

Australian Safety and Quality Framework for Health Care

Putting the Framework into action: Getting started



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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.

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 people who **directly provide healthcare services to consumers, patients and clients**. You may be a doctor, nurse, allied health or other type of healthcare practitioner working alone, or in a team, to deliver healthcare services in an acute or primary care setting. These settings may include public and private hospitals, day facilities, outpatient clinics, specialists' rooms, general practices, community health clinics and private allied health practices.

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 healthcare provider you have a responsibility for ensuring that the care you provide to patients is safe and aligns with known best practice and established clinical standards. However, your responsibilities for safety and quality go beyond your care for individual patients. You also have a responsibility to participate in the quality and safety systems that have been established in the organisation in which you work to ensure that safe care is provided to all patients at all times. 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 providers 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 managers, and people who work in policy development and governance roles so that everyone can work towards common goals in developing a safe and high-quality healthcare system.

AREAS FOR ACTION: **1.2 Increase health literacy, and**
1.3 Partner with patients, families and carers to share decision making about their care

Consumers have told us that it is important for them to participate in decision making processes about their health so that they can make an informed decision about their care. At the same time, members of the healthcare team are fully aware of the requirements for informed patient consent and are looking for ways to improve the involvement of patients, families and carers in decision-making.

Making decisions about treatment and screening where there are a number of options to choose from is not easy. The technical nature of this information, and concepts such as relative risk, can be unfamiliar to patients and families. In addition, the volume of information required can sometimes be overwhelming. The use of written material to provide information about particular procedures or treatments is now well-established but tends to be generally used after a decision about treatment has been taken.

Patient decision aids are evidence-based tools that help people become involved in decision-making by providing information about the options and outcomes and by clarifying personal values. The largest and most consistent benefits of patient decision aids, relative to usual care, are better knowledge of options and outcomes and more accurate perceptions of outcome probabilities.

Patient decision aids may be videos, booklets, or websites that prepare patients for decision making by providing them with information about treatment and screening options, and outcomes relevant to their health. They help patients consider the possible benefits and harms in an unbiased way so that they can make choices about their health care which fit with their personal values and preferences. Clinicians can use these with their patients in consultations, in addition to routine clinical counselling.

As a member of a healthcare team, you should:

- 1** Be aware of the availability of patient decision aids relevant to your areas of practice.
- 2** Determine which patient decision aids you will use in your practice.
- 3** Make sure that you plan the timing of discussions with your patients, families and carers to make the best use of the patient decision aids.

Patient decision aids can particularly help patients with low education levels and low literacy to take a more active role in their care. You should have an understanding of the education and literacy levels of your patients. This will support more effective use of patient decision aids.



Links to tools, resources, and literature relating to these topics are available at www.safetyandquality.gov.au

AREA FOR ACTION: 1.4 Provide care that respects and is sensitive to different cultures

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 that makes sense to a patient in the context of their cultural background in a language that they can understand. Proficiency in everyday, conversational English does not mean that a person necessarily has the capacity to understand more clinical or technical terms when English is used.

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. Although use of interpreters is straightforward in concept, it is well recognised that timely availability of interpreters to simplify this two-way communication in health care is difficult to achieve for a wide variety of reasons. Clinicians should use translated information about routine clinical and administrative matters as well as using interpreters for more specific discussions.

In order for any clinician to communicate effectively and appropriately with their patients, it is important that they understand the cultural norms and language needs of their particular patient population. All clinicians should make use of training opportunities to understand the cultural beliefs of the most common cultural groups in their patient population and also be aware of their own cultural assumptions.

As a member of a healthcare team, you should:

- 1** Regularly check with your patient that they understand the information you are providing to them, particularly where there may be technical or complex information relevant to choices about treatment.
- 2** Be aware of how to organise an interpreter in your service and be able to find alternatives if an interpreter is not available.
- 3** Be aware of and respect the cultural beliefs held by the patients you treat.

