium assessment tools applicable to the setting (see Action 8.5)
		  ○ If delirium is detected, investigate and treat the causes of delirium; comprehensive history taking and physical examination can enable targeted investigations
		  ○ Investigate (or refer for investigation) other causes of cognitive impairment – for example, a person may have developed cognitive impairment as a result of a recent acquired brain injury or an undiagnosed dementia, requiring further assessment, treatment and follow-up
		  ○ Partner with patients, carers and family members who have a central role in the prevention, early recognition, assessment and management of cognitive impairment; develop systems for their early consultation and involvement
		  ○ Comprehensively assess and develop an individualised plan (see Action 5.12 and 5.13)
		  ○ Provide relevant information to patients, carers and families in an easy-to-understand format, including information on delirium risk, delirium, and the roles of patients, carers and families; delirium may be a frightening experience for patients and families, and can be associated with feelings of remorse and shame
		  ○ Respond to other care needs, including assistance with nutrition and hydration (see Action 5.27), reorientation, safe mobilising, maintaining or restoring functioning, and providing meaningful activities; these strategies also assist in prevention of delirium and other geriatric syndromes, and a well-structured and well-supported volunteer program can assist in implementation
		  ○ Set goals of care based on the needs and preferences of the person with cognitive impairment; use processes for informed consent, shared and substitute decision-making, and advance care planning to set goals of care
		  ○ Manage medication issues, including
		  ▪ treating pain and reducing sedation
		  ▪ undertaking medication reconciliation, and reviewing to identify, reduce or stop medicines that can cause or exacerbate cognitive impairment (see Action 4.10)
		  ▪ providing accurate medicines lists (see Action 5.12)
		  ▪ consulting, informing and educating patients, carers and substitute decision-makers (as well as the patient's general practitioner and care facility) about these processes
		  ○ Communicate effectively and seek information to provide individualised care
		  ○ Respond appropriately to behavioural symptoms (see 'Manage the use of antipsychotic medicines', below)
		  ○ Provide a supportive environment– for example, implement evidence-based design principles in scheduled major capital works or refurbishments, as well as through simple, small-scale changes at the ward and room level (see Actions 1.29 and 1.30), and support carers and family members when they choose to be actively involved in a person's care
		  ○ Manage transitions effectively, including
		  ▪ information exchange and transfer of responsibilities among all relevant health service organisations and care providers, including seeking early primary care input (see Actions 6.7 and 6.8)
		  ▪ access to hospital substitution, outreach, fast-track or transition programs
		  ▪ referral for appropriate follow-up for undiagnosed cognitive impairment and after a delirium episode
		  ▪ for example, many patients who are identified with cognitive impairment or experience delirium may have undiagnosed dementia
		  ○ If a comprehensive diagnostic process is not appropriate during admission, arrangements must be put in place for post-discharge assessment; ensure that referral pathways are in place for post-discharge assessment and involve and inform patients and carers about ongoing care decisions.
		• For patients at risk of delirium, implement multi-component delirium prevention strategies.
		• For all patients, be alert to, and assess for, delirium when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported (see Action 8.5).
		• Manage the use of antipsychotic medicines: Incorporate best practice and legislation for the use of antipsychotics and other psychoactive medicines for people with cognitive impairment into policies and procedures. This includes:
		  ○ Conducting a comprehensive, formal assessment of any behavioural symptoms or changes, including assessment of potential unmet needs
		  ○ Communicating effectively and understanding the person
		  ○ Involving carers and family members
		  ○ Creating a supportive environment
		  ○ Managing training and education of the workforce (see Action 5.30)
		  ○ Avoiding physical restraint, if possible, and following guidance in Action 5.35 to minimise restraint
		  ○ Trying non-pharmacological approaches in the first instance
		  ○ Seeking behavioural management advice when required
		  ○ Starting pharmacological treatment only if a patient is severely distressed, or is at immediate risk of harm to themselves or others, and non-pharmacological interventions have been ineffective
		  ○ If pharmacological interventions are prescribed
		  ▪ following 'start low, go slow, time limit and review'
		  ▪ selecting the agent based on evidence according to diagnosis, severity and patient factors such as comorbidities
		  ▪ avoiding multiple agents
		  ▪ considering evidence and pharmacokinetics when selecting dose, frequency and timing
		  ▪ documenting indications for use and providing instructions for community prescribers
		  ○ Monitoring and collecting feedback on the use of antipsychotics and other psychoactive medicines.

5.30		• Risks are minimised by undertaking strategies to recognise, prevent, treat and manage cognitive impairment.

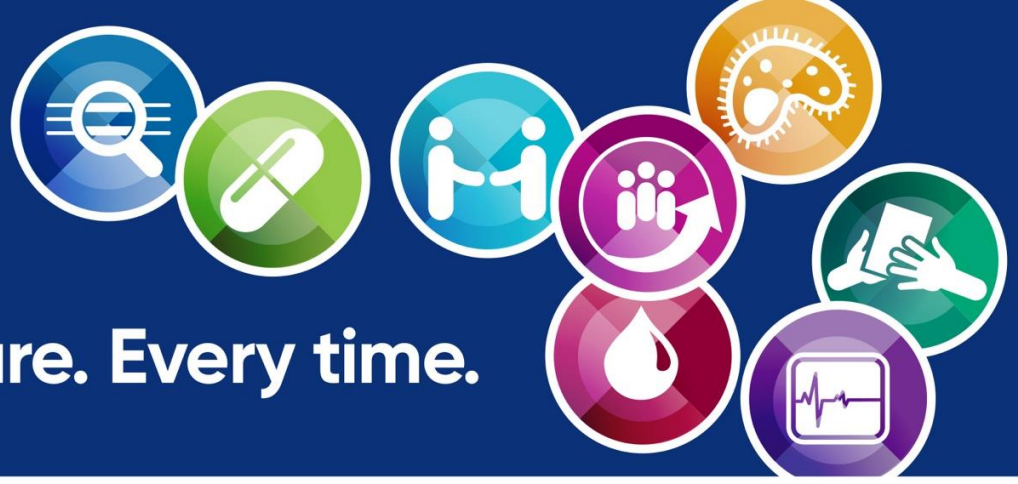
		• Clinicians, patients, carers and families work together to minimise anxiety or distress experienced by the person with cognitive impairment.

