



Implementing the Comprehensive Care Standard

Review and improve comprehensive care delivery

August 2019



Published by the Australian Commission on Safety and Quality in Health Care

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ISBN: 978-1-925948-31-8

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Australian Commission on Safety and Quality in Health Care. Implementing the Comprehensive Care Standard: Review and improve comprehensive care delivery. Sydney: ACSQHC; 2019.

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Introduction

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

The second edition of the NSQHS Standards includes the following eight standards:

- Clinical Governance Standard
- Partnering with Consumers Standard
- Preventing and Controlling Healthcare-Associated Infection Standard
- Medication Safety Standard
- Comprehensive Care Standard
- Communicating for Safety Standard
- Blood Management Standard
- Recognising and Responding to Acute Deterioration Standard.

One of these standards, the Comprehensive Care Standard, relates to the delivery of comprehensive care for patients within a health service organisation. Safety and quality gaps are frequently reported as failures to provide adequate care for specific conditions, or in specific situations or settings, or to achieve expected outcomes in particular populations.

Reviewing the delivery of comprehensive care is important for ensuring patients are receiving care that meets their clinical and personal needs; that risks are efficiently and effectively identified and mitigated; that the agreed comprehensive care plan is achieving what it aimed to do; and that patient goals and expectations are being met. The way that comprehensive care is delivered should be reviewed at the end of the care episode, but it also may need to be reviewed during the episode of care if there are changes in the patient's condition, expectations, needs, diagnoses or prognosis, or if the care plan is ineffective.

The way comprehensive care is delivered needs to align with the comprehensive care plan, acknowledging that health care is an iterative process. The workforce needs to be agile and responsive to changes in the patient's needs and context, and modify and adapt the comprehensive care plan and the way that care is delivered to meet those changing needs. It is also important for the health service organisation to review the delivery of comprehensive care across the organisation and examine variation in practice and outcomes. Understanding variation in comprehensive care can help to target improvement efforts.

This paper

This paper provides practical advice for clinicians and health service organisations about reviewing and improving comprehensive care delivery. It is part of a series of resources supporting implementation of comprehensive care that are based on six essential elements:


- Element 1: Clinical assessment and diagnosis
- Element 2: Identify goals of care
- Element 3: Risk screening and assessment
- Element 4: Develop a single comprehensive care plan
- Element 5: Deliver comprehensive care
- Element 6: Review and improve comprehensive care delivery.

This paper addresses Element 6: Review and improve comprehensive care delivery. See Appendix 1 for some example tools for evaluating comprehensive care.

The elements were developed to support practical implementation of the Comprehensive Care Standard, and more information about all of the essentials elements is available from: [Implementing the Comprehensive Care Standard: Essential elements for delivering comprehensive care.](#)

This paper has been developed for:

- Clinicians involved in the delivery of care, providers of clinical education and training, research organisations and other health bodies
- Managers and executives responsible for developing, implementing and reviewing processes to support identification of goals
- Planners, program managers and policymakers responsible for the development of state and territory government or other strategic programs dealing with the processes associated with providing comprehensive care.



Element 6: Review and improve comprehensive care delivery

Purpose

- To confirm that the health care delivered aligns with the comprehensive care plan
- To allow for the revision or modification of the comprehensive care plan and delivery, in response to changes in patient health and circumstances
- To review the delivery of comprehensive care and support ongoing quality improvement.

Principles

- Delivery of comprehensive care takes a quality improvement approach, and is dynamic and responsive to changes in the patient's health and circumstances
- Review of the delivery of comprehensive care is person-centred, involving the patient, their family, carers and other support people
- Review of the delivery of comprehensive care involves collaboration from the multidisciplinary team
- Review of comprehensive care plans and delivery are timely
- Review of comprehensive care delivery involves revisiting diagnoses, clinical and personal goals of care
- Multiple avenues are available and used to prompt review of the delivery of comprehensive care.

Consumer actions

- Patients communicate and work with the multidisciplinary team to review and revise goals and comprehensive care plans as needed
- Families, carers and other support people participate in and engage with review processes as aligned with the patient's wishes.

Clinician actions

- Clinicians deliver care that is person-centred and appropriate to changes in the patient's diagnoses, condition, experience or expectations
- Clinicians work collaboratively in a multidisciplinary team to achieve the patient's goals of care and communicate changes in the patient's circumstance
- Clinicians care for the patient in a dynamic and individualised way, being responsive and alert to changes in circumstances
- Clinicians involve family, carers and other support people in alignment with the patient's wishes
- Clinicians use multiple avenues to prompt review of comprehensive care delivery.

Organisational actions

- Health service organisations establish policies and processes to review whether the care a patient receives aligns with the comprehensive care plan, meets the patient's needs, and mitigates relevant risks
- Health service organisations provide access to training and education to the multidisciplinary team on the use of the organisation's processes for reviewing the delivery of comprehensive care
- Health service organisations provide systems to capture information on the review of comprehensive care delivery
- Health service organisations periodically review the agreed policies and processes for the delivery of comprehensive care, including for screening, care planning and delivery
- Health service organisations monitor variation in practice and outcomes for comprehensive care and take action for improvement.

What is needed to review and improve?

*Implementing the Comprehensive Care Standard: A conceptual model for delivering comprehensive care*¹ describes the important domains necessary to create the organisational conditions for comprehensive care but can also be used as an organising structure for reviewing and improving comprehensive care delivery.

