Monitoring Clinical Practice and the National Safety and Quality Health Service Standards

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The NSQHS Standards

Standard 1
Governance for Safety and Quality in Health Service Organisations

Standard 2
Partnering with Consumers

Standard 3
Healthcare Associated Infections

Standard 4
Medication Safety

Standard 5
Patient Identification and Procedure Matching

Standard 6
Clinical Handover

Standard 7
Blood and Blood Products

Standard 8
Preventing and Managing Pressure Injuries

Standard 9
Recognising and Responding to Clinical Deterioration in Acute Health Care

Standard 10
Preventing Falls and Harm from Falls

A better way to care
NSQHS Standards

About the - WHAT

Not the - HOW
Risk management approach

Risk management is the design and implement of activities to identify and avoid or minimise risks to patients, employees, visitors and the institution.

Then:

Health services will need to demonstrate they have undertaken a comprehensive risk analysis

Strategies that are implemented should focus on areas of greatest risk

Risks will vary across wards/facilities of health service, so not all strategies will be applicable or a priority in all parts of the health service.
Data and Monitoring

This information is key to:

• Measuring and managing risks
• Changing clinical practice and management
• Informing decision making
• Identifying areas for improvement
• Driving and evaluating continuous quality improvement
• Providing evidence for accreditation
Standard 1 - Governance for Safety and Quality

**Focus is on systems**

- Setting up policies and processes
- Clarifying accountability and responsibility
- Providing a structure for good clinical practice
- Determining reporting and monitoring
- Specifying workforce requirements
- Setting the framework for ensuring patients rights
### Standard 1 – Need for clinical information

<table>
<thead>
<tr>
<th>1.2 The board, chief executive officer and/or other higher level of governance within a health service organisation taking responsibility for patient safety and quality of care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.2.1</strong> Regular reports on safety and quality indicators and other safety and quality performance data are monitored by the executive level of governance</td>
</tr>
<tr>
<td><strong>1.2.2</strong> Action is taken to improve the safety and quality of patient care</td>
</tr>
<tr>
<td><strong>1.5 Establishing an organisation-wide risk management system that incorporates identification, assessment, rating, controls and monitoring for patient safety and quality</strong></td>
</tr>
<tr>
<td><strong>1.5.1</strong> An organisation-wide risk register is used and <strong>regularly monitored</strong></td>
</tr>
<tr>
<td><strong>1.5.2</strong> Actions are taken to minimise risks to patient safety and quality of care</td>
</tr>
<tr>
<td><strong>1.6 Establishing an organisation wide quality management system that monitors and reports on the safety and quality of patient care and informs changes in practice</strong></td>
</tr>
<tr>
<td><strong>1.6.1</strong> An organisation-wide <strong>quality management system is used and regularly monitored</strong></td>
</tr>
<tr>
<td><strong>1.6.2</strong> Actions are taken to maximise patient quality of care</td>
</tr>
</tbody>
</table>
28 core actions require monitoring or audit including

- The use of clinical guidelines
- Scope of practice
- Antimicrobial usage and resistance
- Traceability system for sterile reusable instruments and devices
- Adverse drug reactions
- Patient care mismatching events
- Clinical handover
- Clinical use of blood and blood products
- Blood and blood product risk and treatment
<table>
<thead>
<tr>
<th>This criterion will be achieved by:</th>
<th>Actions required:</th>
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<tbody>
<tr>
<td>1.7 Developing and/or applying clinical guidelines or pathways that are supported by the best available evidence</td>
<td>1.7.2 The use of agreed clinical guidelines by the clinical workforce is monitored</td>
</tr>
<tr>
<td>1.10 Implementing a system that determines and regularly reviews the roles, responsibilities, accountabilities and scope of practice for the clinical workforce</td>
<td>1.10.2 Mechanisms are in place to monitor that the clinical workforce are working within their agreed scope of practice</td>
</tr>
<tr>
<td>3.14 Developing, implementing and regularly reviewing the effectiveness of the antimicrobial stewardship system</td>
<td>3.14.3 Monitoring of antimicrobial usage and resistance is undertaken</td>
</tr>
<tr>
<td>3.17 Implementing systems to enable the identification of patients on whom the reusable medical devices have been used</td>
<td>3.17.1 A traceability system that identifies patients who have a procedure using sterile reusable medical instruments and devices is in place</td>
</tr>
<tr>
<td>4.3 Authorising the relevant clinical workforce to prescribe, dispense and administer medications</td>
<td>4.3.2 The use of the medication authorisation system is regularly monitored</td>
</tr>
<tr>
<td>4.4 Using a robust organisation-wide system of reporting, investigating and managing change to respond to medication incidents</td>
<td>4.4.1 Medication incidents are regularly monitored, reported and investigated</td>
</tr>
<tr>
<td>4.9 Ensuring that current and accurate medicines information and decision support tools are readily available to the clinical workforce when making clinical decisions related to medicines use</td>
<td>4.9.2 The use of the information and decision support tools are regularly reviewed</td>
</tr>
<tr>
<td>5.2 Implementing a robust organisation-wide system of reporting, investigation and change management to respond to any patient care mismatching events</td>
<td>5.2.1 The system for reporting, investigating and analysis of patient care mismatching events is regularly monitored</td>
</tr>
<tr>
<td>5.4 Developing, implementing and regularly reviewing the effectiveness of the patient identification and matching system at patient handover, transfer and discharge</td>
<td>5.4.1 A patient identification and matching system is implemented and regularly reviewed as part of structured clinical handover, transfer and discharge processes</td>
</tr>
<tr>
<td>6.4 Implementing a robust organisation-wide system of reporting, investigation and change management to respond to any clinical handover incidents</td>
<td>6.4.1 Regular reporting, investigating and monitoring of clinical handover incidents is in place</td>
</tr>
<tr>
<td>7.2 Undertaking a regular, comprehensive assessment of blood and blood product systems to identify risks to patient safety and take action to reduce risks</td>
<td>7.2.1 The risks associated with transfusion practices and clinical use of blood and blood products are regularly assessed</td>
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</table>
Standard 3 – Preventing and Controlling Healthcare Associated Infections

