

CEC eChartbook Portal Extract

Quality Systems Assessment

2012 Quality Systems Assessment Survey Indicators

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QUALITY SYSTEMS ASSESSMENT

2012 Quality Systems Assessment Survey Indicators

Why is this important? The Quality Systems Assessment (QSA) is a clinical risk management tool which provides clinical teams and managers with a means of assessing compliance with policy and standards, identifying clinical risks and deficiencies in practice and highlighting and sharing exemplary practice relating to clinical quality and patient safety. Its main strength is that it provides a comparative self-assessment of performance against high priority patient safety and quality policies and standards. This data can be used by health services managers and clinical teams to drive improvement.

Unlike much of the quantitative data in the eChartbook portal, the QSA charts reflect data based on the perceptions of managers and clinical staff working in local health districts (LHDs) and health networks. The results provided here, unless stated otherwise, reflect data provided at the department/clinical unit level for the LHDs and networks. The self-assessment themes are chosen annually based on issues that emerge from incident reporting, state-wide policy and national and international quality and safety literature. The specific self-assessment questions for these themes are developed in consultation with expert clinician groups convened for this purpose. This section used data from the QSA self-assessment 2012, that focused on End of life care (EOL) patient management (including palliative care, challenges in EOL patient care, patient centred approaches); Safety and quality culture; Patient based care; Clinical governance and clinical audit; Death review; Between the Flag (BTF); and Clinical handover. Between August and October 2012, the self-assessment was undertaken by over 1,500 respondents across and at various levels of the NSW health system. The overall response rate was 96 per cent.

Findings:

End of life (EOL) care: The majority of deaths in Australia, like other developed countries, occur among older people. In 2012, about two third of deaths registered in Australia were among people aged 75 or over, and 88

per cent deaths in those aged 65 years and over had three or more chronic conditions [1-2]. As the Australian population is ageing the need for skilled health professionals in dealing with these complex medical conditions, co-morbidities and effective EOL care is rapidly increasing. Effective palliative care becomes important for all clinical units, primary health care environments and aged care services. During 2012, as part of the QSA program NSW public health organisations (PHOs) undertook a self-assessment to better understand attitudes and practices in EOL care across the system.

Across NSW, about 60 per cent of the departments/clinical units providing care for people who are dying or approaching the end of their life responded that they routinely identified patients that are likely to die in the next 6-12 months so that EOL care planning can begin (Chart EOL01). It varies across LHDs between 38 and 88 per cent. Overall 42 per cent of self-assessment departments/clinical units indicated that they followed a standardised approach in treating patients in the last days of life (Chart EOL02). The rate widely varies across LHDs.

Palliative care is specialist care provided on the basis of a needs assessment for all people living with, and dying from a life limiting illness and for whom the primary goal is quality of life. People approaching the EOL who may benefit from specialist palliative care should be offered this care in a timely way appropriate to their needs and preferences, at any time of day or night. The QSA 2012 survey revealed that across NSW, 89 per cent of departments/clinical units of those providing care for people who are dying or approaching the end of their life, their families and carers responded they were "Always" (100%) or "Often" (67-99%) able to access specialist palliative care services (Chart EOL03). The results vary at the facility level.

In NSW, EOL care are provided in all types of care settings including the acute inpatient hospital setting, emergency departments, hospices, nursing homes

and home care. However many of the problems associated with the provision of EOL care relate to barriers that occur at the interfaces between these settings as well as between services and health care professionals. It is important that patients and their families and carers are given an informed choice based on an understanding of their realistic options and likely outcomes of various treatment modalities. The QSA 2012 survey shows that, of those departments/clinical providing care for EOL patients among them about 75 per cent cases the patient treating team “Always” (100%) or “Often” (67-99%) deliver care in consultation with the patient and family (Chart EOL04). The results vary at the facility level. The results also revealed more than 80 per cent of units responded that transfers within or to other facilities and releases are planned and managed in a manner that promotes coordination and continuity of care for patients (Chart EOL05).

Supporting relatives’ involvement with the dying person is an important aspect of EOL care for both patients and their families. Careful communication and access to health interpreters are required to identify and address differences in cultural perspectives in EOL care, and to respond respectfully to these differences. Across NSW 84 per cent of the departments/clinical units “Always” or “Often” provided information to EOL patients, families and carers about treatment and care options, medication and what to expect at each stage (Chart EOL06). The results were consistent across LHDs. About 77 per cent of clinical units “Always” or “Often” reported that culturally appropriate palliative care and EOL support are provided which includes care preferences, spiritual requirements and bereavement expression, with a significant variation observed across LHDs (Chart EOL07). Seventy per cent of departments/clinical units “Always” or “Often” had 24 hour access to interpreters trained in EOL care (Chart EOL08). Across NSW 84.4 per cent of departments/clinical units reported that patients are nursed in a single room to ensure privacy and allow uninterrupted access for families/carers “Always” or “Often” (Chart EOL09). Consistently, more than 95 per cent of department/units at LHD level reported that families and carers of patients receive timely verification and certification their death “Always” or “Often” (Chart EOL10). The QSA 2012 survey has asked the respondents to indicate the most challenging issues regarding the management of EOL care patients. Staff discomfort in having end of life

discussions with patients and their families was the primary issue, followed by incomplete documentation in the medical records, inability or unwillingness of health professionals to identify and treat patients who are dying, and poor communication between staff and family/carers. Access to or delays in medications and the inability to give pain medication were the least challenging issues identified by respondents for EOL care (Chart EOL11). Mixed results were reported at LHD level in the challenges they faced in managing patients requiring EOL care.

Safety and Quality Culture: Patient safety and quality culture are essential values of the NSW public health system. Achieving such a culture requires an understanding of the values, beliefs, and norms about what is important in the organisation and what attitudes and behaviors related to patient safety are expected and appropriate. Significant effort has been invested in establishing policies, systems, cultural supports and workforce development to identify gaps in practice, develop best practice responses and implement improvement strategies across the system.

In 2012, 98 per cent of departments/units “Strongly agreed (57per cent)” or ‘Agreed (41 per cent)” that there is a positive patient safety (PPS) and quality culture exists at their department/units (Chart PPS12). The results were consistent across LHDs. Charts PPS12a to PPS12c shows the trends in positive patient safety culture at LHD level between 2007/08 to 2013. The results showed that the level of ‘Strongly agree or Agree’ about positive patient safety and quality culture remains at high level across the LHDs with slightly increased from 97 per cent in 2007/08 to 98 per cent in 2013. The rates were slightly fluctuated across years and dropped to around 95 per cent during 2009-2010 and then increased again in later years.

Patient Based Care: Patient based care (PBC) is recognised as a dimension of quality and safety in health care, and involves transforming care to include patients, families and carers as ‘care team’ members. Patient based care highlights the important role health systems can play at all levels to respect patients’ preferences and values, providing emotional support, continuity and access to care. This includes providing patients, families and carers with coordinated care along with supportive communication, education and the inclusion of family and friends [3]. The evidence about patient based care

demonstrates an association with; decreased mortality, decreased rates of hospital-acquired infection, decreased surgical complications, higher quality clinical care/best practice and improved patient functional status [4-7]. In 2012, about 81 per cent of the departments/units “Strongly agreed (33 per cent)” or ‘Agreed (48 per cent)” that patients and their families and/or carers are viewed as integral members of the health care team (Chart PBC13).

Clinical Governance and Clinical Audit: Effective Clinical Governance will only occur at all levels of the organisation where delegation of responsibility and accountability for performance goes hand in hand with empowerment of staff through their involvement in planning, decision making and improvement activities. Across NSW, 94 per cent of the departments/units “Strongly agreed (39 per cent)” or ‘Agreed (55 per cent)” that the unit has a clear, integrated and effective governance framework for safety and quality, including risk management and clinical incident management systems (Chart GVF14).