5.31	Predicting, preventing & managing self-harm & suicide	• The workforce has the skills and knowledge to engage collaboratively to identify and respond to patients at risk of self-harm or suicide.
		• Identify risk of self-harm:
		  o Maintain an empathic, non-judgmental approach while implementing clinical actions. Engage therapeutically with the person to understand what the act or thought of self-harm means for the person. Self-harm can be related to suicidal thoughts or can be independent of these. The person may or may not be clear about their intent. Some self-harm may be enacted without suicidal ideation, but still present a risk to the person's life. Always consider self-harm seriously.
		  o Processes of respectful and effective therapeutic engagement create safety for people who have thoughts of self-harm or suicide. Avoid making presumptions about the person's intent, including whether the person's self-harm does or does not indicate suicidal thoughts or is 'attention-seeking'. Communicate with the person, their carers and family, and other clinicians in non-judgmental language.
		  o The Royal Australian and New Zealand College of Psychiatrists endorses the national guidelines developed in the United Kingdom by the National Institute for Health and Care Excellence on the clinical management of self-harm.
		• Identify risk of suicide:
		  o When a person presents with suicidal thoughts, or has attempted suicide, their immediate physical safety is a priority. Use the environment, formal observation, and engagement with the person and any accompanying support people to ensure that the person remains safe until comprehensive assessment is conducted and a collaborative care plan is initiated.
		  o Access specialist mental health expertise to assess and manage a person with suicidal thoughts.
		  o Ensure that you are aware of the local process and how to escalate care.

5.32		• Adequate follow-up support is arranged and agreed by the nominated participants for when people who have self-harmed or reported suicidal thoughts leave the health service organisation. • Develop a collaborative post-discharge treatment plan involving the person, their carers and family, and key service providers before the person leaves the health service organisation • Communicate this plan verbally and in writing to all people who have a role in implementing the plan • Ensure that the plan is implemented. • Ensure that development of the plan is collaborative and recovery oriented, using the principles of shared decision making outlined in the Partnering with Consumers Standard. Engage the person, their carers and family, and any other person involved in implementing the plan, and give them the opportunity to advise whether actions within the plan are feasible.
5.33	Predicting, preventing & managing aggression & violence	• The risk of aggression and violence is minimised by reducing environmental or procedural triggers for aggression. • Identify factors in the environment that could trigger aggression or complicate management of aggression when it occurs • Identify elements of the organisation's procedures that could contribute to stress, which may lead to aggression • Implement strategies to lessen stresses caused by environmental or procedural factors.

5.34		• Collaborative processes are used to minimise the risk of aggression and violence, and incidents are managed safely when they occur.
		• Screening for risk of aggression and violence is an important and complex undertaking for members of the healthcare workforce.
		• Predictive factors for risk of aggression include:
		  o Previous history of aggression or violence
		  o Intoxication or withdrawal from licit or illicit substances
		  o Acute brain injury
		  o Cognitive impairment.
		• Where applicable, ensure your training for de-escalation is current.

5.35	Minimising restrictive practices: restraint	• Harm relating to the use of restraint is minimised. • Demonstrate implementation of strategies to reduce the use of restraint. • Ensure that members of the workforce who implement restraint are trained to do so safely. • Monitor and document appropriate observations during and subsequent to restraint. • When restraint has occurred, offer debriefing for the people involved, including patients, carers and members of the workforce. • Restraint is the restriction of an individual's freedom of movement. • It includes mechanical restraint, physical restraint, and chemical or pharmacological restraint. • Be alert to changes in a person's behaviour or demeanour that may suggest a deterioration in their mental state. Be receptive to information from the person themselves, and from their carers and families. People who have experienced mental health issues, or cared for someone who does, often have detailed knowledge about what can lead to a deterioration in their mental state, and what strategies are most effective for restoring their capacity to manage their mental state without the use of restrictive practices. • Where applicable, ensure your training for de-escalation is current.
5.36	Minimising restrictive practices: seclusion	• Harm relating to the use of seclusion is minimised. • The use of seclusion outside designated mental health services is unlawful, and health service organisations should ensure that it does not occur. • Implement strategies to minimise the use of seclusion • Ensure that seclusion is only implemented by members of the workforce who have been trained to implement it safely



		• Monitor and document appropriate observations during and subsequent to seclusion • Review the use of seclusion within the health service organisation. • Where applicable, ensure your training for de-escalation is current.

Communicating for Safety

Key Messages:

- The intent of this standard is to ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for patients.
- Effective Clinical Handover is vital for patient safety.
- Good Handovers do not happen by chance. Good handover requires the use of four key principles:
    - Preparation by staff involved
    - Leadership of and active participation in the handover process
    - structured communication and understanding of the information they should and shouldn't be included
    - transfer of accountability between the giver and receiver.
- Use structured communication (such as SHARED) to ensure optimal transfer of essential information.
- Handover must include a transfer of accountability for tasks and ongoing patient care.
- Handovers occur in many settings (e.g. transfers, discharges and between shifts). Apply the handover principles to all these handovers of care.