**Governance and systems for infection prevention, control and surveillance**
Effective governance and management systems for healthcare associated infections are implemented and maintained.

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<tr>
<td><strong>3.3</strong> Developing and implementing systems and processes for reporting, investigating and analysing healthcare associated infections, and aligning these systems to the organisation’s risk management strategy</td>
<td><strong>3.3.1</strong> Mechanisms to regularly assess the healthcare associated infection risks are in place</td>
</tr>
<tr>
<td></td>
<td><strong>3.3.2</strong> Action is taken to reduce the risks of healthcare associated infection</td>
</tr>
<tr>
<td><strong>3.4</strong> Undertaking quality improvement activities to reduce healthcare associated infections through changes to practice</td>
<td><strong>3.4.1</strong> Quality improvement activities are implemented to reduce and prevent healthcare associated infections</td>
</tr>
<tr>
<td></td>
<td><strong>3.4.2</strong> Compliance with changes in practice are monitored</td>
</tr>
<tr>
<td></td>
<td><strong>3.4.3</strong> The effectiveness of changes to practice are evaluated</td>
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### Standard 4 – Medication Safety

#### Medication management processes
The clinical workforce is supported for the prescribing, dispensing, administering, storing, manufacturing compounding and monitoring of medicines.

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<tr>
<td>4.9 Ensuring that current and accurate medicines information and decision support tools are readily available to the clinical workforce when making clinical decisions related to medicines use</td>
<td>4.9.1 Information and decision support tools for medicines are available to the clinical workforce at the point of care</td>
</tr>
<tr>
<td></td>
<td>4.9.2 The use of information and decision support tools is regularly reviewed</td>
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<tr>
<td></td>
<td>4.9.3 Action is taken to improve the availability and effectiveness of information and decision support tools</td>
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</tbody>
</table>
### Standard 9 – Recognising and Responding to Clinical Deterioration in Acute Health Care

**Establishing recognition and response systems**
Organisation-wide systems consistent with the National Consensus Statement are used to support and promote recognition of, and response to, patients whose condition deteriorates in an acute health care facility.

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<tr>
<td>9.2 Collecting information about the recognition and response systems, providing feedback to the clinical workforce, and tracking outcomes and changes in performance over time</td>
<td>9.2.1 Feedback is actively sought from the clinical workforce on the responsiveness of the recognition and response systems</td>
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<tr>
<td></td>
<td>9.2.2 Deaths or cardiac arrests for a patient without an agreed treatment-limiting order (such as not for resuscitation or do not resuscitate) are reviewed to identify the use of the recognition and response systems, and any failures in these systems</td>
</tr>
<tr>
<td></td>
<td>9.2.3 Data collected about recognition and response systems are provided to the clinical workforce as soon as practicable</td>
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<tr>
<td></td>
<td>9.2.4 Action is taken to improve the responsiveness and effectiveness of the recognition and response systems</td>
</tr>
</tbody>
</table>
Data sources

- Incident reporting
- Complaints
- Administrative data sets
- Patient clinical record
- Surveys
- Process audits
- Clinical data sets – VLADS
- Clinical quality registries
Clinical Quality Registers

- Subset of all clinical registers
- Collect key clinical information
- Relates to individual health care encounters
- Provide information on risk adjusted outcomes
- Primary purpose is to improve the safety and quality of health care provided to patients
NSQHS Standards and Clinical Quality Registries

- Effectiveness and Appropriateness
- Clinical Quality Registries
- Clinical Care Standards
- Safety

NSQHS Standards
Implementing the NSQHS Standards

- Not achievable without the engagement throughout the organisation

- **Standard 1 requires:**
  - Patient safety and quality of care to be considered in business decision making
  - **Governance body to receive reports on safety and quality and takes action to improve safety and quality**
  - **The workforce to be informed** about safety and quality
  - Risk management
  - Training in safety and quality
Meeting the requirements of the NSQHS Standards

Performance data from clinical quality registry information needs to be available to:

- Clinicians, and
- Health services

- Provide comparisons with peer health services
- Timely
- Clinically relevant