Clinical audit is an essential and integral part of clinical governance and quality improvement process that seeks to improve patient outcomes through systematic review of care against explicit criteria, the identification from the review of action to improve clinical practice and the implementation of such actions. The QSA survey 2012 revealed that 89 per cent of the departments/units have a program or system in place that provides a standardised approach for clinical audit which is either based on a local facility approach or an approach applied across the LHD (41 per cent local approach and 47 per cent LHD approach) [Chart CLA15]. Eighty per cent of the departments/units reported that they had undertaken a clinical audit in relation to a clinical outcome in the preceding 12 to 18 months (Chart CAL16). About 63 per cent of the departments/units reported that they have nominated clinical audit lead/manager who is responsible for facilitating clinical audit in the facility (e.g. training/development of staff). The rates vary widely across LHDs (Chart CLA17).

Death Review: The NSW Health Patient Safety and Clinical Quality Program (PSCQP) requires each public health organisation to have in place a system for screening medical records of all patients who have died in their service. The intent of the process is to ensure appropriate mandatory reporting and

review of patient deaths; and to determine whether changes in practice are needed to improve the safety and quality of patient care at the local and system level. A standardised mortality review in a system focused on quality can set the stage for, and facilitate, the improvement process.

The QSA survey 2012 found that 91 per cent of the departments/units reported “Always” or “Often” reviewing all relevant deaths in the unit when or if they occur (Chart DR18). The results were consistent across LHDs. About 69 per cent of the departments/units reported that a standardised framework or guideline was followed for the review of all deaths (Chart DR19).

Between the Flags: The early recognition of deteriorating patients is an issue in hospitals and in health care delivery across the world. Between the Flags (BTF) Program was designed by the CEC to establish a ‘safety net’ in all NSW public hospitals and healthcare facilities to systematically identify and respond to clinical deterioration in patients, and was introduced in January 2010 to NSW hospitals. In order to establish 'safety net' the BTF program has developed three observations charts namely: SAGO (Standard Adult General Observation), SMOC (Standard Maternity Observation Chart) and SPOC (Standard Paediatric Observation Chart). The QSA survey 2012 revealed that 88 per cent (14 out of 16) of LHD level respondents indicated they had “Fully implemented” or “Mostly implemented” the SAGO chart in their district / network facilities. A similar higher rate of implementation at LHD/network facilities was also observed for SMOC (87 per cent; 13 out of 15) and SPOC (100 per cent; 16 out of 16) charts respectively (data not shown). Across NSW, 84 per cent of the departments/units “Strongly agreed (47 per cent)” or ‘Agreed (39 per cent)” that the BTF DETECT (detecting deterioration, evaluation, treatment, escalation and communicating in teams) program has contributed to improving the knowledge and skills of staff in recognising and responding to the deteriorating (Chart BTF20). About 81.8 per cent agreed that BTF program has benefitted patient safety in their departments/clinical units (Chart BTF21). Eighty per cent of the departments/clinical units agreed that the Clinical Emergency Response Systems (CERS) policy has improved the system for obtaining urgent assistance when a patient is clinically deteriorating (Chart BTF22). The QSA 2012 survey has asked the respondents

to highlight the top 3 barriers or challenges to escalating the care of the deteriorating patient that apply to their departments/clinical units (Chart BTF 23). About a quarter (26 per cent) of the units does not feel any barriers and the reported main barriers/challenges by others are as follows:

- Team feel situation under control in ward setting and escalation not required (41 per cent);
- Staff failure to recognise deterioration (36 per cent);
- Staff not wanting to bother doctors or senior nurses (24 per cent);
- Staff not knowing when or how to escalate (24 per cent); and
- A previous negative experience.

Clinical Handover: When a patient's health information is communicated from one health professional to another, such as from the staff of one shift to another, the process of "clinical handover" occurs. The use of standardised tools and methods minimises content omissions, incomplete or unclear information, conflicting advice and time wasting [8]. The QSA survey 2012 found that at state level about 93 per cent of the departments/units used one of the standardised tools for clinical handover (Chart CH24). The rates were consistent across LHDs. About 83 per cent of the departments/clinical units reported that they conducted either "Always (52 per cent)" or "Often (31 per cent)" shift to shift clinical handover at patient's bedside at least once every 24 hours. And the rate varies across LHD levels (Chart CH25). Across NSW, 65 per cent of the departments/units "Strongly agreed (22 per cent)" or "Agreed (44 per cent)" that the statewide Safe Clinical Handover program has improved and reinforced local clinical handover processes (Chart CH26). In 2012, self-assessment respondents were asked to identify the top three challenges to clinical handover in units and 26 per cent of them mentioned that they do not feel any barriers (Chart CH27). The reported main barriers/challenges are as follows:

- Lack of protected time to provide or receive a detailed handover (35 per cent);
- Lack of time to prepare for a handover (29 per cent);
- Lack of training in effective clinical handover, communication and teamwork skills (27 per cent); and
- Lack of standardisation of clinical handover processes within the unit.

Implications: The QSA self-assessment responses should always be interpreted in the local context. The responses do, however, provide an opportunity to highlight areas which may require improvement at a system level. In summary, the results from the 2012 QSA survey indicate that:

- The perception of positive quality and patient safety culture has been sustained over time, and in 2012 it reached to 97 per cent;
- Sixty per cent of clinical units reported they routinely identified EOL care patients who were likely to die in the next 6-12 months;
- About 42 per cent of clinical units indicated that they followed a standardised approach to treating patients in their last days of life;
- The 2012 self-assessment also showed a strong awareness and adherence to quality and safety requirements - particularly in the areas of clinical governance, clinical review processes, death review, clinical handover and management of end of life care patients.
- LHDs supported by the CEC BTF program, should progressively implement strategies to address the barriers to escalation of care of the deteriorating patient, identified by staff at the unit level.
- The self-assessment results identified a number of issues and gaps that need to be addressed. These include the early and timely identification of dying patients, communication between health professionals and patients and their families, the human experience of dying, the lack of a standardised approach and the policy environment.

What we don't know: The responses given by participants may reflect a practice and/or perception gap. The action plans developed as a result of the self-assessment may have resulted in changes/improvements that have occurred since. Local context or implementation stage for programs/practices being assessed may influence the responses provided.

References

[1] ABS (Australian Bureau of Statistics) 2013. Deaths, Australia, 2012. ABS cat. no. 3302.0. Canberra: ABS.

[2] AIHW (Australian Institute of Health and Welfare) 2013. Analysis of AIHW National Mortality Database.

[3] Bauman AE, Fardy HJ & Harris PG. Getting it right: why bother with patient based care? *Med J Aust* 2003; 179 (5): 253-256.

[4] Meterko M WS, Lin H, Lowy E, Cleary PD. Mortality among patients with acute myocardial infarction: The influences of patient-centered care and evidence-based medicine. *Health Service Research* 2010. 45(5):1188–1204

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[6] Murff HJ, France DJ, Blackford J, Grogan EL. Relationship between patient complaints and surgical complications. *Qual Saf Health Care*. 2006; 15:13-16.

[7] Jha AK, Orav EJ, Zheng J, Epstein AM. Patients' perception of hospital care in the United States. *The New England Journal of Medicine* 2008; Volume 359 (18):1921-31.