Action:	Intent:	Key Tasks & Strategies for Improvement:
6.01	Clinical governance	• Safety and quality systems support effective clinical communication.
6.02	Quality improvement	• Quality improvement systems are used to support the effectiveness of clinical communications.

6.03	Partnering with consumers	• Principles of person-centred care, shared decision making, and health literacy inform the way clinicians communicate with patients, carers and families during the key high-risk situations.
		  ○ Actively involve patients in their own care
		  ○ Meeting the patient's information needs
		  ○ Ensuring shared decision-making

6.04	Effective communication	• Processes to support effective clinical communication are in place for key high-risk situations, where effective communication with patients, carers and families, and between clinicians and multidisciplinary teams is critical to ensure safe patient care. • Consider all the situations and times in the organisation when identification, procedure matching and information about a patient's care need to be communicated or transferred to ensure that the patient receives the right care. • Apply the principles of 'Speaking with good judgement' with each interaction and particularly when you may have concern about a patient or staff member's safety.

6.05	Correct identification & procedure matching	• A comprehensive, organisation-wide system is in place for the reliable and correct identification of patients when care, medicine, therapy and other services are provided or transferred.
		• At least three approved patient identifiers are required each time identification occurs. This provides manual and electronic patient identification systems with the best chance to correctly match a patient with their record, without imposing impracticable demands on information gathering.
		• Patient identifiers may include:
		  ○ Patient name (family and given names)
		  ○ Date of birth
		  ○ Gender
		  ○ Address (including postcode)
		  ○ Healthcare record number
		• Use at least three identifiers:
		  ○ On admission or at registration
		  ○ When matching a patient's identity to care, medicine, therapy or services
		  ○ Whenever clinical handover or patient transfer occurs
		  ○ Whenever discharge documentation is generated
		  ○ In specific service settings, if they are different from those generally used across the organisation.

6.06		• Explicit processes are in place to correctly match patients with their intended care, to ensure that the right patient receives the right care. • Correct identification is particularly important at transitions of care, where there is an increased risk of information being miscommunicated or lost. Transitions of care occur frequently in health care and include situations when a patient's care is transferred between members of the clinical workforce, to another health service organisation or to their primary care clinician. At these times, information about a person's identity is critical to ensuring safe patient care. Consider this action alongside other actions within this standard (in particular, Actions 6.7 and 6.8). • The WHO Surgical Safety Checklist has been demonstrated to improve patient safety and is widely used in Australia. This checklist includes elements relating to patient identification and procedure matching and can be used as the patient identification and procedure-matching protocol. There is also an Australian and New Zealand version of this checklist. The key steps that underlie these protocols of care are: ○ If necessary, mark the site of the procedure

		○ Verify the identity of the patient ○ Verify the details of the procedure being undertaken, including the site of the procedure ○ Take a timeout or similar stop with all members of the team to do a final check before starting the procedure ○ Confirm all documentation, samples, and other information and materials following completion of the procedure. • Promote closed-loop communication and allow an opportunity for participants to ask questions or clarify concerns. • If appropriate, support patients, carers and families to take part in the processes to correctly match patients to their care. This may include asking a patient to confirm details about their identity, or asking the patient, family or carer to confirm details about care. For surgical safety checks, the timeout check could be done while the patient is still awake to enable them to contribute to the conversation, rather than performing it after the anaesthetic is given.
6.07	Clinical handover	• Accurate and relevant information about a patient's care is communicated and transferred at every clinical handover to ensure safe, high-quality patient care. • Practice the use of the Mater structured handover tool SHARED (Situation, History, Assessment, Risk, Expectation, Documentation) to provide a framework for communicating the minimum information content for clinical handovers.
6.08		• Clinicians use structured clinical handover processes that are consistent with the key principles of clinical handover, to effectively communicate relevant, accurate and up-to-date information about a patient's care to ensure patient safety. • Nominate all key participants for clinical handovers. Consider the need for multidisciplinary input, including clinical and non-clinical workforce members (such as nursing, allied health or psychosocial clinicians, if appropriate). • The designated leader manages and facilitates the handover. This is usually the role of the most senior clinician present; however, this will depend on the handover, and it may be more appropriate to designate a clinician who is involved in coordinating a patient's care. • Participate in multidisciplinary team handovers or rounds. • Providing patients (and carers and families, if appropriate) with discharge information, including about any follow-up appointments.
6.09	Communicating critical information	• Emerging or new critical information, alerts and risks are communicated in a timely manner to clinicians who can make decisions about care, and to the patient, family and carer, to ensure safe patient care. • Types of critical information could include: ○ Changes to medicines ○ New critical results of diagnostic tests, including pathology tests, radiology exams or ultrasound procedures, and results from any diagnostic test that is conducted at the point of care (for example, at the bedside) ○ Missed results ○ Wrong diagnosis ○ Change in patient goals ○ Allergies or adverse drug reactions ○ Issues with equipment or medical supplies ○ Information that requires follow-up with another clinician or the patient (or family or carer, if appropriate). • Participate in safety huddles to discuss potential risks and identify safety issues • Attend education sessions on 'Speaking with Good Judgement' and apply these principles when addressing problems or concern. • Adhering to established agreed communication processes and pathways between clinicians, multidisciplinary teams, and pathology, biochemistry and radiology, to ensure that members of the workforce are clear about who to communicate new critical results to, and who is responsible for the action or follow-up. • The SHARED framework may be a helpful structure to use when communicating a critical situation or change in patient condition (developed by Mater Health Services Brisbane as part of the Commission's National Clinical Handover Initiative).
6.10		• Patients and carers can communicate critical information and risks about their care to clinicians. • Where possible, allocate specific times for patients, carers and families to communicate with their care team, rather than leaving patient and family queries to random encounters with the workforce. • Ensure patients, carers and family members are provided with clear instruction and education on local processes for how they can escalate care too if they are concerned. ○ SEQ – Patient and Carer Escalation of Care (PACE) ○ CQN – Recognise, Engage, Act, Call & Help (REACH).
6.11	Documentation	• Relevant, accurate, complete and timely information about a patient's care is documented in the healthcare record to support safe patient care. • For documentation to support the delivery of safe, high-quality care, it should ○ Be clear, legible, concise, contemporaneous, progressive and accurate ○ Include information about assessments, action taken, outcomes, reassessment processes (if applicable), risks, complications and changes ○ Meet all necessary medico-legal requirements for documentation. • Documentation is complete and current (for example, new or emerging information is recorded, daily progress notes or care plans are documented, a discharge summary is completed at the time of discharge). • Clinicians provide the right documents and use them correctly.