Figure 1 shows the domains:

1. **A focus on patient experience:** having an organisation-wide commitment to the delivery of care that is person-centred, and working to improve the experience of patients by engaging them in their own care and sharing decisions.
2. **Systems, processes and protocols to deliver comprehensive care:** having systems, processes and protocols to guide and support healthcare providers to deliver comprehensive care consistently and effectively, in the areas of teamwork, collaboration, risk identification and mitigation, goal setting, care planning and review, and care coordination.

3. **Organisational culture and governance to support a comprehensive care approach:** having organisation-wide governance, leadership and systems that embed the delivery of high-quality person-centred comprehensive care as the organisational standard.

Different states and territories and private hospital groups may already have well developed systems that influence how comprehensive care is implemented and evaluated. Regardless of the structure there are a number of common steps for improvement work.

Figure 1: Conceptual model for supporting the delivery of comprehensive care



Improving comprehensive care

Evaluation of new programs, processes and systems is important to establish their efficacy and to determine if changes are needed to optimise performance. Baseline measurement and ongoing monitoring of existing systems is also necessary to track changes over time and ensure that systems are operating effectively.

There are different and well-established approaches to safety and quality improvement in health care. Some methodologies are listed in **Table 1**. Common

to these strategies is the concept that improvement requires a process of change management to be successfully sustained.

Table 1: Healthcare improvement methodologies

Methodology	Description	State and territory organisations	Relevant international health care organisations
Model for improvement	A model to support change management based on Deming's work and developed by <u>Associates in Process Improvement</u>	<u>Better Care Victoria</u> <u>NSW Clinical Excellence Commission</u> <u>QLD Clinical Excellence Division</u>	<u>Institute for Healthcare Improvement</u> <u>International Society for Quality in Health Care Improvement</u>
Lean/Six sigma/ Accelerated Improvement Methodology	A stepped process to reduce waste and increase value of services offered	<u>NSW Agency for Clinical Innovation</u> <u>SA Health Clinical Improvement Unit</u>	<u>Kaiser Permanente</u>

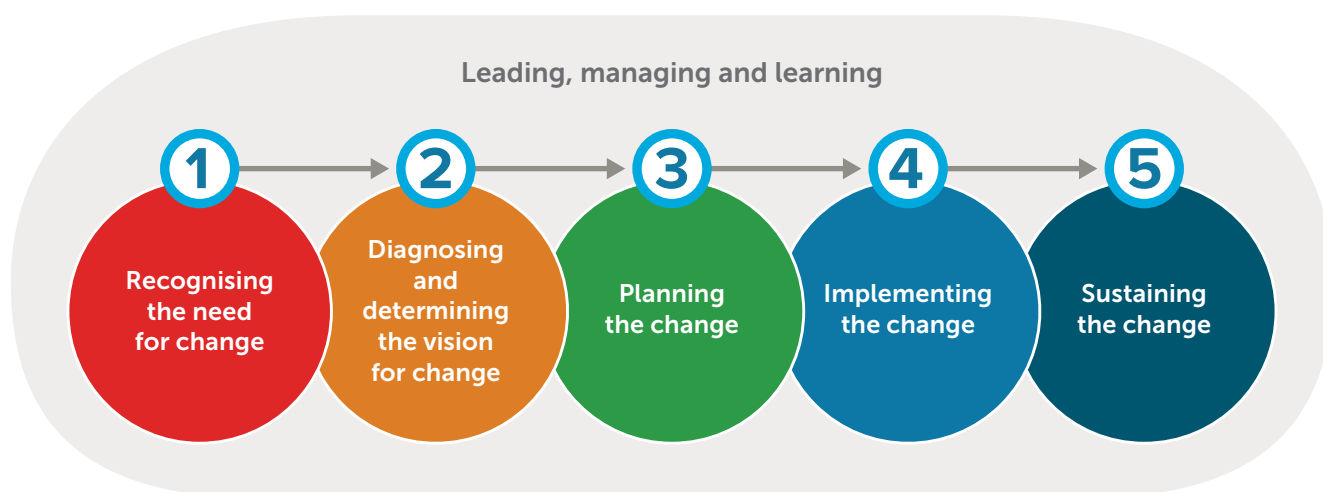
Change management

Learning organisations continuously change with good leadership and management. Change is usually purposeful, but sometimes contested. The process of change has a number of stages (Figure 2).²

Recognising that change is needed is the starting point for making improvement.

The processes of diagnosing problems, determining the changes needed, planning, implementing and sustaining change require measurement and evaluation, and are underpinned by strong leadership and good management practices. During the change process it is important to continue to do things that work and stop things that do not have an impact.

Figure 2: Change process²



Measuring for improvement

Standardised measures for review and improvement can be used by clinicians to enhance interventions and care for patients, and can be used by system managers, government and national agencies to encourage gains in safety, quality and patient outcomes.

This requires monitoring, measurement, reporting, learning and action at all levels of the health system – making the information available to patients, carers and consumers, clinicians, hospitals, administrators, policy-makers and government, so that learning and improvements can be made.

A multifactorial approach to monitoring and reporting on patient safety and quality is becoming increasingly common nationally and internationally, and systems implementing this approach are realising improved outcomes as a result.

People want to be assured that health care is safe and high-quality. Providing this assurance requires robust measurement and reporting of data that meaningfully and usefully assesses patient safety and appropriateness of care.