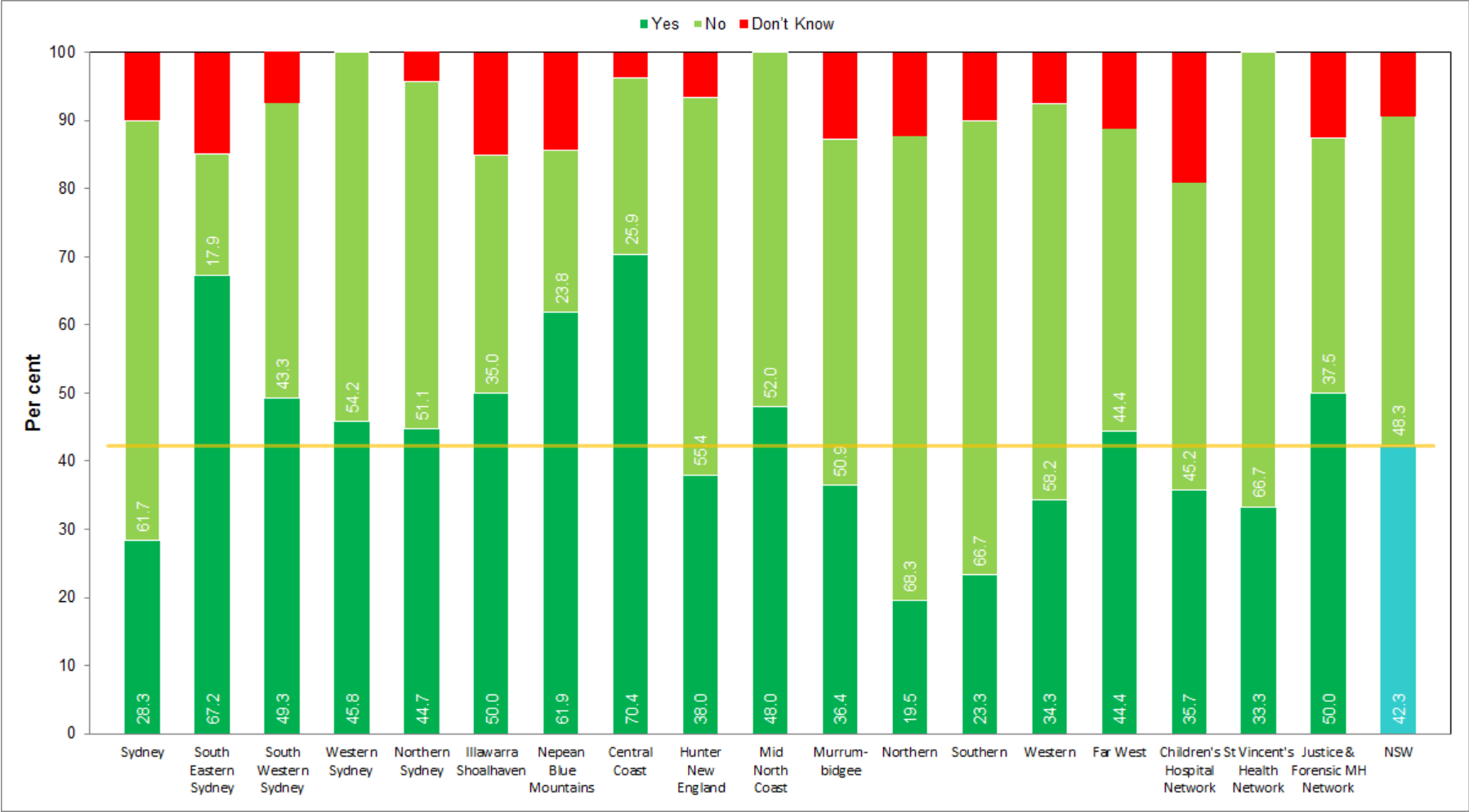
[8] Payne CE, Stein JM, Leong T & Dressler DD. Avoiding handover fumbles: a controlled trial of a structured handover tool versus traditional handover methods. *BMJ Qual Saf*. 2012 Nov; 21(11):925-32.

EOL01 –Percentage of departments/clinical units have process in place in early identification of patients whose death may be likely in the next 6-12 months for end of life (EOL) care by LHD in NSW 2012



Source: Quality Systems Assessment, Clinical Excellence Commission.

EOL02 – Percentage of departments/clinical units have standardised approach for EOL care by LHD in NSW 2012



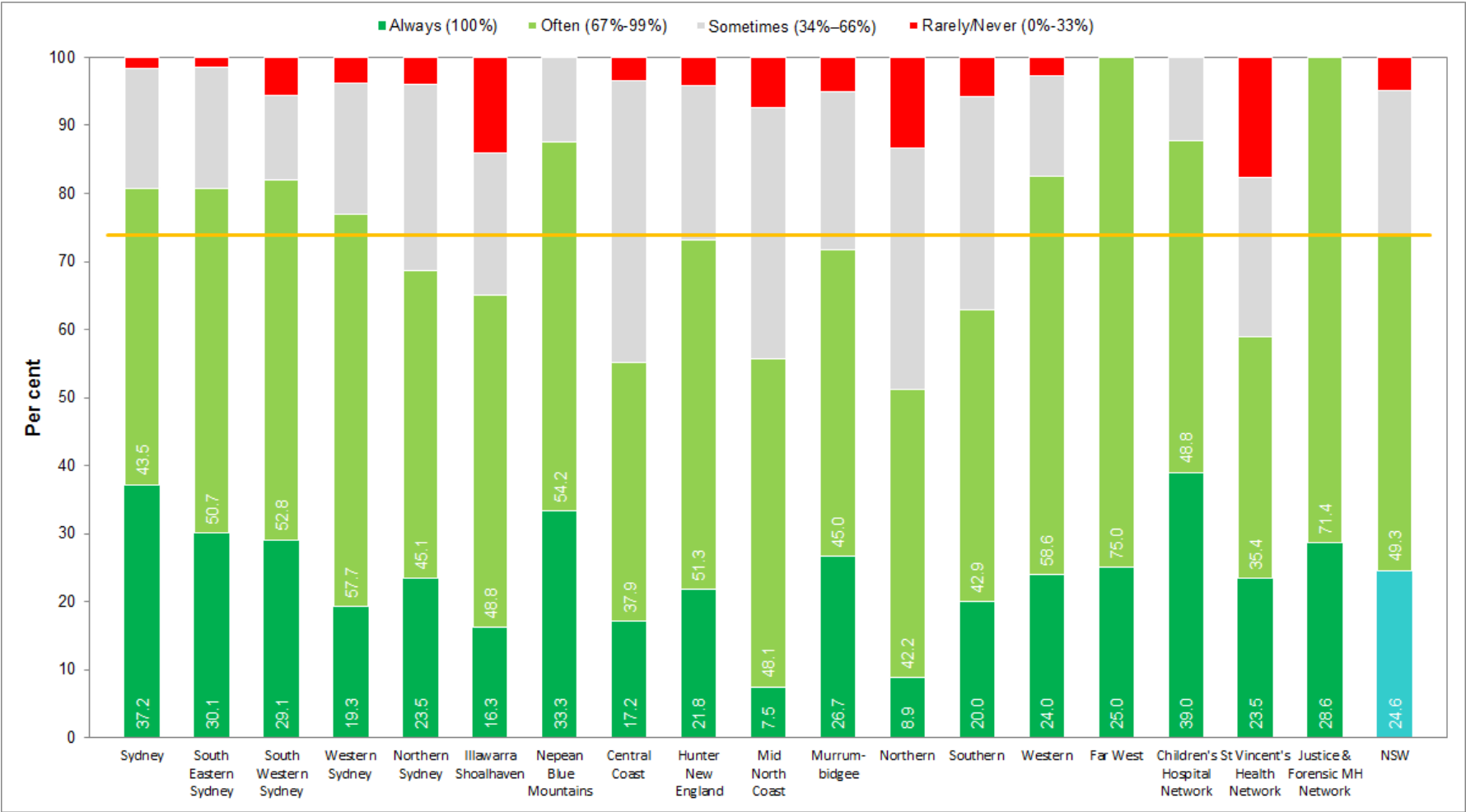
Source: Quality Systems Assessment, Clinical Excellence Commission.