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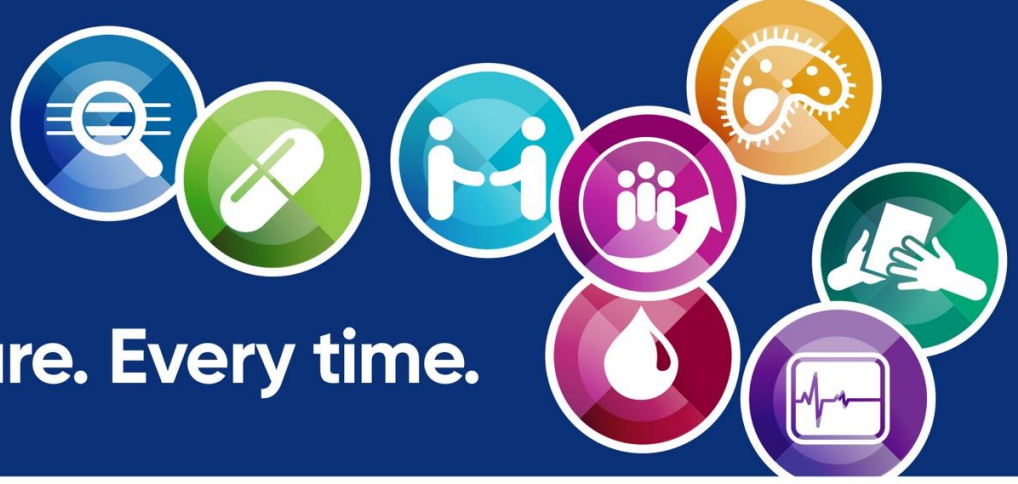

Blood Management Standard

Key Messages:

- The intent of this standard is to identify risks, and put in place strategies, to ensure that a patient's own blood is optimised and conserved, and that any blood and blood products the patient receives are appropriate and safe.
- Blood is a precious resource and must be used safely and effectively.
- Follow strict protocols to ensure administration of the right blood to the right patient for the right reason.
- We need to monitor correct patient identification and consent for safe administration of blood and blood products.

Action:	Intent:	Key Tasks & Strategies for Improvement:
7.01	Clinical governance	• Safety and quality systems support clinicians in blood management.
7.02	Quality improvement	• Quality improvement systems are used to support blood management. • If clinical decisions result in a deviation from policies and procedures, record the deviation and the justification for the deviation, including any patient blood management (PBM) strategies implemented. Ensure that the blood management governance group routinely reviews deviations to identify outliers. This will help identify where changes in clinical behaviour are appropriate, and where refinement of the policy, procedure or protocol is needed to reflect best practice. • If adverse patient outcomes are identified through incident monitoring (see Action 1.11), ensure that the blood management governance group assesses whether these incidents could be reduced by improving policies and procedures. • Investigate, audit or assess practices against national evidence-based guidelines. For example, to assess compliance with clinical practice guidelines, compare the use of products per procedure by unit/ clinician or surgeon to identify and analyse outliers.

7.03	Partnering with consumers	• Patients and carers are informed about patient blood management principles, the risks and benefits of using blood and blood products, and all treatment options by:
		  ○ Actively involve patients in their own care
		  ○ Meeting the patient's information needs
		  ○ Ensuring shared decision-making.
		• Provide information to patients and carers about optimizing their own blood, PBM strategies, and the potential need for blood and blood products, including all treatment options, risks and benefits. Provide this in a format that can be understood and is meaningful and ensure that patients are given the opportunity to ask questions. Ensure that the information is current, and that clinicians have ready access to it.