Measurement and reporting on safety and quality informs people designing, delivering and funding health care about any gaps or variation in the delivery of health care, the impact of improvement activity, and how a health service organisation performs compared with national and international standards. Key to effective measurement is:

- Ensuring robust health information standards and clinical indicators are available for health service organisation and system use
- Providing a model for local, regional and national monitoring of patient safety and quality
- Supporting consistent and transparent public reporting on safety and quality by all sectors of the health system, including both public and private hospitals.

Some guiding principles that are core to safety and quality measurement include³:

- There is no single measurement of safety
- Safety monitoring is critical and does not receive sufficient recognition
- Anticipation and proactive approaches are required
- Investing in technology and expertise in data analysis is required
- Mapping safety measurement and monitoring should be organisation-wide
- Metrics include national requirements and locally relevant information
- Clarity of purpose is needed when developing safety measures
- Empowering and devolving responsibility for the development and monitoring of safety metrics is essential and makes it everyone's business
- Collaboration between regulators and the regulated is critical
- Manage unintended consequences, e.g. perverse incentives.

A wide range of strategies may be used to deliver high-quality comprehensive care and there are also many ways of collecting data to inform measurement and evaluation processes. Understanding what aspect of care is being evaluated will inform the measurement strategy and process for evaluation of any improvement activity. It is important to assess existing and automated systems to capture information and the potential burden of adding measurements in relation to the perceived benefits. It may also be necessary to stop collecting data that is not adding value to patients, carers, families and the healthcare workforce.

Collecting and interpreting data about comprehensive care

The Commission continues to progress work on a range of measures that can be monitored together to obtain a comprehensive and accurate picture of patient safety, and provide relevant information that can be fed back to clinicians to encourage improvements. These measures use multiple sources of data including that which is routinely coded from patient healthcare records (International Classification of Diseases data). They include:

- Assessment to the NSQHS Standards for the purpose of accreditation
- A suite of outcome indicators (mortality)
- The national list of hospital-acquired complications (HACs)
- Surveys of patient hospital experience (AHPEQS) – patient reported measures
- Structured analyses of selected sets of incident types
- Surveys of organisational safety culture.

The national framework is being designed to have common specifications for measuring safety and quality consistently and transparently, and apply across different levels of the health system. The information generated by monitoring and collection of planned core common metrics will help to address the approaches to patient safety, set out below, as suggested by Vincent⁴ for safety measurement and monitoring:

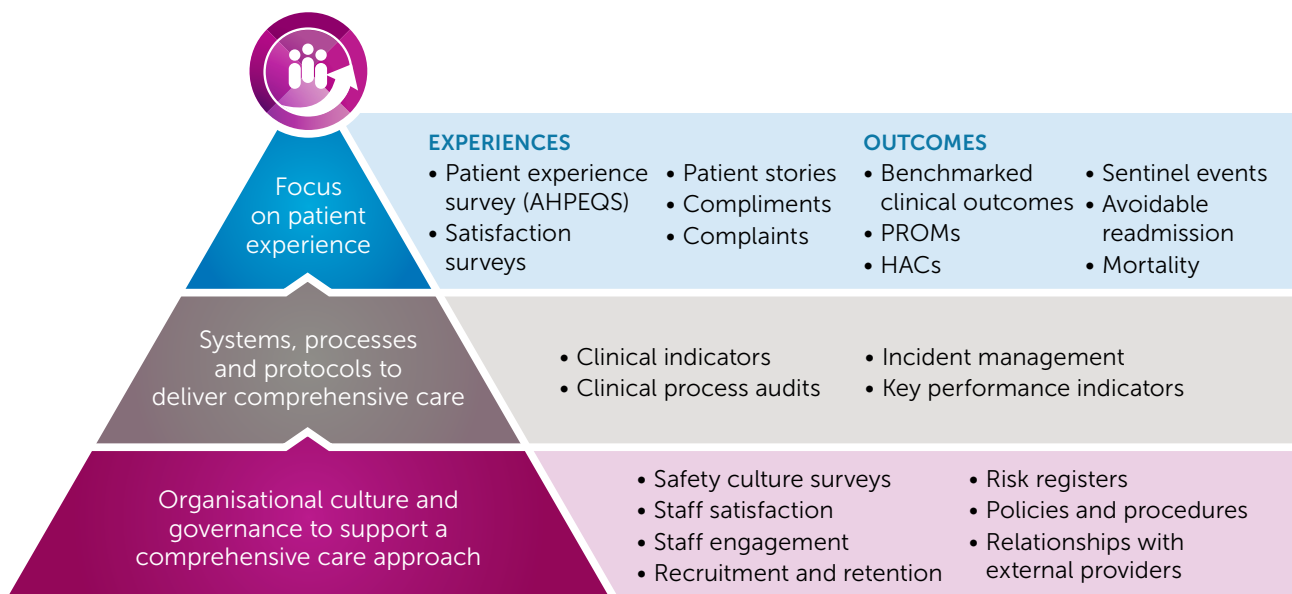
- Past harm
- Reliability
- Sensitivity to operations
- Anticipation and preparedness
- Integration and learning.

There are many factors that can have an impact on the experiences and outcomes of patients, including the clinical care that they receive, communication with clinicians and other members of the workforce, and their own personal circumstances. Despite this complexity, it is important to measure a number of different aspects of care from the perspective of the patient, carers and other support people, as well as the clinicians and the organisational systems to know whether the overall objectives for delivering comprehensive care have been achieved.

Some examples of information sources that could be used to review and improve comprehensive care delivery are listed in **Figure 3**, although no assessment of the validity of each individual information source is included. These sources of information could be used to examine specific areas of patient care or be examined collectively to get a broader picture of the state of care delivery within a service or facility.