EOL03 – Percentage of departments/clinical units reporting that they have palliative care services EOL patients by LHD in NSW 2012



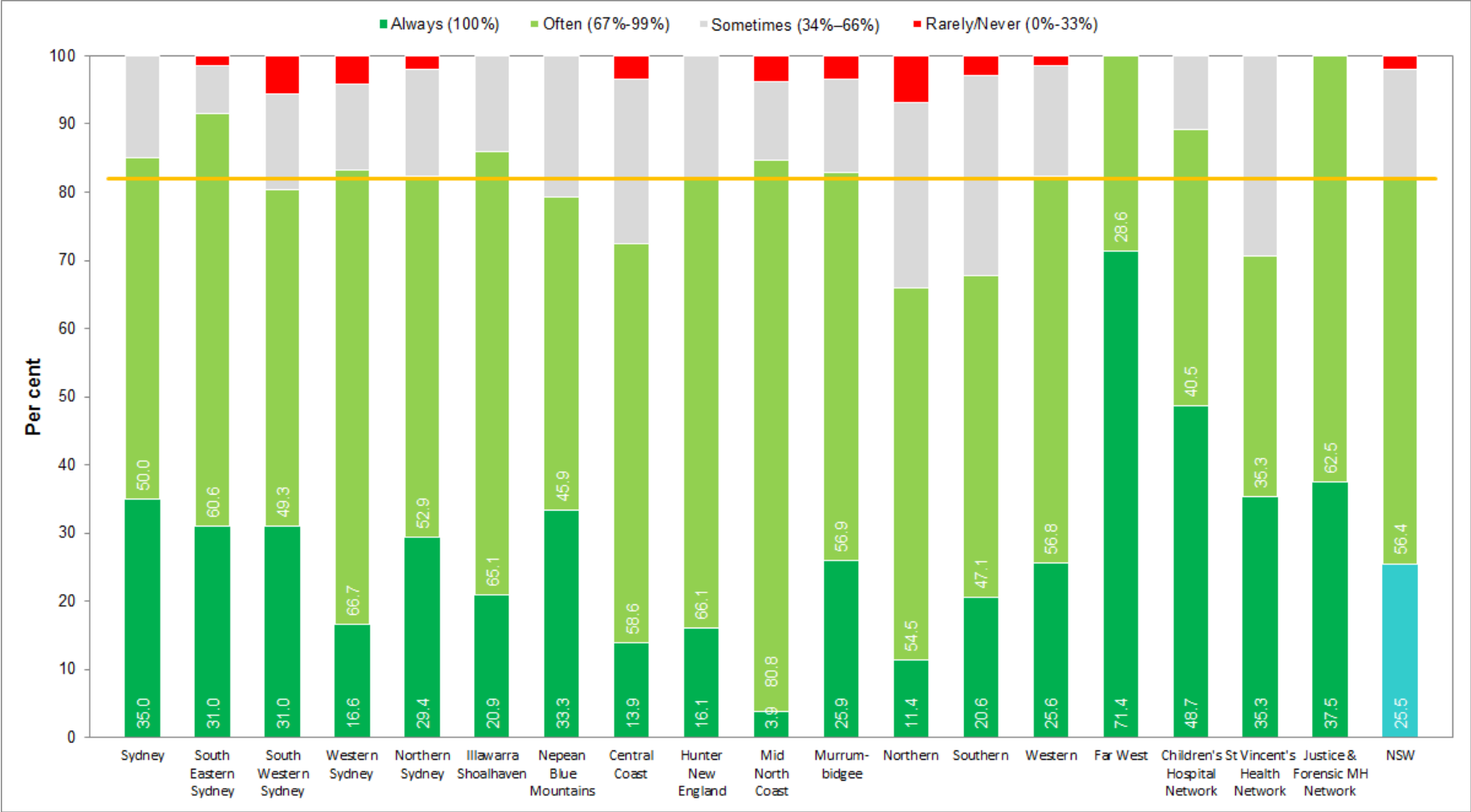
Source: Quality Systems Assessment, Clinical Excellence Commission.

EOL04 –Percentage of departments/clinical units established patient treating team for EOL care by LHD in NSW 2012



Source: Quality Systems Assessment, Clinical Excellence Commission.

EOL05 –Percentage of departments/clinical units having transfer within facilities or release are planned and managed by LHD in NSW 2012



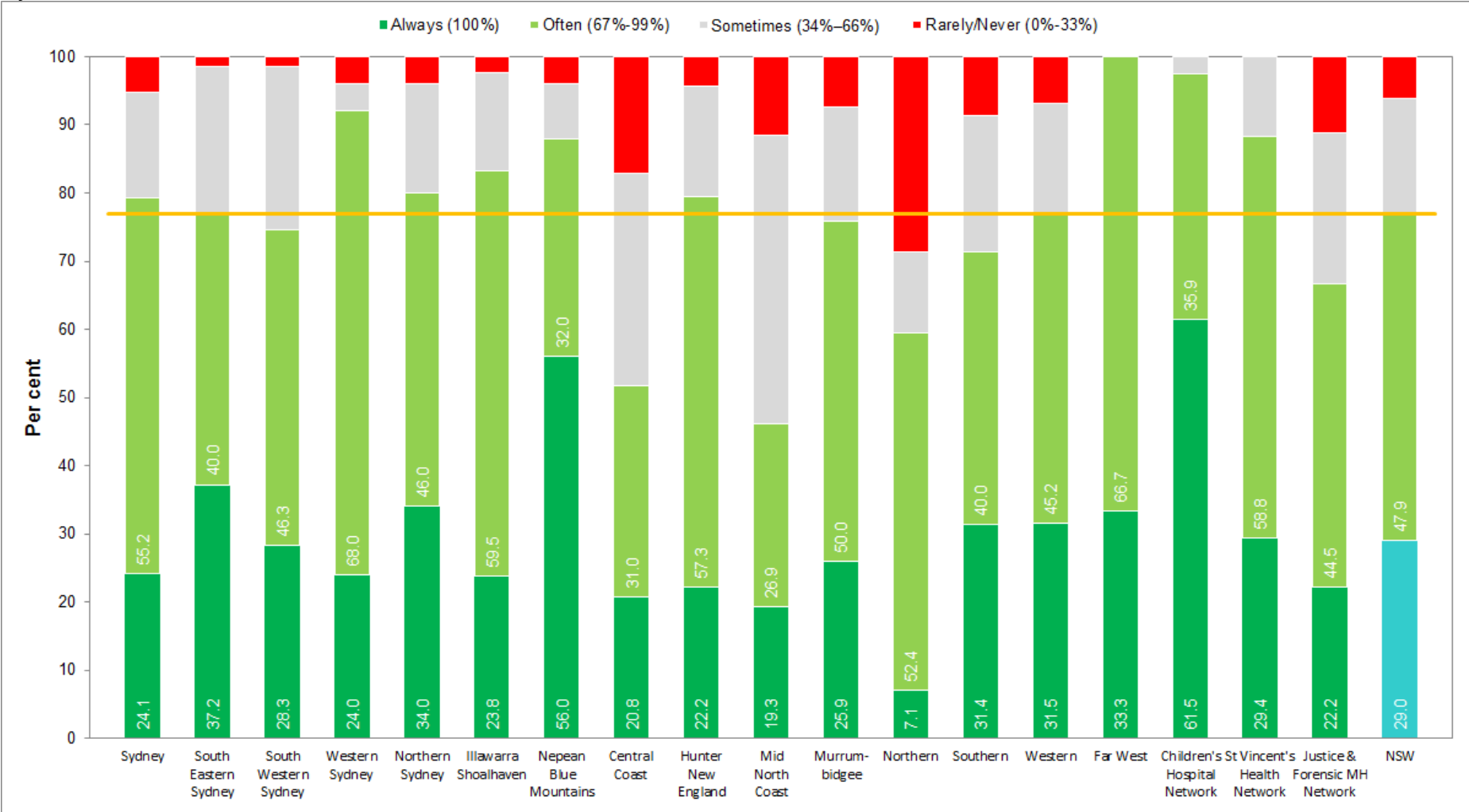
Source: Quality Systems Assessment, Clinical Excellence Commission.