7.04	Optimising & conserving patients' own blood	• PBM strategies are in place to ensure that the clinical use of blood and blood products is appropriate and safe, and strategies are used to reduce the risks associated with transfusions.
		• Documenting blood management history and decisions:
		  ○ Accurately recording a patient's blood and blood product transfusion history, including any previous reactions and specific indications for use, in the patient's healthcare record is essential to enable easy and accurate review of records.
		  ○ Review of transfusion history is also an important component of the pre-transfusion process. It can identify any red cell antibodies, transfusion reactions or special patient requirements, and improve transfusion safety by reducing the risk of an adverse transfusion reaction.
		• Establish perioperative standard practice for assessment and management of anaemia.
		• Implement processes to communicate elective surgical time frames to patients' primary carers to enable effective anaemia management in the primary care sector, if possible.
		• Ensure that all clinicians apply PBM as the standard of care for patients facing a medical or surgical intervention who are at high risk of significant blood loss. Put processes and procedures in place for the various practices that can be initiated before, during and after surgery or other treatments.
		• Provide orientation and training on PBM for all clinicians involved in the clinical pre-, intra- and post-administration or prescription of blood or blood products.
		• Optimise patients' own red blood cell (RBC) mass, haemoglobin and iron stores:
		  ○ Preoperative anaemia is independently associated with an increased risk of morbidity and mortality and increases the likelihood of RBC transfusion. Managing anaemia before elective surgery can improve a patient's pre-surgery clinical status, and reduce post-surgery morbidity, mortality and length of stay.
		  ○ Establish a definitive diagnosis of anaemia, including whether it is related to the patient's current condition and if it is correctable. Some forms of anaemia cannot be prevented (if caused by a failure in the cell production process), but others (for example, anaemia caused by blood loss or dietary deficiency) can be prevented and managed. Before the treatment or surgery:
		  ▪ Identify, evaluate and manage anaemia as the key strategy for optimising RBC mass, haemoglobin and iron stores in all patient groups
		  ▪ Communicate with the patient's general practitioner to identify, evaluate and manage anaemia as the key strategy for optimising RBC mass, haemoglobin and iron stores in all patient groups
		  ▪ Implement preoperative anaemia assessments within the health service organisation
		  ▪ Develop communication systems between the hospital and the primary care sector to reduce presurgical risks of transfusion
		  ▪ Ensure that assessment and management of iron stores are considered when managing anaemia and optimising RBC mass

NSQHS STANDARDS

		▪ Use evidence-based therapies for boosting the production of RBCs and optimising RBC mass in specific groups of patients ▪ Consider using perioperative or day clinics to identify, evaluate and manage anaemia. • Identify and manage patients with, or at risk of, bleeding: o Assessment of bleeding risk is a key component of PBM strategies to minimise blood loss. Patients may be at increased risk of bleeding as a result of: ▪ Advanced age ▪ Decreased preoperative RBC volume (small body size or preoperative anaemia) ▪ Medicines affecting haemostasis, including complementary medicines ▪ Medical conditions causing haemostatic defect, including hereditary bleeding disorders and acquired medical conditions such as chronic kidney or liver disease ▪ The type of surgery. o Identify patients at high risk of bleeding or excessive blood loss, including history of bleeding diathesis. Use a structured patient interview or questionnaire before surgery or invasive procedures to assess bleeding risk. This should include: ▪ Personal or family bleeding history ▪ Previous excessive post-traumatic or post-surgical bleeding ▪ Detailed information on the patient's medicines, including complementary medicines. o Numerous medicines and complementary therapies affect haemostasis. In the case of anticoagulant or antiplatelet agents, cessation or bridging therapy may be required to minimise blood loss. o To assess bleeding risk before and during treatment, use a multidisciplinary approach to bleeding management and excessive blood loss, including: ▪ Appropriate diagnostic testing to measure haemostatic capacity for at-risk patients ▪ For patients at risk of suffering from adverse outcomes from ongoing blood loss over time • minimising phlebotomy • use of small-volume blood collection tubes • use of closed blood sampling systems to minimise loss of blood ▪ Identifying medicines that affect haemostasis ▪ Optimising physiological conditions conducive to haemostasis ▪ Applying appropriate pharmacological support ▪ Appropriate use of cell salvage ▪ Appropriate use of factor concentrate. • Determine the clinical need for blood and blood products, and related risks: o Allogeneic blood is a valuable adjunct to health care, but it is a limited resource, and transfusion can be a risk for patients. Therefore, diagnosing patient-specific haemostatic dysfunction to support patientspecific treatment will improve patient outcomes, and reduce unnecessary and inappropriate transfusion. The goal of effective management of critical bleeding is rapid and targeted treatment with ongoing assessment of treatment effect. o Evidence-based blood management strategies should be applied for all patients to ensure optimisation of the patient's own blood, but also to reduce the patient's exposure to allogeneic transfusion and many of the associated risks of transfusion. o Human and systems risks associated with transfusions may be preventable, but other risks relate to the nature of blood products and can only be avoided by avoiding transfusions. Risks associated with allogeneic blood transfusion include: ▪ Wrong blood incidents ▪ Transmission of bloodborne infections ▪ Haemolytic transfusion reaction ▪ Immunosuppression. o Review patients' healthcare records and discuss with them their previous and current transfusion risks before transfusion, to identify at-risk patients. This may involve: ▪ Prescribing and ordering special products to suit the patient's transfusion needs ▪ Amending administration practices, such as infusion rate ▪ Increased monitoring of the patient during a transfusion ▪ Undertaking bedside checks before transfusion ▪ Matching patient and intended treatment. o Where there is, or may be, a need to treat the patient with blood and blood products: ▪ Identify the cause of bleeding quickly ▪ Implement algorithms to manage bleeding (for example, massive transfusion protocol, bleeding management algorithms) ▪ Develop procedures and work unit guidelines to support appropriate, timely and effective access to providing and transfusing prohaemostatic, anticoagulant, antifibrinolytic and antithrombotic therapies ▪ Support the use of cell saver to salvage and replace the patient's own blood when appropriate ▪ Develop and maintain good lines of communication between the clinical environment and blood banks ▪ Provide ongoing education to support evidence-based bleeding management and sustainability of practice for all patients ▪ Understand the risks of using and administering blood and blood products ▪ Ensure that safe transfusion practices are followed when blood products are administered ▪ Ensure assessment and reporting of adverse reactions or outcomes. o Consider implementing the following initiatives to support these activities: ▪ Maintain meticulous surgical techniques as the cornerstone of intraoperative blood conservation