Interpreting information from some of these data sources and directly linking it to care delivery can be difficult. It is important to consider the privacy and confidentiality issues associated with collecting, using and storing data. Data should be collected in line with relevant privacy and confidentiality legislation, as well as organisational policies and processes. Some examples of data collection tools appear in Appendix 1.

Figure 3: Some examples of information sources for reviewing and improving comprehensive care delivery



Measuring patient experience

Surveys of **patient experience** are one of the most common ways of capturing the perceptions and experiences of patients, carers and families when they receive health care. One example is the Australian Hospital Patient Experience Question Set (AHPEQS), which is a nationally agreed set of indicators developed by the Commission for health service organisations to use when asking consumers what they observed and how they felt about their care.⁵ The focus on experiences of patients provides information that can be used to improve the way that health care is delivered. **Patient satisfaction surveys** could be used to help recognise issues and as part of an evaluation strategy. They do not provide a basis for taking action for improvement.

Patient stories provide another way of examining the impact and outcomes of comprehensive care delivery. They are qualitative rather than quantitative, and thematic analysis of patient narratives can provide a rich source of information about people's experiences of health care in the context of their life, and the health system as a whole, that cannot be collected in other ways.⁶ There can be resistance to using patient stories if they are seen as isolated anecdotes. An increasing number of tools provide a framework for collecting information through patient stories in a robust way.⁶⁻⁸

Complaints are also important sources of feedback that support improvement work. Thematic analysis of complaints may identify gaps and quality issues with services. They could include issues with policies, procedures, treatment, behaviour and communication failures. They are qualitative and should be responded to by an appropriate delegate within the organisation. Complaints could be used to support diagnosing and developing the change vision.

Compliments also contain important information about service delivery and provide positive reinforcement to the clinical workforce about the service they are providing. Outstanding services could share their strategies to support the spread of practice improvement and add value to the health care system.

Measuring culture and governance

Measurement of culture in health settings is seen as an important way to identify safety issues early and drive safety and quality improvement. Hospital staff are often the first to notice concerning patterns of unsafe practice and the conditions which increase or decrease the likelihood of such practice. Patient reports of good experiences in a health service organisation are associated with a strong safety culture and positive experiences for the workforce.^{9,10}

Patient safety culture can be measured through surveys of hospital staff, qualitative measurement (focus groups, interviews), ethnographic investigation or a combination of these. Surveys of hospital staff are the most common and use quantitative self-reported measures to examine the dimensions of safety culture. They include questions about staff attitudes, behaviours and perceptions. There are many validated tools available. The Commission is in the process of developing a toolkit to support measurement of patient safety culture in Australia – this will include a short validated survey along with an implementation guide to support the use of this information to drive improvement.

Organisational culture can be gauged from **workforce feedback** which could also provide useful information about comprehensive care and indicate areas for improvement or change. Information from the workforce can come from **satisfaction or other surveys**, interviews and focus groups. Workforce feedback can be useful for understanding how comprehensive care is being delivered and the level of **engagement** in the workplace.

Recruitment and retention could be used as part of reviewing and evaluating service delivery. High turnover in the workforce can compromise the safety and quality of care. Reviewing data related to recruitment and retention when there is high turnover could be used as part of a strategy to review culture and governance processes when providing comprehensive care. Initiatives to improve work-life balance or increase satisfaction at work for the workforce are likely to have unmeasured benefits to the provision of safe, quality care.

Risk registers are living documents that could be used to identify potential risks in an organisation or specific service, and support preparation for potential issues that can disrupt service provision. Information from the risk register could be used for many purposes to assess improvement opportunities in comprehensive care.

Policies, procedures and other documents can provide information about the structures and processes that have been put in place to support comprehensive care. Documents might include policies, procedures and guidelines, meeting records, training materials and project plans. Examples of the type of information that can be gathered from such documents include governance processes, details of the provision of training to the workforce, information about models of care, risk screening and assessment, and goal setting. Assessing gaps between expectations set out in policy and the way in which work is undertaken can provide opportunities for improvement.

Relationships with external care providers could be examined to assess care coordination and continuity of care. External providers are integral to many aspects of care provision. Examining opportunities to strengthen these relationships, and integrate models of care and care pathways, would be beneficial to the provision of comprehensive care.

Systems and processes

Clinical indicators provide a quantitative measure of a target care process or intervention.¹¹ They are usually expressed in a numerical format and can possibly be used as a benchmarking tool. Measures may be specific or generic. Some examples of commonly collected clinical indicators include infection rates, cardiac arrest rates, blood transfusions, unanticipated events, timeliness of procedures, access to services, and exit block.

Clinical process audits can provide information about what is actually being done to deliver comprehensive care. For example, audits of healthcare records can identify whether goals were achieved, and whether healthcare associated complications were avoided. Other activities include counting the number of projects to optimise patient care or implement changes to care processes. Some examples of audit questions appear in the next section.

Incident management systems provide an approach to the identification and management of patient safety events, and a tool that aims to reduce repeat occurrences of preventable events and promote organisational learning. Most states and territories have defined systems for the reporting and management of patient safety events. Theming events that relate to the provision of care can help to identify where improvements could be made at a local and state or territory level.

Key performance indicators (KPIs) provide a quantitative measure of a service that may be set internally or externally and are often part of service agreements. Waiting times, costs and length of stay are common subjects of set KPIs that are used to monitor performance. KPIs may comprise of some of the other information sources described.