EOL06 –Percentage of departments/clinical units provided information to patients/families/carer about stages of EOL care by LHD in NSW 2012



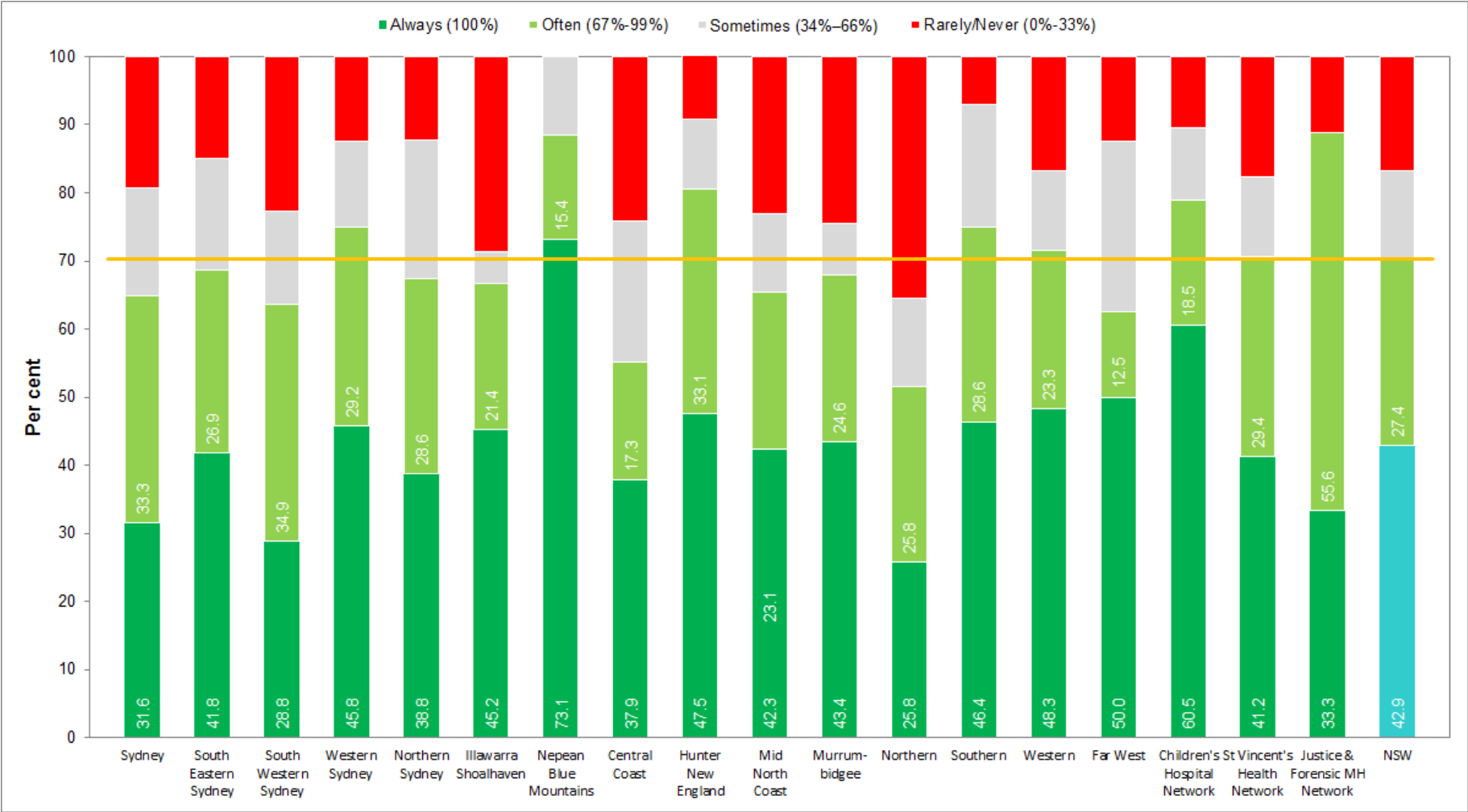
Source: Quality Systems Assessment, Clinical Excellence Commission.

EOL07 –Percentage of departments/clinical units provided culturally appropriate palliative care and EOL support by LHD in NSW 2012



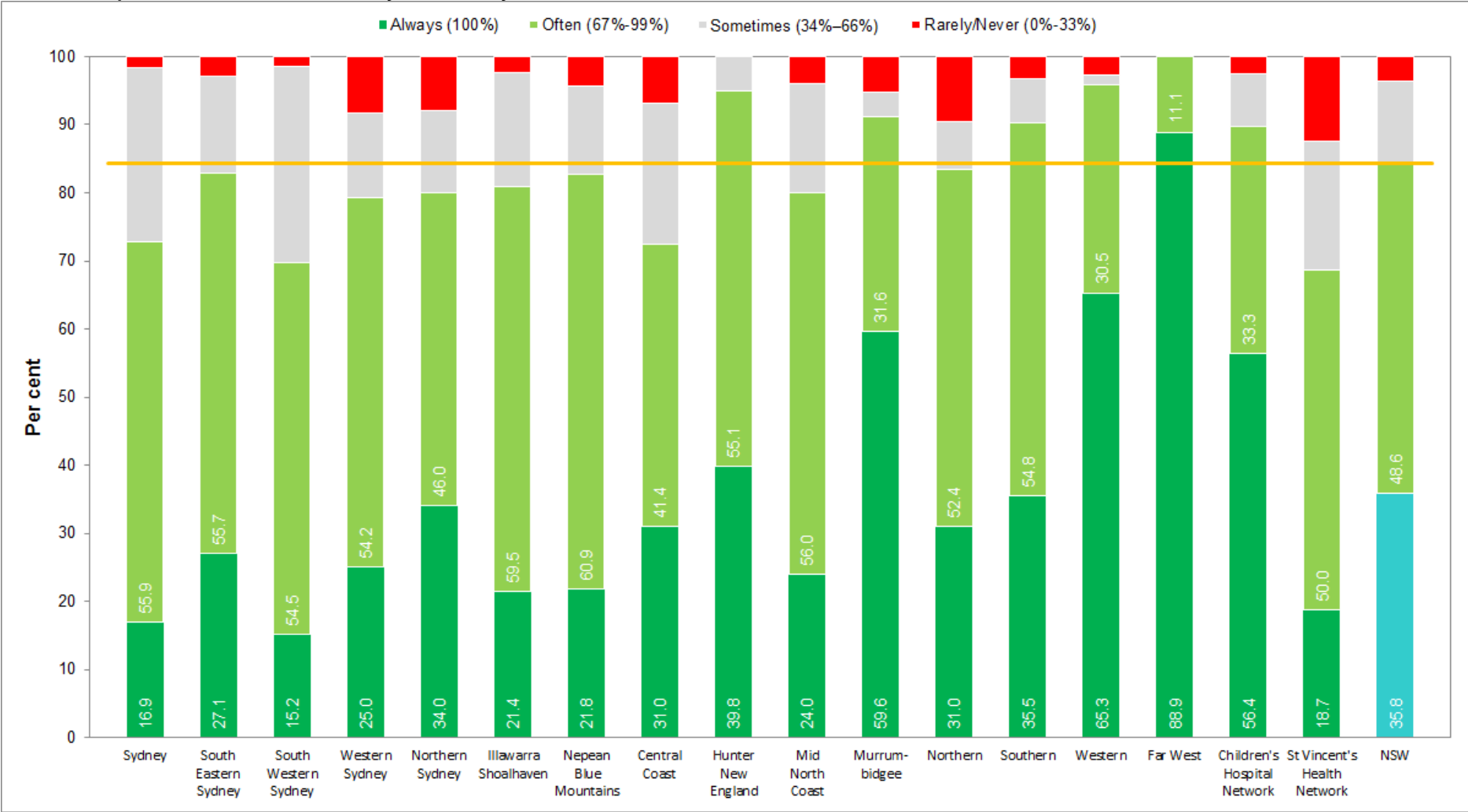
Source: Quality Systems Assessment, Clinical Excellence Commission.