		▪ Implement strategies and techniques to minimise iatrogenic anaemia ▪ Consider cell salvage in the surgical setting ▪ Consider all treatment options ▪ Consider using point-of-care testing devices to provide rapid bedside monitoring to help the clinician direct appropriate targeted therapy ▪ Implement single-unit RBC transfusion practice for haemodynamically stable patients (prescribing only one unit at a time), with clinical reassessment of the patient before prescribing a subsequent unit; although restrictive transfusion thresholds (triggers) are an effective method of reducing and conserving RBC use, RBC transfusion should not be dictated by a haemoglobin 'trigger' alone, but take account of clinical signs and symptoms, and patient tolerance of anaemia.
7.05	Documenting	• The history of blood product use, and relevant clinical and product information are documented in the patient's healthcare record to minimise risks and optimise clinical outcomes. • Document comprehensive information, including blood use, transfusion history and transfusion details, before, during and after transfusions. • Transfusion-related adverse events can be associated with high rates of morbidity or mortality. To reduce this risk, assess the patient for a history of RBC antibodies, transfusion reactions or any other special transfusion requirements. • Routinely document the following information in the patient's healthcare record: o Patient consent, limited consent or refusal, including documentation of information provided to the patient o Relevant medical conditions o Indications for transfusion or administration of the blood product o Any special product or transfusion requirements (for example, irradiated products) o Known patient transfusion history, including RBC antibodies, transfusion reactions, and any adverse reactions to blood or blood products o Blood or blood product identification to ensure traceability, such as the blood pack donation numbers (or the product ID and batch number for plasma and recombinant blood products) o Blood transfusion compatibility label, or the report form, if applicable (this includes a statement of compatibility) o Type and volume of product transfused or administered o Date and time of both start and end of transfusion o Evidence of observations documented on an appropriate form o Pathology results, including haemoglobin levels and ferritin, as appropriate o Patient response to administration of blood products, including occurrence and management of any adverse reactions. • Ensure that transfusion details also appear in discharge documentation. If the patient becomes unwell after receiving blood, their transfusion history is important for the treating doctor.
7.06	Prescribing & administering blood & blood products	• Systems are in place to ensure that the clinical use of blood and blood products is appropriate, and strategies are used to reduce the risks associated with transfusions. • Clinicians prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria. • Effective data collection systems to assess and feedback statistics by specialty and clinician. • Clinician involvement in clinical pathway development. • Receive orientation or training for the prescription and administration of blood and blood products. • Provide education, training and tools to the workforce to support the introduction of PBM practices in the clinical setting.
7.07	Reporting adverse events	• Transfusion-related adverse events are reported to enable identification of previous adverse reactions or special transfusion requirements, and to drive improvement opportunities. • Capture blood-related incidents in incident management and investigation systems and provide reports from these systems to the blood management governance group to inform activities in the blood management quality improvement system (see Action 7.2). • Access to summary analysis of blood- and blood product–related incidents. • Report transfusion adverse events in accordance with regulator and supplier requirements, as well as local policies and procedure. • Capture transfusion-related incidents, including near misses, in the organisation's incident management and investigation systems under a category for incidents relating to blood and blood products. • Report adverse events to the pathology service provider, the Australian Red Cross Blood Service or product manufacturer, and the Therapeutic Goods Administration (TGA; if required). Reporting adverse transfusion events allows identification of other patients at risk because of patient identity error (for example, ABO-incompatible transfusion to a second patient) or because other blood components collected from the implicated donor may also be affected (for example, in cases of bacterially contaminated blood components), and assists in monitoring safety and quality of a product (for example, allergic reactions). The Blood Component Information booklet describes adverse reactions and identifies which reactions must be reported to the Australian Red Cross Blood Service. For commercial products, check with the manufacturer to identify their adverse event reporting requirements. Links to suppliers are on the NBA website. • Receive orientation or training for reporting transfusion-related adverse events in accordance with national guidelines and criteria.
7.08		• The health service organisation participates in relevant haemovigilance activities to improve the effective and appropriate management of blood and blood products, and to ensure the safety of people receiving and donating blood. • Provide haemovigilance reporting to the blood management governance group, which is responsible for:

		○ Independently reviewing adverse events ○ Establishing validity classification and assessing imputability ○ Reporting adverse events to state and territory systems (see the NBA haemovigilance reporting website). • All members of the workforce involved in haemovigilance programs are expected to receive relevant orientation or training.
7.09	Storing, distributing & tracing blood and blood products	• Blood and blood products are managed appropriately to ensure that they are available and safe for clinical needs. • Provide orientation and training to all members of the workforce involved in the management of blood and blood products, including ordering, traceability, receipt, storage, collection and transport of blood and blood products.
7.10	Availability of blood	• Blood and blood products are managed to minimise wastage and ensure that product is available to meet clinical demand in times of shortage. • Provide training to the workforce about ensuring blood availability. • Record wastage in a system and monitor wastage reports. • Identifying strategies to ensure that products remain within specifications so that they do not need to be disposed of, including maintaining temperature requirements, reducing unnecessary handling and storing appropriately.

Recognising and Responding to Acute Deterioration

Key Messages:

- The intent of this standard is to ensure that a person's acute deterioration is recognised promptly and appropriate action is taken.
- Acute deterioration includes physiological changes, as well as acute changes in cognition and mental state.
- Abnormal clinical observations (e.g. abnormal respiratory rate, blood pressure and heart rate) are often present prior to patients having a cardiac arrest, unplanned admission to intensive care or unexpected death.
- Improving our recognition of, and response to, these abnormal observations, will improve outcomes for our patients. You can do this by ensuring observations are taken and then escalated appropriately:
  - if a patients' observations meet 'Clinical review criteria', ensure the appropriate escalation occurs (Nurse in charge and medical officer)
  - if a patients' observations meet MET call or code blue criteria, a MET call or code blue call MUST be called.
- Escalating clinical concerns is good clinical practice.
- Use SHARED to structure your communication when escalating care.
- If a more junior member of staff escalates concerns to you be supportive and responsive.

