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Australian Safety and Quality Framework for Health Care
What is the Framework?

The Australian Safety and Quality Framework for Health Care describes a vision for safe and high-quality care for all Australians, and sets out the actions needed to achieve this vision. The Framework specifies three core principles for safe and high-quality care. These are that care is consumer centred, driven by information, and organised for safety. Health Ministers endorsed the Australian Safety and Quality Framework for Health Care in 2010.

The Framework provides 21 areas for action that all people in the health system can take to improve the safety and quality of care provided in all healthcare settings over the next decade. The Framework should:

- be used as the basis of strategic and operational safety and quality plans
- provide a mechanism for refocusing current safety and quality improvement activities and designing goals for health service improvement
- be used as a guide for reviewing investments and research in safety and quality, and
- promote discussion with consumers, clinicians, managers, researchers and policy makers about how they might best form partnerships to improve safety and quality.

How can you put the Framework into action?

You should use the Framework in a way that suits your needs and circumstances. This will vary depending on your role and responsibilities, and the nature of your organisation. As a manager you have a leadership role, and share responsibility for the safety and quality of health services delivered to patients and consumers. In this role, you are likely to be involved in strategic and operational planning. You will be supporting the clinical and non-clinical workforce to carry out operational plans and to deliver healthcare services. The Framework will support this work.

This ‘Getting started’ document will help you to start putting the Framework into action. It highlights several of the Framework’s 21 areas of action that particularly apply to healthcare managers and describes some examples of activities to help you. The Framework, including all 21 areas for action by people in the health system, is published in full on the final page of this document.

This document is supported by the website of the Australian Commission on Safety and Quality in Health Care. This website contains up-to-date resources, tools, and links on all of the safety and quality issues covered in the Framework. The Commission will develop and publish further papers to support the application of the Framework and specific areas of action within it.

‘Getting started’ documents have also been developed for the healthcare team and people who work in policy development roles so that everyone can work towards common goals in developing a safe and high-quality healthcare system.

Who is this document for?

Everyone who works in health has a part to play in creating a safe and high-quality healthcare system. This document has been prepared specially for those who have a management role within the health system. This includes roles with responsibility for managing people, equipment, facilities and other resources needed to deliver healthcare services. You may be a hospital manager, practice manager, or a manager of a service, ward or unit. You may be a non-clinical manager or administrator, or a nurse, doctor or other clinician who also has management responsibilities.
Accessing healthcare services in a timely way is important to consumers, and is associated with better health outcomes. Barriers to timely access can arise from many sources. One such barrier is the way that our health systems have often evolved for the convenience and preference of our doctors, nurses and clerical staff rather than being designed specifically to improve patient access. This means that systems such as outpatient booking processes, patient transfer processes, or admission procedures may not be responsive to the needs of patients and consumers.

One approach to improving access to health services has been the use of process redesign. There has been a considerable focus on the science of redesigning processes of care over the last decade, with many Australian and overseas examples of simple but successful changes to the order and coordination of how tasks are done. These changes have reduced the time patients must wait for care and improved the capacity of health services to provide care in line with known best practice and established clinical standards.

The secret of these improvements has been the adoption of a standard approach that includes: a mapping of the particular process to be redesigned; the use of the local healthcare workers and consumers involved in the process to understand how it could be done differently; agreement on what specific improvement is to be achieved; and the gathering of measures that tell you how well, or not, the changed process is achieving the intended improvement. This approach is well documented and of proven value in improving the access of patients to care. It does not need large amounts of resources, however, it does require organisational commitment, support and coordination to make sure that the identified improvements are put into practice.

As a health manager, you should:

1. Be aware of process redesign approaches, and how they can be applied in your setting.
2. Establish the priority of improvements that are most needed for the patient groups that use your service.
3. Plan and implement an approach to achieve change. This includes identifying appropriate members of the clinical and non-clinical workforce, enabling them to spend time doing this work, and supporting them by involving other internal or external experts who have experience in this approach.

Consumer feedback and health service experience consistently tell us that wait times are an issue that needs to be addressed so that people can get better access to services. You may consider focusing your process redesign approaches to reduce waits for inpatient admission through emergency departments, reduce waits for elective surgery admissions, or reduce waits in general practice or other primary healthcare services.

Links to tools, resources, and literature relating to these topics are available at [www.safetyandquality.gov.au](http://www.safetyandquality.gov.au)
Area for action: 1.4 Provide care that respects and is sensitive to different cultures

Miscommunication between health professionals and patients who speak a different language or come from a different cultural background is common and is associated with poor health outcomes. Consumers tell us that a fundamental aspect of consumer centred care is their capacity to understand the information that is being given to them and the healthcare worker’s capacity to understand the questions and concerns of each patient and family member.