EOL08 –Percentage of departments/clinical units have 24 hour access to interpreters for EOL patients by LHD in NSW 2012



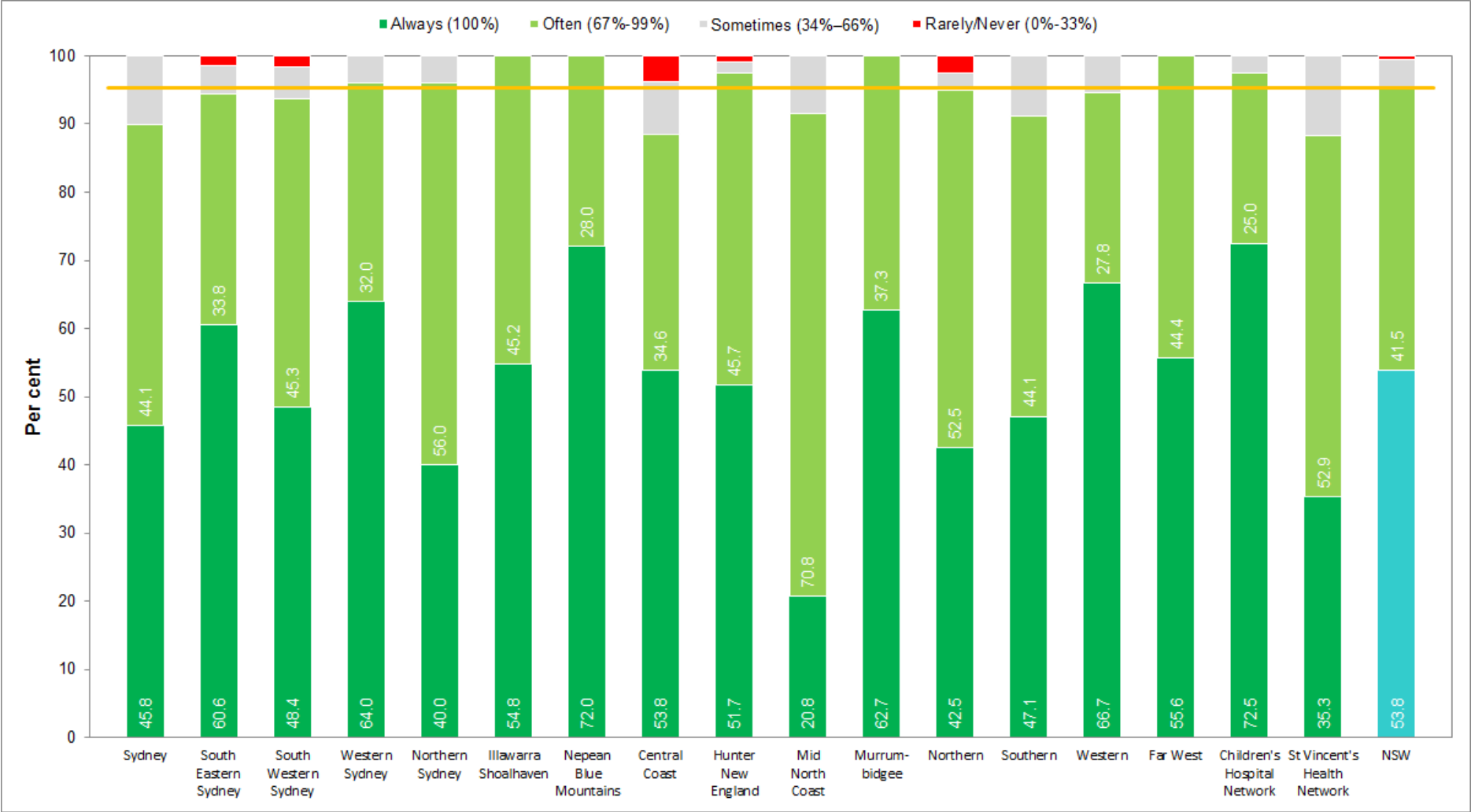
Source: Quality Systems Assessment, Clinical Excellence Commission.

EOL09 –Percentage of departments/clinical units provided care in a single room to ensure privacy and uninterrupted access for family/carer by LHD in NSW 2012



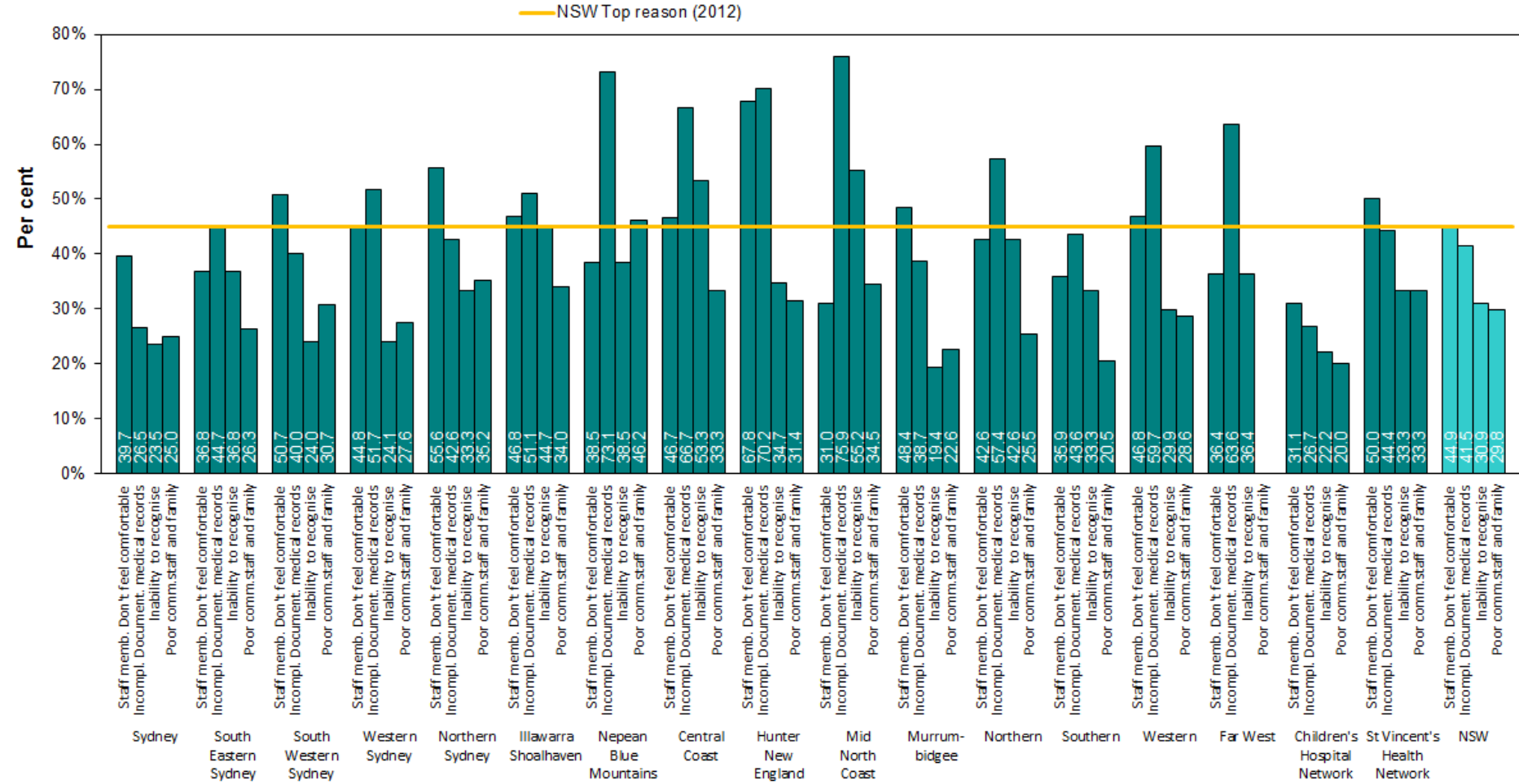
Source: Quality Systems Assessment, Clinical Excellence Commission.