Action:	Intent:	Key Tasks & Strategies for Improvement:
8.01	Clinical governance	• Safety and quality systems support clinicians in recognising and responding to acute deterioration.
8.02	Quality improvement	• Quality improvement systems are used to support recognition of, and response to, acute deterioration.
8.03	Partnering with consumers	• Clinicians understand the systems for partnering with consumers and use them when recognising and responding to acute deterioration by ○ Actively involve patients in their own care ○ Meeting the patient's information needs ○ Ensuring shared decision-making. • Provide information to patients about recognition and response systems tailored to their specific needs and level of health literacy. • Seek consent for non-urgent treatment in line with policies that reflect relevant legislation. • Although clinicians are not legally required to seek consent from substitute decision-makers for urgent treatment, it is recommended that they consult them, if possible, to avoid starting treatment that is contrary to a person's expressed wishes. • If patients have the capacity to take part in the decision-making process when an episode of acute deterioration occurs, ensure that clinicians use the processes for involving patients in their own care, shared decision making, and meeting patients' information needs. • If patients do not have the capacity to participate and do not have a documented advance care plan, but a substitute decision-maker is available, ensure that clinicians seek information from the substitute decision-maker about the patient's previously expressed preferences for care. Use this information to decide how to respond. • When patients lack the capacity to take part in decision-making and a substitute decision-maker is not available, clinicians should decide how to respond to acute clinical deterioration using documented information such as current advance care plans, goals of care, treatment-limiting orders, and information from carers and family. • If the treating team is responding to an acute deterioration in a person's mental state, and the person is refusing treatment or is otherwise unable to consent to treatment, decide if the person will be treated as an involuntary patient under mental health legislation. Provide access to legal advice for the workforce to ensure that they practise within this legislation. When a person is an involuntary patient under mental health legislation, members of the workforce should still seek to involve the person in decision-making about their care as much as possible, consistent with maintaining safety. • Provide information to patients about recognition and response systems in a format that is easily understood and meaningful, and ensure that patients are given the opportunity to ask questions.

8.04	Recognising acute deterioration - Physiological	• Patients with acute physiological deterioration are identified early. • Develop individualised vital sign monitoring plans to manage the clinical risks and needs of each patient. • The frequency of required monitoring may vary between individual patients, and as a patient's clinical situation, clinical risks and goals of care change. • Frequency of monitoring often varies, perhaps because of differences in individual clinicians' clinical judgement, poor communication among teams, varying views about the importance of monitoring, and a lack of guidelines to inform practice. It is therefore necessary to develop systems to ensure that vital signs and other parameters for detecting deterioration in a patient's physical, mental or cognitive condition are being measured. These systems need to ensure that the right parameters are monitored for each patient, and that monitoring occurs at the appropriate frequency (number of times per day) and for the appropriate duration (number of days or weeks). Consistent documentation of measured vital signs and other observed indicators is important for changes to be tracked over time.

8.05	Recognising acute deterioration – mental state	• Adverse outcomes relating to acute deterioration in a person's mental state are prevented through early recognition and effective response.
		• Ensure that members of the workforce are alert to signs of deterioration in a person's mental state, including for people who have not been previously identified as being at high risk.
		• Ensure that members of the workforce are alert to the signs of delirium.
		• Ensure that members of the workforce can implement an initial response and keep the person safe until arrangements are made for specialist review.
		• Be alert for signs of deterioration in a person's mental state:
		  o Initial screening should identify people who are at risk of acute deterioration in their mental state, including patients at risk of developing delirium.
		  o If screening identifies risk of deterioration in a person's mental state, conduct a complete mental state examination.
		  o Comprehensive assessment should differentiate among potential causes for the person's deterioration in mental state.
		• Use comprehensive care plans to manage patients at risk:
		  o conduct a comprehensive assessment as outlined in the Comprehensive Care Standard.
		  o The comprehensive care plan can incorporate information from a person's advance care plan. When a person is experiencing deterioration in their mental state, they may be able to self-report this to members of the workforce. Similarly, carers or family members may recognise the specific signs that they know indicate the person's mental state is deteriorating. Integrate this information into the comprehensive care plan, and engage the person – and, with permission, their carers and family – in decision-making.
		  o Ensure that all members of the workforce involved in a person's care are aware of the contents of the comprehensive care plan and are alert to changes that have been identified as individual markers indicating a deterioration in the person's mental state.
		  o For all patients at risk of delirium, this plan should include tailored delirium prevention interventions, regular monitoring and reassessment for delirium with any changes.
		• Monitor patients at risk:
		  o Develop systems to routinely monitor patients at risk of deterioration in mental state.
		  o If delirium is identified as a cause of deterioration in the person's mental state, use indicators from the Delirium Clinical Care Standard for local review and feedback mechanisms.
		  o A comprehensive assessment is required to rule out possible delirium, pain and other physical problems
		• Assess observed or reported changes:
		  o With possible delirium, diseases can have atypical presentations in older people, so do not dismiss a family member's non-specific concerns (for example, the person 'is not usually like this') and assess the person for delirium.
		• Use tools and resources:
		  o No tool currently sets out objective criteria for tracking deterioration in a person's mental state equivalent to observation charts for physiological deterioration. Nonetheless, there are parameters that can indicate deterioration in a person's mental state, and these can be used to develop individualised monitoring plans in collaboration with the person, and their carers and families.