The basic requirement for effective and respectful communication is to provide information to a patient that makes sense to them in the context of their cultural background and in a language that they can understand.

Each patient’s clinical situation will vary, and while pre-prepared information translated into different languages can be a valuable tool to assist with communication, the need for a dynamic, interpreter-supported conversation will remain. Early recognition of the language needs of particular patients can allow healthcare workers to plan ahead for specific opportunities to have a conversation with patients and families. Although use of interpreters is straightforward in concept, it is well recognised that timely availability of interpreters to simplify this two-way communication is difficult to achieve for a wide variety of reasons.

In order for any health service to be more prepared to communicate effectively and appropriately with its patients, it is important to know the cultural and language distribution of the particular patient population. Using that knowledge, information about routine clinical and administrative matters can be developed, pre-printed and made available at key locations within the organisation. This preparation is essential to making effective and appropriate communication the normal way of working.

You also need to acknowledge the cultural diversity of your clinical and non-clinical workforce and ensure mechanisms and processes are established that take these differences into account.

As a health manager, you should:

1. Support your workforce in their use of interpreters with patients and families. This includes making sure that the process for requesting, booking and using an interpreter is well organised, simple to use and that assistance is available where problems arise. In some cases, healthcare workers may also need assistance in determining whether a patient requires an interpreter and this is another area where support could also be provided.

2. Be aware of the cultural background of your workforce, particularly in circumstances where language difficulties may arise. For example, do your rostering arrangements mean that the majority of your weekend duty clinicians are temporary residents for whom English is a second language?

3. Provide opportunities for your workforce to learn about the key cultural beliefs of the most common cultural groups in your patient population through written materials and in continuing education. In addition, you should explore the experience of your patients regarding cultural and language issues in order to understand whether changes need to be put in place. Such changes might include targeted cultural information regarding your patient population in orientation and other specific training opportunities for healthcare workers.

Links to tools, resources, and literature relating to these topics are available at [www.safetyandquality.gov.au](http://www.safetyandquality.gov.au)
Principle: Consumer centred

Area for action: 1.5 Involve consumers, patients and carers in planning for safety and quality

Evidence increasingly shows that health systems are safer when consumers, patients, their families and carers are involved in their design and delivery. When healthcare administrators, providers, patients, and families work together, safety, quality, and operational outcomes improve, costs decrease, and provider and patient satisfaction increases.

Consumers and patients have experiences and perspectives as users of health services that are invaluable when brought to planning and improvement activities. Structured, prospective involvement of patients, carers and consumers within the governance arrangements of your organisation will enhance the understanding of consumers’ desires and priorities in all aspects of planning and care delivery. Options include involving consumers, patients and carers in committees and advisory groups, redesign of care processes, and the development of new programs and facilities.

Successful and positive engagement can be difficult to achieve and requires considerable focus on the part of managers to actively seek and support partnerships with interested individuals and consumer groups. This helps to build up an ongoing relationship with consumers, patients and carers who are then better prepared and able to participate in safety and quality planning alongside clinical and non-clinical staff.

As a health manager, you should:

1. Understand the governance structures in place within your organisation to involve consumers, patients and carers in safety and quality planning.

2. Actively seek to involve patients, carers and consumers in planning for safety and quality. This may be as members of committees and advisory groups, advisors for process redesign work, or participants in planning groups for new facilities.

3. Ensure that your clinical and non-clinical workforce understands and values the input from patients, consumers, families and carers. This may require training as part of ongoing continuing education.

Links to tools, resources, and literature relating to these topics are available at www.safetyandquality.gov.au
For most patients, modern health care requires the involvement of multiple health practitioners in their care. This can be within a particular health service or across different services and sectors. Patients and consumers tell us that one of the most important things to them is that each health practitioner they see is aware of their history and their treatment plan. Lack of this information causes considerable anxiety and frustration on the part of the patient and the health practitioner as well as being a recognised cause of delays in treatment, the unnecessary duplication of investigations, and even the provision of inappropriate care.

Clinical handover refers to the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis. Clinical handovers occur at shift change, when patients are transferred between health services or wards, as well as during admission, referral or discharge. Millions of clinical handovers occur annually in Australia and this is therefore a high risk area for patient safety with consequences that can be serious.

In 2007, the Australian Commission on Safety and Quality in Health Care established the National Clinical Handover Pilot Program to improve handover communication. This Program involved more than 30 hospitals across Australia, as well as primary health and aged care services, and has resulted in the development and piloting of a number of practical, structured tools for improving clinical handover. These include protocols and support material for improving shift change handover, tools for transfers between facilities and materials on team communication. These tools were accepted for use in Australia’s hospitals by Health Ministers in April 2010.