EOL10 –Percentage of departments/clinical units provided timely verification and certification of death to families and carer of dead patients by LHD in NSW 2012



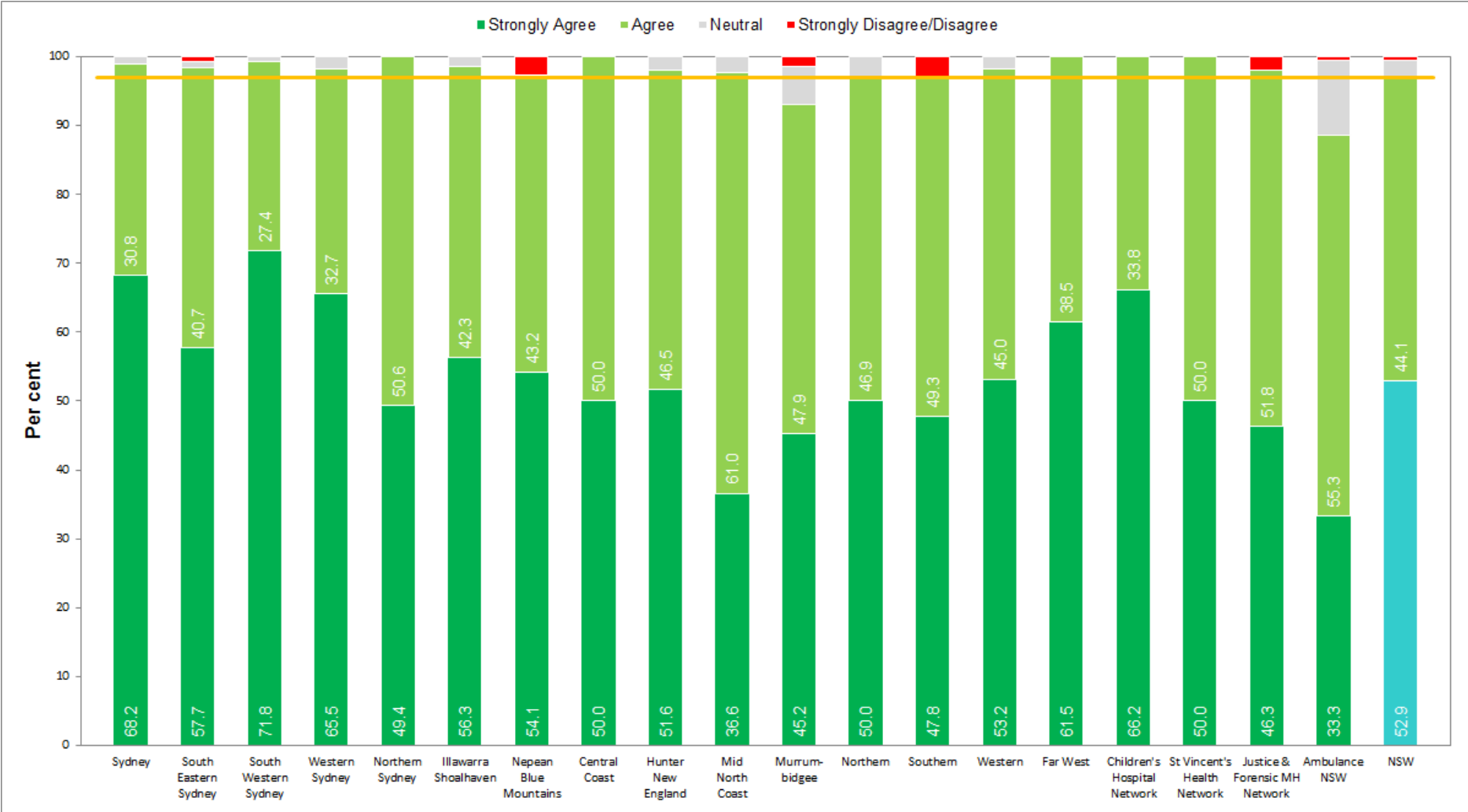
Source: Quality Systems Assessment, Clinical Excellence Commission.

EOL11 –Percentage of department/units have reported most challenging issues to manage EOL care patients by LHD in NSW 2012



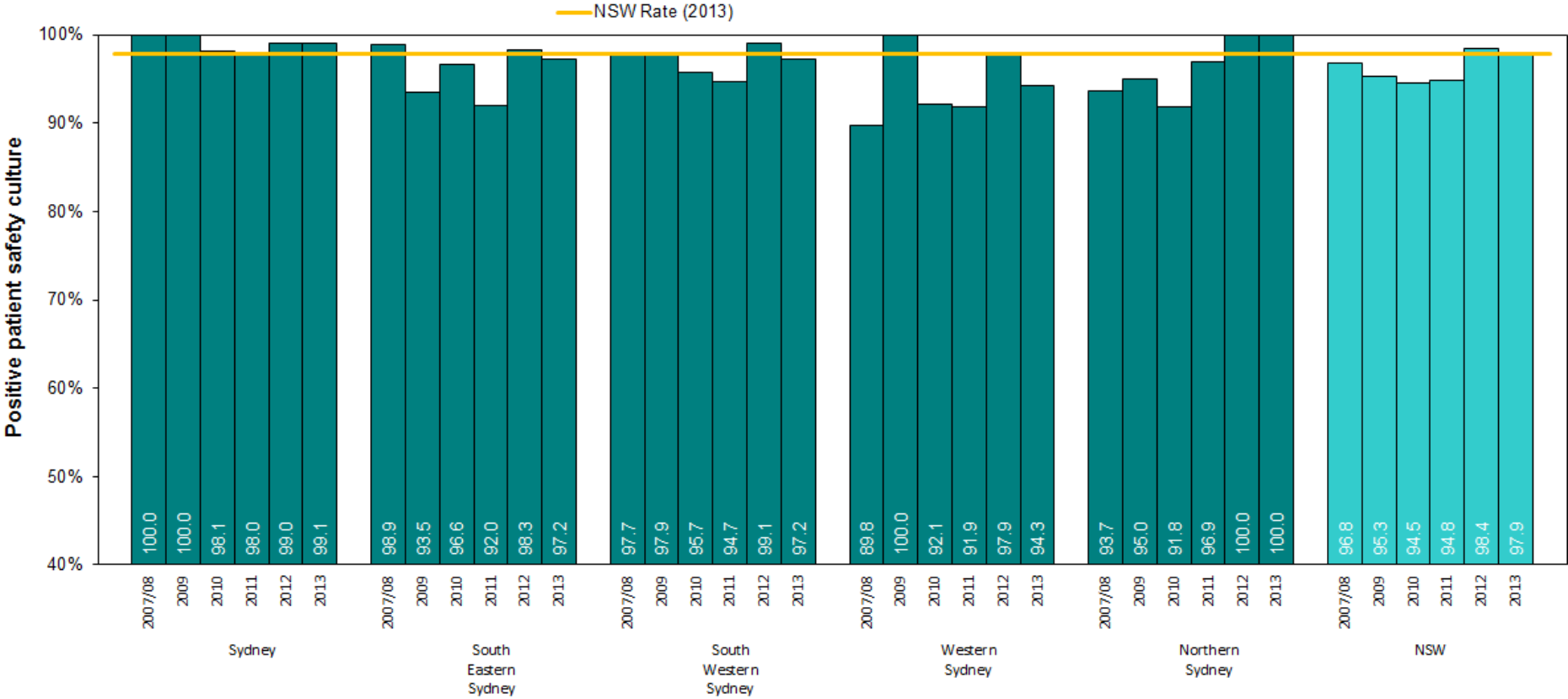
Source: Quality Systems Assessment, Clinical Excellence Commission.