Measuring outcomes

Patient-reported outcome measures (PROMs) capture a person's perception of their own health through questionnaires. PROMs are filled out by the patient without influence of the clinician. They ask the patient to assess aspects of their health such as the severity of their symptoms, daily functioning, distress, quality of life, anxiety, unmet needs and self-efficacy. PROMs can be either generic (measuring aspects of health that are relevant irrespective of the condition) or condition-specific or population-specific.

PROMs are useful to measure the impact of a treatment or procedure on a person's quality of life and self-reported health (where the measures are taken before and after the intervention), and to measure trends in a person's progress at regular time points (in the case of long-term conditions). PROMs can be used to help identify patient treatment preferences, improve communication with clinicians and providers, and support shared decision making.¹² Aggregated PROMs data can also be used to inform quality improvement activities, research and support the development of health policy.

Qualitative information about the experiences of patients, families, carers and other support people can be collected through focus groups and formal semi-structured interviews, as well as through more informal discussions that can occur in waiting rooms or other locations. Other qualitative information that can be useful to consider when measuring and evaluating consumer partnerships can come from complaints, incident reports, online feedback portals, social media platforms, patient journey mapping, World Café events, and community forums.

Clinical outcomes can be measured in specific and general groups. Morbidity and mortality can be reviewed for variance using measures like standardised mortality ratios, deaths in specific cohorts, and outcomes from recognised health issues such as stroke, myocardial infarction and sepsis.

A **hospital-acquired complication (HAC)** refers to a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring. The Commission has developed a national list of 16 HACs which are monitored due to their impact on patients, health services and the healthcare system.

Sentinel events are a subset of adverse patient safety events that are wholly preventable and result in serious harm to, or death of, a patient. Sentinel events are reported by states and territories in the Productivity Commission's annual Report on Government Services (RoGS). The list of sentinel events was updated in 2018.

An **avoidable hospital readmission** occurs when a patient who has been discharged from hospital (index admission) is admitted again within a certain time interval, and the readmission is clinically related to the index admission. This has the potential to be avoided through improved clinical management and/or appropriate discharge planning in the index admission.

The core hospital-based outcome indicators (CHBOIs) contain a range of **mortality** indicators which have been developed to enhance safety and quality reporting and feedback.



Conclusion

Reviewing care that is delivered is part of ensuring health service organisations enable clinicians to provide meaningful person-centred comprehensive care. Improvement relies on robust systems and processes incorporated into an organisational approach to ensure that organisations learn and change to continuously deliver excellent comprehensive care.

Learning organisations use the information they have about their processes and systems to evolve the way in which they perform. Some of the ways that health service organisations can improve is by using change methodology and tools to solve problems and adapt approaches to providing care. It is also important to ensure that proposed changes are communicated and translated into practice throughout the service. Adopting standard change management and improvement methodology, and embedding these practices in the workplace so they become part of the culture, is critical to success.

Measuring and monitoring key aspects of service delivery that relate to comprehensive care is an important aspect of change management required to improve safety and quality. The domains which should be measured and monitored include:

- Patient experience
- Patient outcomes
- Systems and processes
- Organisational culture

Health service organisations should consider what is required to meet the needs of the population they serve so that comprehensive care is constantly improving and the focus remains on positive patient experience.

Appendix 1: Example tools for evaluating comprehensive care

There are many actions and processes that could be evaluated to determine the quality of comprehensive care. Some examples of questions that could be considered have been presented in various topics below. The questions presented could be modified to be relevant to local conditions, patient populations and service delivery models.

Potential clinical workforce questions related to provision of comprehensive care

Questions for the clinical workforce	Response	Action
1. Each patient is comprehensively assessed for conditions and issues that have been identified	Always to never 5-point Likert scale	5.4, 5.11
2. Common risks to patients admitted to my ward/ service/organisation have been identified	Yes / No	5.1
3. There are risks that are not captured	Yes / No	5.2b
4. If yes to question 3, please specify	Free text response	5.2b
5. The risk screening process used account for the risks in your ward/unit/organisation	Yes / No	5.7a
6. Patients admitted to my ward ward/unit/organisation are screened or assessed for the following risks:		5.1b, 5.7b, 5.10
• Dying during this admission or the next days or weeks	Yes / No	5.15
• Pressure injuries	Yes / No	5.21
• Falls	Yes / No	5.24
• Nutrition and hydration	Yes / No	2.27
• Delirium	Yes / No	5.29a
• Cognitive impairment	Yes / No	5.30a
• Self-harm and suicide	Yes / No	5.31a, 5.31b
• Aggression and violence	Yes / No	5.34a
• The need for restraint	Yes / No	5.35
7. How often are goals of care identified with patients, families, carers and other support people?	Always to never 5-point Likert scale	5.3a, 5.3c, 5.13b
8. How often are decisions about care shared with patients, families, carers and other support people?	Always to never 5-point Likert scale	5.3c
9. How often are goals of care revised or reviewed with patients, families, carers and other support people?	Always to never 5-point Likert scale	5.3a, 5.3c, 5.13b
10. Are there sufficient policies and procedures and resources to support provision of comprehensive care in your workplace?	Yes / No	5.1a