**As a health manager, you should:**

1. Be aware of the risks that occur in handover situations and identify and agree on a form of structured handover that is appropriate for your organisation. This handover protocol should be formally documented as part of the organisation’s policies and procedures.

2. Make sure that your clinical workforce is consistently using this handover protocol. This means that: (i) healthcare workers need to be aware of the agreed handover protocol, (ii) work processes and rostering arrangements support the use of structured handover, and (iii) you monitor and analyse incident reports or other relevant information for evidence of patient safety incidents arising as a result of poor clinical handover.

3. Make sure that clinical handover protocols apply to the transfer of patients between services, and that these are used consistently and reliably. These transfers may include referrals from GPs to specialists or other primary healthcare practitioners, transfers between hospitals, and discharges from hospitals to primary health and community services.

Links to tools, resources, and literature relating to these topics are available at [www.safetyandquality.gov.au](http://www.safetyandquality.gov.au)
Area for action: 1.8 Promote healthcare rights

The Australian Charter of Healthcare Rights was endorsed by Australian Health Ministers in July 2008. It articulates the basic rights that patients and consumers are entitled to when accessing healthcare services throughout Australia. These rights are Access, Safety, Respect, Communication, Participation, Privacy and Comment. The Charter applies to the whole healthcare system and allows patients, consumers, families, carers and service providers to have a common understanding of the rights of people receiving health care. It is applicable to all health settings anywhere in Australia, including public hospitals, private hospitals, general practice and other ambulatory care environments.

The Charter has been shaped by all stakeholders in health care and is strongly supported by consumers as the framework for healthcare providers to give consumers high-quality care and for consumers to actively seek the best care. The Charter can be adapted for the needs of specific environments and services as long as the seven core rights in it remain.

All healthcare organisations should now be using a local charter of healthcare rights, either by simply adopting the Australian Charter (or state-based versions where relevant) or by adapting the Charter for local circumstances.

As a health manager, you should:

1. Be aware of your local charter of healthcare rights, and how it applies in your organisation. If there is not currently a charter than applies in your organisation, you should explore adopting or adapting the Australian Charter of Healthcare Rights.

2. Support your workforce to provide care in accordance with the rights of patients and consumers. This may require reviewing organisational systems to ensure that the rights included in the Charter are reflected in policies and protocols regarding the delivery of care.

3. Ensure that all patients being treated within your organisation receive information regarding their rights in a way that they can understand and use.

In addition, you should make sure that patients and consumers are supported to provide comments and make complaints about the service they receive and that these comments and complaints are acted upon promptly.

Links to tools, resources, and literature relating to these topics are available at [www.safetyandquality.gov.au](http://www.safetyandquality.gov.au)
Evidence from multiple health systems across the world over the past 15-20 years has demonstrated that around 10% of patients admitted to a hospital will suffer an adverse event. While the incidence of such events in the sub-acute and primary care settings is not yet known, we do know that adverse events occur in these settings that are associated with unnecessary harm to the patient.

Patients, carers and other healthcare consumers have made it clear that if something goes wrong during their care, the first thing they want is to be told about it promptly with as much information as is known at that stage. They want to know what is being done to minimise any harm that may come from the adverse event, how the incident is being investigated, and, perhaps most importantly, what is being done to prevent such an incident from happening again.

In addition to the ethical imperative that this places on the health professional to give prompt and full information to the person inadvertently harmed, there are good reasons for supporting the practice of openly informing and supporting patients when something goes wrong. Being open, honest and truthful is the basis for the essential relationship of trust that patients have with their health providers and the facilities in which they are treated. Patients and their families must be openly informed of harmful incidents in order to make decisions about further treatment and future consent. A well designed open disclosure approach will also provide them with emotional and practical support throughout the episode.

Open disclosure can help health professionals understand how harm has occurred and to learn from it. Importantly, it can also assist them to overcome any trauma they may suffer as a result of the incident.

A comprehensive open disclosure process therefore supports both patients and health care professionals through difficult and traumatic circumstances and optimises the opportunity to learn from the, albeit unwanted, experience. A learning, rather than a blaming, culture makes for safer and higher quality care.

As a health manager, you should:
1 Be aware of the open disclosure process within your organisation and your own role within it.
2 Make sure that your workforce is supported to effectively participate in the open disclosure process.
3 Make sure that all patients (and/or their carers) who are inadvertently harmed during their care are communicated with in accordance with the open disclosure policy.