In addition, you should take the opportunity to explore the underlying cultural assumptions within your healthcare team and consider how these might differ from those of your most common patient groups.



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AREA FOR ACTION: 1.6 Improve continuity of care

Health consumers are particularly conscious of the need to have continuity of care as they traverse the healthcare system (see also 'Area for action: 1.7 Minimise risks at handover'). This continuity of care for patients must apply within a healthcare team as well as between any team and other health professionals. Healthcare delivery is increasingly complex and multidisciplinary and all professionals are now working within teams of their own professions as well as with colleagues from other disciplines.

The recording of accurate, complete and timely information about a patient is more important than ever in ensuring that the correct treatment

is continued by all health professionals. This information should be accompanied by an up-to-date plan of intended treatment that is available wherever and whenever a patient is seen by a health professional.

Clinicians should be conscious of, and use, current and evolving communication mechanisms including paper based and electronic medical records, and handover and transfer documentation, as well as working with patients to make sure they have sufficient information and understanding of their treatment to be able to effectively participate in maintaining the continuity of their own care.

As a member of a healthcare team, you should:

- 1** Make sure that you regularly and accurately update the clinical record and intended treatment plan of all patients whose treatment you are involved.
- 2** Be able to effectively use the electronic and paper based clinical systems in your organisation.
- 3** Work with patients to make sure they have sufficient information and understanding of their treatment to be able to participate in maintaining the continuity of their own care.



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AREA FOR ACTION: 1.7 Minimise risks at handover

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 appropriate 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 member of a healthcare team, you should:

- 1** Be aware of, and always use, the agreed handover protocol for your organisation.
- 2** Make sure that clinical handover protocols are used when patients are transferred between services. 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.
- 3** Involve patients, families and carers in handover where possible and appropriate. This has the effect of increasing the involvement of patients in their care and can bring safety and quality benefits.



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AREA FOR ACTION: **2.1** Use agreed guidelines to reduce inappropriate variation in the delivery of care

Clinical care for individual patients is ideally a product of best available evidence for the treatment of a particular diagnosis, matched and adapted to suit the clinical circumstances of a particular patient. The increasing development of clinical guidelines, standards and protocols has greatly assisted in the delineation of good, evidence based practice, but has also created a new challenge for clinicians: that of knowing when and how to tailor this guidance for a particular individual. Inappropriate variation in care (for example, where care is based solely on clinician preference without consideration of current agreed practice) is a well recognised cause of poor quality and increased numbers of adverse events.

At the same time, the wide variety of overlapping, and occasionally contradictory, guides add further uncertainty to the choices facing clinicians in the practice of their profession. Complexity also emerges from the fact that many patients have multiple diagnoses and, therefore, a number of guidelines and standards may be applicable simultaneously.

Clinicians can reduce the confusion and risk associated with this complex situation by consciously choosing a set of well-constructed clinical guidelines to use consistently within their own areas of practice, and by participating in decisions about the agreed guidelines to be used by any healthcare team in which they work.

As a member of a healthcare team, you should:

- 1** Adopt clinical guidelines that you will use consistently within your own area of practice. These can be adapted for your practice and tailored to the needs of individual patients.
- 2** Make sure that these guidelines are consistent with the clinical guidelines used by any clinical team of which you are a member.
- 3** Feed back your own experience of using clinical guidelines into any organisational or professional review process, and adopt new information as it becomes available. Consistent application of well evidenced clinical guidelines is a part of high-quality, safe clinical practice.



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AREAS FOR ACTION: **2.2** Collecting and analysing safety and quality data to improve care, and
2.3 Learn from patients' and carers' experiences

An essential part of improving the safety and quality of care provided to patients is the gathering, analysis and use of information regarding clinical performance across the organisation. This information can be in the form of data about operational performance, clinical outcomes, and the experience of patients receiving care.