Questions for the clinical workforce	Response	Action
11. If no to question 10, please specify gaps, omissions and redundant policies and procedures	Free text response	5.1a
12. Is training sufficient to support comprehensive care in your workplace?	Yes / No	5.1c
13. If no to question 12, please specify gaps, omissions and redundant training requirements	Free text response	5.1c
14. Patients have access to the appropriate multidisciplinary team members in my workplace	Always to never 5-point Likert scale	5.4c, 5.5a
15. Multidisciplinary team members understand their role in providing care to patients where I work	Always to never 5-point Likert scale	5.5b
16. Multidisciplinary teamwork and collaboration is part of the workplace culture	Always to never 5-point Likert scale	5.5a, 5.6
17. Communication between team members is appropriate, clear and respectful	Always to never 5-point Likert scale	5.6
18. Care is provided in alignment with best practice and evidence	Always to never 5-point Likert scale	5.13f
19. Comprehensive care plans are developed and appropriate for each patient	Always to never 5-point Likert scale	5.12, 5.13
20. Comprehensive care plans are accessible to all members of the multidisciplinary team and the patient	Always to never 5-point Likert scale	5.12
21. Patients receive care that matches the comprehensive care plan	Always to never 5-point Likert scale	5.14
22. Changes in patient condition are responded to appropriately	Always to never 5-point Likert scale	5.14b, 5.14c, 5.14d
23. Comprehensive care is provided to patients at the end of life*	Always to never 5-point Likert scale	5.15, 5.16, 5.19, 5.20
24. Advance care plans are included in the comprehensive care plan	Always to never 5-point Likert scale	5.9, 5.17
25. Information about how well comprehensive care is delivered in my workplace is available and discussed to inform improvement	Always to never 5-point Likert scale	5.2
26. Are there any other comments you would like to make about comprehensive care where you work?	Free text response	

*See also end-of-life audit toolkit.

Clinical information that could be used to review comprehensive care provision

Reviewing local data related to hospital-acquired complications, adverse events, sentinel events or avoidable readmissions could be used to assess comprehensive care. Data could also be benchmarked to national patient data. Aggregating data by age, gender, comorbidities, type and urgency of admission, and in context to the annual facility activity, is one way that this information could be used to assess opportunities for improvement, or whether improvements have been made.

- Age
- Gender
- Postcode of patient's residence
- Indigenous status
- Admission urgency
- Admission type
- Cognitive impairment on admission
- Unplanned admission to ICU during this episode of care
- Stayed in expected ward for entire admission
- Comorbidities
- Sentinel events resulting in serious harm or death, such as:
 - Surgery or other invasive procedure performed on the wrong site
 - Surgery or other invasive procedure performed on the wrong patient
 - Wrong surgical or other invasive procedure performed
 - Unintended retention of a foreign object in a patient after surgery or other invasive procedure
 - Haemolytic blood transfusion reaction resulting from ABO incompatibility
 - Suspected suicide of a patient in an acute psychiatric unit/ward
 - Medication error
 - Use of physical or mechanical restraint
 - Discharge or release of an infant or child to an unauthorised person
 - Use of an incorrectly positioned oro- or naso-gastric tube
- Hospital-acquired complications or adverse events during admission such as:
 - Pressure injury
 - Falls
 - Healthcare-associated infections
 - Unplanned return to theatre due to surgical complication
 - Respiratory complications
 - Venous thromboembolism
 - Renal failure
 - Gastrointestinal bleeding
 - Medication complication
 - Delirium
 - Persistent incontinence
 - Malnutrition
 - Cardiac complications
 - Third and fourth degree perineal laceration
 - Neonatal birth trauma
 - Self-harm
 - Aggression
 - Violence
 - Restraint use during admission
 - Others specific to service

Aligning to care processes

The following is an example of audit items for patients with hip fracture:

Process	Description	Gaps to assess
Process 1	% patients that received appropriate assessment on admission	Gaps in patient care related to appropriate diagnostic imaging, analgesia and cognitive assessment using a validated tool (e.g. ED pathway)
Process 2	% patients receiving regular pain assessment and analgesia	Gaps in patient care related to regular pain assessment and management (e.g. within 30 minutes of arrival in ED)
Process 3	% patients that received care defined in the ANZ guideline for hip fracture care	Gaps related to patients being admitted within an orthogeriatric (or similar) model
Process 4	% patients requiring surgery have an operation within 48 hours	Gaps that lead to any delays to surgery
Process 5	% patients mobilised day after surgery	Gaps related to mobilising patients such as the development of pressure injuries
Process 6	% patients are assessed and provided a prevention plan prior to discharge	Gaps related to prescription of bone protection medications
Process 7	% cases with a transition plan prior to discharge within 48 hours	Gaps related to outcomes (e.g. discharge destination, readmissions, further fractures, mortality)

Training and education would be required for auditing to ensure understanding of the requirements to meet each process.

Assessing organisational risks

Risk of harm questions	Response	Action
1. Does your organisation use administrative and clinical data to identify the most frequently experienced risks of harm to patients: <ul style="list-style-type: none"> • Across the organisation? • At ward level? 	Yes / No Yes / No	1.10
2. Has your organisation identified high risk wards or patient groups?	Yes (specify: _____) No	1.15
3. Do current models of care address most frequently experienced risk of harm?	Yes / No	1.15, 5.4
4. Does your organisation have an agreed screening approach including the key points when screening may be required?	Yes / No	1.15
5. Has your organisation endorsed specific screening and assessment tools?	Yes (specify: _____) No	1.15
6. Do you have ward-specific agreed screening approaches including tools and the key points when screening may be required?	Yes (specify: _____) No	