Open disclosure at the time of the adverse event is essential. However you should also make sure that communication with patients, families and carers is ongoing until the results of all investigations and organisational decisions arising from the event are known. This information should also be provided to the patient and their family.

Links to tools, resources, and literature relating to these topics are available at www.safetyandquality.gov.au
Area for action: 2.2 Collecting and analysing safety and quality data to improve care

An essential part of improving the safety and quality of the care provided to patients is the gathering, analysis and use of information regarding clinical performance. All types of healthcare organisations should have a clearly defined set of safety and quality information that is gathered and consolidated into meaningful indicators for clinicians, managers and the executive. Your role in this process will vary depending on the position you hold. You may have direct responsibility for clinicians delivering care, be responsible for broader functions or areas of the organisation, or hold a senior management position with organisation-wide responsibilities. Regardless of particular roles, all managers have a shared responsibility for the quality of care being provided within their area and should make sure that safety and quality information is gathered and included within overall reporting and decision-making processes.

As a health manager, you should:

1. Make sure that you are aware of your role in the safety and quality reporting framework of your organisation.
2. Participate in safety and quality information gathering and analysis, and support the clinical and non-clinical workforce for whom you are responsible to do so.
3. Make sure that changes and improvements in care identified from the collection and review of safety and quality data are put into practice.

It is essential that information and data about the safety and quality of care is given to clinicians in ways that enable them to consider their performance over time and to identify improved results that may come about as a consequence of changes in care processes. You should identify and use methods to provide this information that are appropriate to your organisation. For example, the use of statistical process control charts has been shown to be very effective in illustrating performance over time and in helping to identify those changes that are significant.

Links to tools, resources, and literature relating to these topics are available at www.safetyandquality.gov.au
Area for action: 2.3 Learn from patients’ and carers’ experiences

Information about the safety and quality of care provided within the health system should not be limited to data about processes and clinical outcomes. An understanding of the actual experience of patients being treated is essential for an accurate appreciation of overall safety and quality of care. The “real life” experience of patients and carers provides a unique perspective. If taken together with information that comes from clinical and other data generated within a health service, it provides a more accurate picture of safety and quality performance.

Understanding the experience of patients and carers is best achieved by using a variety of approaches. Some of these are “passive” approaches that rely on recording, collating and reporting of comments and complaints made across the organisation. Other, more active, approaches should also be used to seek the views of consumers, patients, families and carers in an ongoing way. These approaches include the use of regular, standard and formal mechanisms such as surveys or focus groups.

As a health manager, you should:

1. Review information from complaints and comments received about your organisation or service to identify any areas for improvement. Information from individual complaints should also be aggregated to identify the existence of trends and emerging issues.

2. Make sure you are aware of the processes within your organisation to seek feedback from patients, consumers, carers and families. Where relevant, you should participate in these processes, and support your workforce to do so.

3. Use information about the experiences of patients and carers to improve the care provided in your organisation. Options may include reviewing the results of patient surveys to identify actions that can be taken to improve care, involving consumers, patients and carers in planning processes, and ensuring that the stories from individual patients are reflected in education and training.

When reviewing information about the experiences of patients and carers, and considering how to improve safety and quality within your organisation, you should seek the opinions of the clinical workforce, and from patients themselves. Their views can provide useful insights about the meaning of the information, and identify actions that could be taken to address concerns.

Links to tools, resources, and literature relating to these topics are available at www.safetyandquality.gov.au
Areas for action: 3.1 Health staff take action for safety, and 3.3 Managers and clinical leaders take action for safety

The principles of clinical governance that have been in place for more than a decade recognise that individual clinicians and managers have a responsibility for the safety and quality of care being provided to patients. The other major development associated with this concept is the recognition that the ways in which health systems are organised is the main determinant of patient safety. This means that health managers and clinical leaders have both the responsibility and the mechanism for improving patient safety and quality of care within their own organisations.

Managers and clinical leaders bring to organisational decision-making and planning their expert knowledge of service delivery and local safety and quality problems and solutions. This means that they are in an ideal position to work with clinicians and consumers to redesign systems and processes to improve care and to use organisational structures to implement those redesigned processes.

The growing day-to-day pressures on everyone working in health, combined with a historical health care focus on financial and activity performance, has meant that it can be difficult for the clinical and non-clinical workforce to find the time and the energy to focus on safety and quality improvements. A key role for managers is to make it clear that the priority of improving performance in patient safety and quality is equally as important as improving activity and financial performance, a concept often referred to as the “triple bottom line”. This means modelling behaviour that reflects this reality as well as making sure that organisational priorities and mechanisms are structured to support this activity.