8.06	Escalating care	• The health service organisation has an effective system for escalation of care to minimise risks for patients who are acutely deteriorating. • All members of the workforce (clinical and non-clinical) have the authority to escalate concern about a patient or visitor's physical or mental wellbeing and seek medical assistance. • Escalation protocols provide clear, objective criteria that prompt clinicians to call for help, and endorse calling for help when clinicians, patients, family members or carers are subjectively concerned about a patient acutely deteriorating. • Consider local clinical capacity and access to mental health expertise to decide whether the response can be implemented by the treating team, or referral should be made to a clinical psychiatry liaison or other available service. Engage the patient, and their carer and family in shared decision making about escalation of care. Patient pain and distress that are unable to be managed using available treatments may indicate acute deterioration that needs urgent treatment. Include pain and distress as a criterion for escalation in the protocol. • Clinician worry or concern included as a criterion for escalation in the protocol.
8.07		• Patients, family members and carers can directly escalate care • Ensure patients, carers and family members are provided with clear instruction and education on local processes for how they can escalate care too if they are concerned. o SEQ – Patient and Carer Escalation of Care (PACE)

		○ CQN – Recognise, Engage, Act, Call & Help (REACH).
8.08		• The health service organisation has mechanisms for the workforce to escalate care. • If you discover an unresponsive or unwell patient or visitor, please follow local escalation processes and seek medical assistance immediately. • Call the relevant emergency number and state code and location and/or press the emergency buzzer.
8.09		• Members of the workforce take prompt action to deal with acute deterioration. ○ Recognising parameters and thresholds that indicate acute deterioration, including criteria for patient pain and distress, and clinician concern or worry ○ Identifying escalation actions when thresholds indicating acute deterioration are reached ○ Processes and mechanisms for escalating care ○ The role and capacity of responders ○ What to do if the expected response is delayed or does not adequately deal with the problem ○ Communication skills such as graded assertiveness ○ Professional behaviours in successfully operating recognition and response systems • Ensure you have received the relevant training to understand your responsibility for escalating care if it is needed.
8.10	Responding to deterioration	• Clinicians have the skills and knowledge to deal with deterioration, as appropriate for their role. • Clinicians are competent in the skills required to respond to patients whose condition is deteriorating – basic life support (BLS), advanced life support (ALS) and paediatric life support (PALS). • Clinicians who provide clinical care need skills in providing essential emergency interventions for common causes and symptoms of life-threatening physiological deterioration while awaiting help. These include skills in essential emergency management of conditions such as airway obstruction, hypoxia, respiratory distress or suppression, arrhythmia, hypotension, fluid overload, seizures and sepsis. • Clinicians who provide clinical care need skills in responding to aggressive behaviour when attempts to de-escalate the situation have failed and there is potential harm to the patient or to others. • Clinicians working in specific specialties or settings may need training in extra skills to provide an immediate response while awaiting help. For example, clinicians working in a coronary care unit need cardiac resuscitation skills, while those working in maternity settings need skills in managing obstetric emergencies. • Clinicians who have particular roles also need training in other skills. For example, medical emergency team responders need advanced clinical assessment skills and competence in specialist procedures such as intubation. • Clinicians who respond to acute deterioration also require non-technical skills such as graded assertiveness, negotiating patient goals of care, communicating bad news and team leadership.
8.11		• Expert input and assistance is available to manage acute physiological deterioration. • Ensure rapid access to advanced life support for patients who acutely deteriorate. • Establish clinicians' competence in advanced life support with evidence of relevant qualifications (for example, advanced life support certification compliant with Australian Resuscitation Council guidelines or medical qualifications in specialties such as anaesthesia and critical care). Establish competence in paediatric advanced life support for responders in services that provide care to children. • Clinicians need regular opportunities to practise and maintain their skills so that they retain competence. Put systems in place to provide evidence of clinicians' ongoing competence in advanced life support. This may require the organisation to provide access to formal advanced life support training for clinicians. Further benefits can be gained by providing opportunities for members of rapid response teams to train together, and practise using non-technical skills such as leadership, teamwork and communication while managing simulated scenarios of acute deterioration.
8.12		• Care for patients whose mental state is deteriorating is escalated safely and effectively. • Ensure that members of the workforce are aware of, and use, the escalation protocol. • Support referral processes with systems to encourage appropriate documentation about the person's mental state at transitions of care, and to reduce the burden of documentation and data collection when possible.
8.13		• Patients who need other services to resolve the cause of their acute deterioration are rapidly referred to these services. • Identify common causes of acute deterioration using data from the recognition and response systems. These may include common presentations and causes of acute physiological deterioration, such as ○ Airway obstruction and respiratory depression associated with issues such as neurological events or opioid overdose ○ Altered level of consciousness associated with issues such as neurological events, abnormal blood glucose or delirium ○ Respiratory distress associated with issues such as fluid overload, sepsis or exacerbations of existing lung disease ○ Arrhythmias ○ Hypotension associated with conditions such as – sepsis – dehydration – post-surgical bleeding – postpartum maternal haemorrhage – cardiac failure ○ Medicine side effects, interactions or related complications such as allergies or errors. • Understand local processes for rapid referral between services within the health service organisation (for example, mental health services, palliative care, intensive care) and for rapid referral to external acute healthcare services. Include processes for the safe transport of patients in the referral systems. Referral to external services for definitive treatment of acute deterioration may also require referral to emergency transport services.