Risk of harm questions	Response	Action
7. Does your organisation have a policy for:		
• Providing services for patients with or at risk of pressure injury?	Yes / No	1.17, 5.21
• Providing services for patients at risk of falls including prevention, harm minimisation and post-fall management?	Yes / No	1.17, 5.24
• The preparation and distribution of food and fluids in accordance with nutrition care plans?	Yes / No	1.17, 5.27
• Providing services to patients who have cognitive impairment or at risk of developing delirium?	Yes / No	1.17, 5.29
• Predicting, preventing and managing self-harm and suicide in collaboration with patients, carers and families?	Yes / No	1.17, 5.31
• Predicting, preventing and managing aggression and violence?	Yes / No	1.17, 5.33
• Minimising restrictive practices of restraint and seclusion that includes legislative and reporting requirements?	Yes / No	1.17, 5.35, 5.36
8. Are the roles and responsibilities of the multidisciplinary team and consumers in the screening process explicit in organisation-wide policy?	Yes / No / No policy	1.1, 5.5
9. Is administrative and clinical data used to monitor the outcomes of screening and assessment?	Yes / No	1.10, 5.2
10. Is administrative and clinical data used to monitor the delivery of care?	Yes / No	5.2, 5.14d
11. Is the clinical workforce surveyed about their experiences of screening processes?	Yes / No	1.8b, 1.13b
12. Are patients surveyed about their experiences of screening processes?	Yes / No	1.13a, 2.11
13. Is training and education on the agreed approach to screening available to the workforce?	Yes / No	1.19b, 1.20
14. Is training and education on de-escalation strategies available to the workforce?	Yes / No	1.19b, 1.20
15. If the use of restraints is monitored by your organisation, what method is used?	Not monitored / incident monitoring systems / audit/clinical indicators	5.35

Risk screening and assessment clinical note audit questions

Risk requirement	Response	Action
1. Was a relevant screening process used during initial clinical examination and history taking?	Yes / No	5.10
2. Was a relevant screening process used during care?	Yes / No	5.10, 5.14d
3. Did risks identified during the relevant screening process lead to appropriate action/s?	Yes / No	5.10
4. Was there evidence of end-of-life care interventions after relevant screening processes?	Yes / No	5.15
5. Was a skin inspection performed?	Yes / No	5.22
6. Was risk of pressure injury identified?	Yes / No	5.21
7. Were pressure injury prevention interventions provided?	Yes / No / N/A	5.21, 5.23
8. Was a pressure injury documented?	Yes / No	5.21
9. Was best-practice wound management for pressure injury provided?	Yes / No / N/A	5.21
10. Was information about pressure injury prevention provided to the patient, carer and family?	Yes / No / N/A	2.6, 5.23
11. Was risk of falls identified?	Yes / No	5.24
12. Was equipment, devices or tools used to promote safe mobility?	Yes / No / N/A	5.25
13. Was information about falls prevention provided to the patient, carer and family?	Yes / No / N/A	2.6, 5.26
14. Was food and fluid provided in accordance with a nutrition care plan?	Yes / No	5.27
15. Was cognitive impairment documented?	Yes / No	5.29
16. Was risk of delirium identified?	Yes / No / N/A	5.29
17. Were strategies to manage cognitive impairment or delirium documented?	Yes / No / N/A	5.29a
18. Were antipsychotics or psychoactive medicines prescribed?	Yes / No	5.29b
19. Was risk of self-harm or suicide identified?	Yes / No	5.31
20. Were strategies applied to reduce distress when risk of self-harm or suicide was identified?	Yes / No / N/A	5.31
21. Was either risk of aggression or violence identified?	Yes / No	5.33
22. Were de-escalation strategies documented?	Yes / No / N/A	5.34b
23. Was an emergency response for aggression or violence required? (e.g. code black)	Yes / No	1.30a, 5.33
24. Was the patient restrained?	Yes / No	5.35
25. Was use of restraints in accordance with legislation?	Yes / No / N/A	5.35
26. Was use of restraints reported to the facility governing body?	Yes / No / N/A	5.35

Glossary

carer: a person who provides personal care, support and assistance to another individual who needs it because the individual has a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail and aged.

An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are paid, a volunteer for an organisation or caring as part of a training or education program.¹³

clinical governance: an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of safe, effective and high-quality services. Clinical governance systems provide confidence to the community and healthcare organisation that systems are in place to deliver safe and high-quality care.

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

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

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

consumer: a person who has used, or may potentially use, health services, or is a carer for a patient using health services. A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision-making processes.¹⁴

diagnosis: The identification by a medical provider of a condition, disease, or injury made by evaluating the symptoms and signs presented by a patient.¹⁵

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

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

health care: the prevention, treatment and management of illness and injury, and the preservation of mental and physical wellbeing through the services offered by clinicians, such as medical, nursing and allied health professionals.¹⁶

health literacy: the Commission separates health literacy into two components – individual health literacy and the health literacy environment.

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

The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the health system, and it affects the ways in which consumers access, understand, appraise and apply health-related information and services.¹⁷

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

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

leadership: having a vision of what can be achieved, and then communicating this to others and evolving strategies for realising the vision. Leaders motivate people, and can negotiate for resources and other support to achieve goals.¹⁸

multidisciplinary team: a team including clinicians from multiple disciplines who work together to deliver comprehensive care that deals with as many of the patient's health and other needs as possible. The team may operate under one organisational umbrella or may be from several organisations brought together as a unique team. As a patient's condition changes, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient.¹⁹ Multidisciplinary care includes interdisciplinary care. (A discipline is a branch of knowledge within the health system.²⁰)

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

person-centred care: an approach to the planning, delivery and evaluation of health care that is founded in mutually beneficial partnerships among clinicians and patients.²¹ Person-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of person-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of family and carers, and access to care.²² Also known as patient-centred care or consumer-centred care.