As a health manager, you should:

1. Accept shared personal responsibility for the quality and safety of clinical care provided within your organisation.
2. Support the development and implementation of clinical governance systems, structures and processes to make sure your organisation is improving the quality of clinical care.
3. Encourage and support both the clinical and non-clinical workforce to be involved in quality activities and recognise their efforts when they do this. It is important to ensure that the non-clinical workforce understand that they have a role in contributing to the safety and quality of care provided to patients, and to provide ways for them to fulfil this role.

In addition, you should establish and/or promote mechanisms to help anyone take immediate action to prevent harm occurring to patients. You should also encourage and support your workforce to report any event or circumstance that could have resulted, or did result, in unnecessary harm to a patient.

Links to tools, resources, and literature relating to these topics are available at www.safetyandquality.gov.au
Organisational processes and systems can sometimes contribute to poor quality care and compromise patient safety. The inevitability of human error within complex, stressful and technically demanding situations is well recognised in many fields, including healthcare. The recognition of this fact and the use of risk reduction principles in the design of work processes, equipment, and even in facility design is growing. While error analysis and quality improvement are extremely important in producing safer and higher quality health environments, these approaches are essentially reactive.

One proactive approach that is becoming more common in patient safety is ‘human factors’. The human factors approach examines the interactions between people and other elements of a system. These other elements could encompass an environment, a building, a device or machine, a form, a software application or other person or organisation. Human factors approaches examine patient safety risks and known errors that can occur at these interfaces. Having knowledge of these high risks means that healthcare equipment and facility design can consciously support patient safety and quality by incorporating mechanisms to reduce the risk of human error. The increasing use of these approaches to healthcare is beginning to provide benefits for patient safety and quality activity.

**As a health manager, you should:**

1. Be aware of human factors approaches in healthcare, and how they can be applied to identify risks and improve safety.
2. Use those approaches and information in the design of standard operating procedures for existing and new equipment and procedures.
3. Whenever possible, introduce these concepts into the design and/or refurbishment of your facilities.

In addition, you should also take active steps to support nationally and locally agreed approaches that are based on human factors and other evidence. Examples of these include the World Health Organization Surgical Safety Checklist, and local procedures to minimise the risk of “wrong patient, wrong procedure” incidents.

Links to tools, resources, and literature relating to these topics are available at [www.safetyandquality.gov.au](http://www.safetyandquality.gov.au)
### Safe, high-quality health is always:

#### 1. Consumer centred

This means:
- Providing care that is easy for patients to get when they need it.
- Making sure that healthcare staff respect and respond to patient choices, needs and values.
- Forming partnerships between patients, their family, carers and healthcare providers.
- Ensuring that patients and carers report positive experiences of health care.

**I can get high-quality care when I need it.**

- I can get high-quality care when I need it.
- I have information I can understand. It helps me to make decisions about my health care.
- I can help to make my care safe.

**My health care is well organised. The doctors, nurses and managers all work together. I feel safe and well cared for.**

**I know my healthcare rights.**

- If something goes wrong, my healthcare team look after me. I receive an apology and a full explanation of what happened.

#### 2. Driven by information

This means:
- Using up-to-date knowledge and evidence to guide decisions about care.
- Safety and quality data are collected, analysed and fed back for improvement.
- Taking action to improve patients’ experiences.

**My care is based on the best knowledge and evidence.**

**The outcome of my treatment and my experiences are used to help improve care.**

#### 3. Organised for safety

This means making safety a central feature of how healthcare facilities are run, how staff work and how funding is organised.

**I know that the healthcare team, managers and governments all take my safety seriously.**

**The health system is designed to provide safe, high-quality care for me, my family and my carers.**

**When something goes wrong, actions are taken to prevent it happening to someone else.**

### What it means for me as a consumer or patient:

1.1 Develop methods and models to help patients get health services when they need them.

1.2 Increase health literacy.

1.3 Partner with consumers, patients, families and carers to share decision making about their care.

1.4 Provide care that respects and is sensitive to different cultures.

1.5 Involve consumers, patients and carers in planning for safety and quality.

1.6 Improve continuity of care.

1.7 Minimise risks at handover.

1.8 Promote healthcare rights.

1.9 If something goes wrong, openly inform and support the patient.

### Areas for action by people in the health system:

3.1 Health staff take action for safety.

3.2 Health professionals take action for safety.

3.3 Managers and clinical leaders take action for safety.

3.4 Governments take action for safety.

3.5 Ensure funding models are designed to support safety and quality.

3.6 Support, implement and evaluate e-health.

3.7 Design and operate facilities, equipment and work processes for safety.

3.8 Take action to prevent or minimise harm from healthcare errors.