All 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. Clinicians play a vital role in this process by accurately recording information, encouraging patients and families to express their views, and participating in the process of discussion and analysis at the local level.

As a member of a healthcare team, you should:

- 1** Participate in the gathering and analysis of safety and quality information within your organisation. This may include providing clinical or other performance data as part of routine data collection or audit processes.
- 2** Support and encourage patients and families to make their views and experiences known. This may include supporting them to make a comment or complaint, or encouraging them to participate in more formal feedback mechanisms such as patient surveys.
- 3** Review any information provided to you about the safety and quality of the care provided by you, and your healthcare team. This includes reflecting on your own performance, and identifying where changes and improvements can be made. You also need to take action to ensure that the improvements in care identified from these processes are put into practice.

To facilitate your use of safety and quality data, you should develop an understanding of the ways in which this information is presented. This may require some understanding of graphical representation of data such as statistical process control charts, which have been shown to be effective in illustrating performance over time and identifying changes that are significant.



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AREA FOR ACTION: 2.4 Encourage and apply research that will improve safety and quality

Research about safety and quality issues provides the foundation for evidence based processes of care, identifies the changes required to improve clinical practice and health outcomes, and helps to reduce risks and harm associated with the delivery of care. Safety and quality research is a rapidly developing field,

with several journals specifically focussed on this topic. With the existence of improved processes for disseminating and obtaining access to research results and papers, it is getting easier for clinicians to access this information.

As a member of a healthcare team, you should:

- 1** Be aware of, and regularly check, the key sources of safety and quality research results.
- 2** Discuss research findings with colleagues and reflect on how they apply to your clinical practice. You should incorporate these results not only in your own practice but also in the practices of the broader clinical teams you are involved in.
- 3** Include discussion of safety and quality matters in any routine continuing education and peer review activities in which you participate.

You should also look for opportunities to be involved in structured processes of quality improvement, as well as research activity within and outside your organisation.



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AREAS FOR ACTION: **3.2** Health professionals take action for safety, and
3.8 Take action to prevent or minimise harm from healthcare errors

For the majority of occasions where a patient is harmed, the harm is related to the clinical care they have received. All clinicians should act immediately to keep patients safe when they recognise that a patient safety incident has happened or is at risk of happening. It is also critical to report adverse events and the circumstances surrounding the incident so that the organisation can learn from the incident, and take steps to prevent it from happening again.

Reporting “near misses” is also important to help understand how to avoid future incidents from occurring.

Reports of these events need to be analysed to identify actions that can be taken to change the process of care to prevent future patient harm. In the most serious cases where harm has occurred, a structured process, such as a root cause analysis, should be used to identify the key issues and remedy the causes.

As a member of a healthcare team, you should:

- 1** Be aware of and follow the processes for reporting patient incidents and near misses in your organisation.
- 2** Take direct action to reduce or prevent risks of patient harm that you recognise during your clinical or other work. This may include speaking up in an operating theatre if you are unsure that the right procedure is to be performed on the right patient, or contacting a GP if you are unsure about the accuracy of a prescription you may be dispensing.
- 3** Participate in the ongoing analysis of adverse patient events. You should also take an active role in adopting recommendations for change that come from incident analysis and other investigations into healthcare errors.

In addition, you should follow the policies, procedures and protocols that have been developed in your organisation to support the provision of safe and high-quality care. These policies and protocols may cover areas such as patient identification, hand hygiene, falls prevention, medication safety, and clinical handover.



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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.

What it means for me as a consumer or patient:

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.

Areas for action by people in the health system:

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.

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.

2.1 Use agreed guidelines to reduce inappropriate variation in the delivery of care.

2.2 Collect and analyse safety and quality data to improve care.

2.3 Learn from patients' and carers' experiences.

2.4 Encourage and apply research that will improve safety and quality.

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.

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.



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AUSTRALIAN COMMISSION ON
SAFETY AND QUALITY IN HEALTHCARE