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

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

process: a series of actions or steps taken to achieve a particular goal.²³

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

quality improvement: the combined efforts of the workforce and others – including consumers, patients and their families, researchers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development.²⁴ Quality improvement activities may be undertaken in sequence, intermittently or on a continuous basis.

responsibility and accountability for care: accountability includes the obligation to report and be answerable for consequences. Responsibility is the acknowledgement that a person has to take action that is appropriate to a patient's care needs and the health service organisation.²⁵

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

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

risk screening: a short process to identify patients who may be at risk of, or already have a disease or injury. It is not a diagnostic exercise, but rather a trigger for further assessment or action.

safety culture: a commitment to safety that permeates all levels of an organisation, from the clinical workforce to executive management. Features commonly include acknowledgement of the high-risk, error-prone nature of an organisation's activities; a blame-free environment in which individuals are able to report errors or near misses without fear of reprimand or punishment; an expectation of collaboration across all areas and levels of an organisation to seek solutions to vulnerabilities; and a willingness of the organisation to direct resources to deal with safety concerns.²⁶

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

shared decision making: a consultation process in which a clinician and a patient jointly participate in making a health decision, having discussed the options, and their benefits and harms, and having considered the patient's values, preferences and circumstances.²⁷

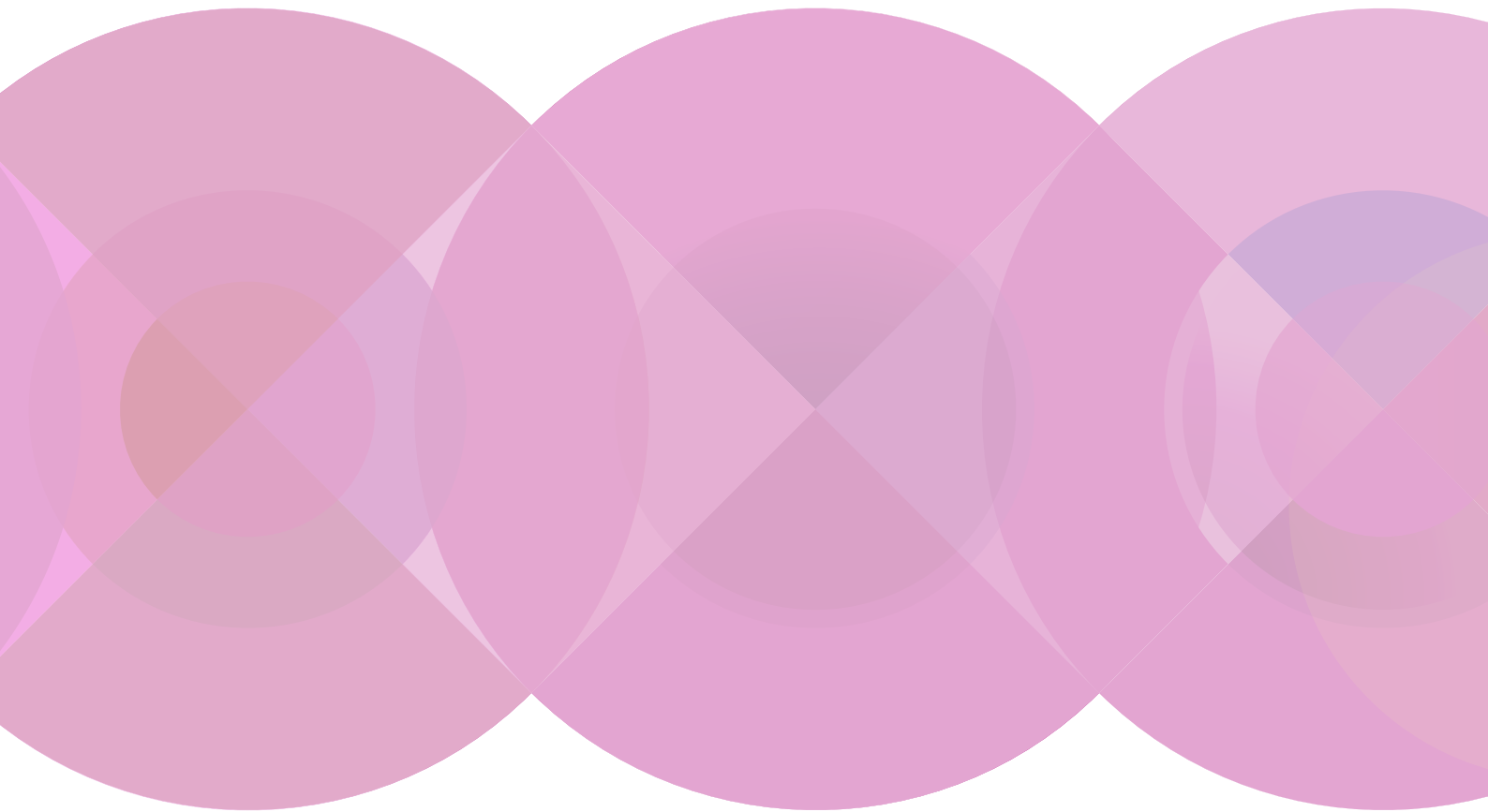
training: the development of knowledge and skills.

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

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