PPS12 –Percentage of department/units have positive patient safety culture by LHD in NSW 2012



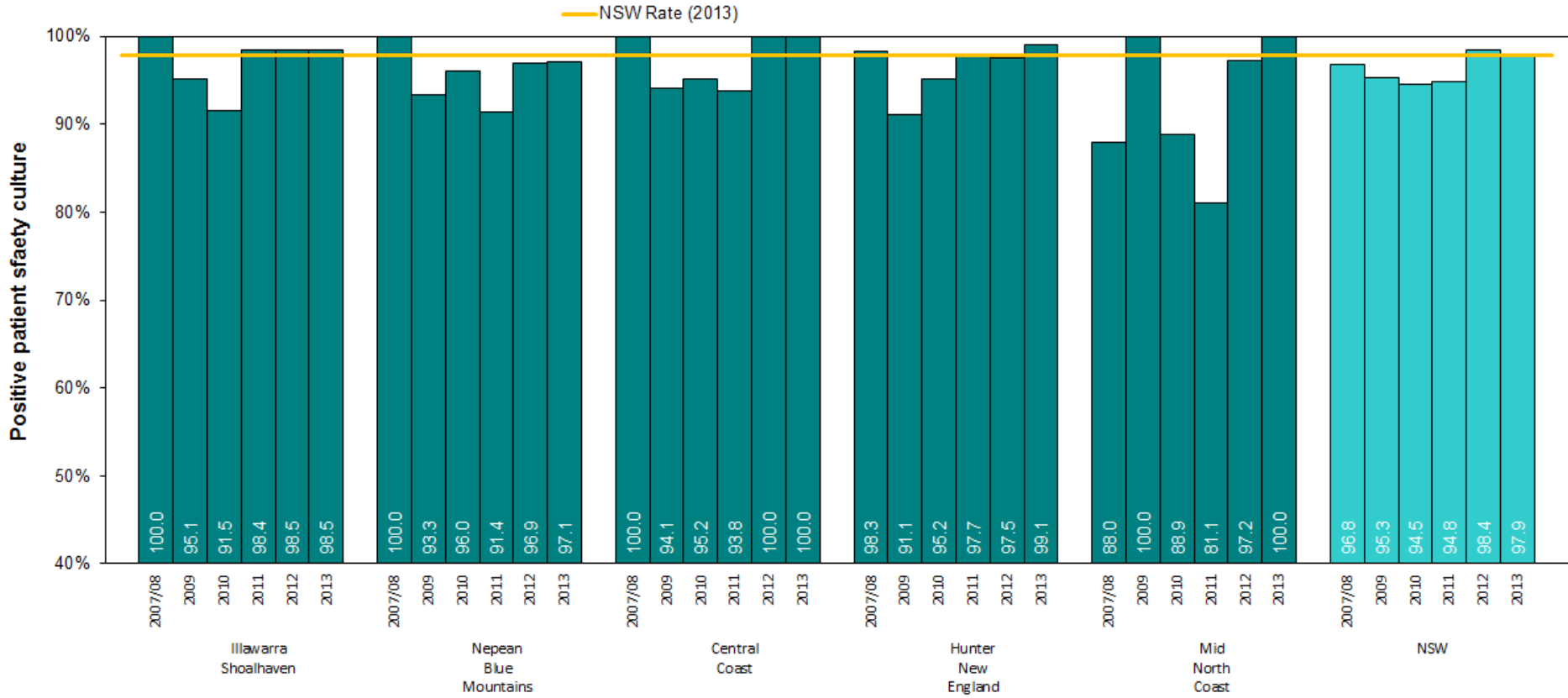
Source: Quality Systems Assessment, Clinical Excellence Commission.

PPS12a – Trend in percentage of departments/clinical units reporting that they have positive patient safety culture by LHD in NSW 2007/08 to 2013



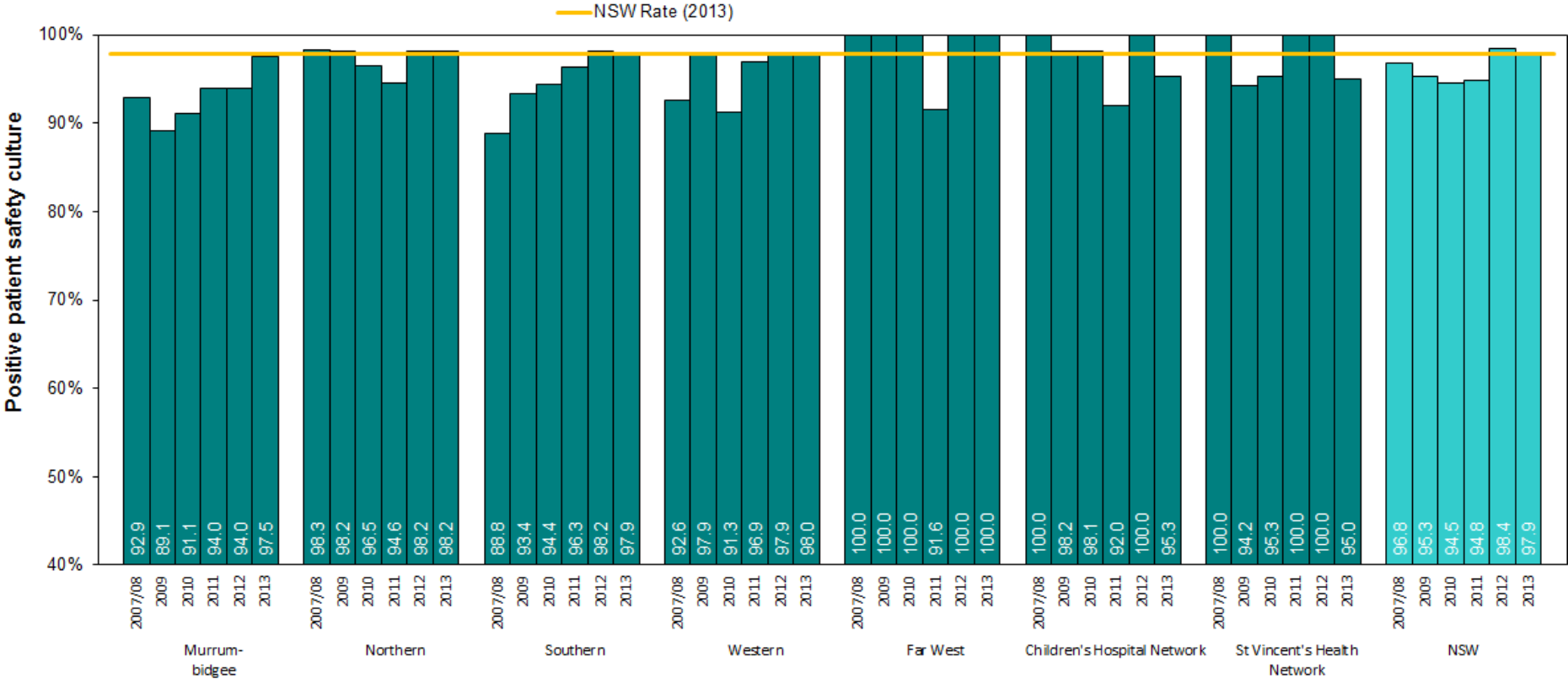
Source: Quality Systems Assessment, Clinical Excellence Commission.

PPS12b – Trend in percentage of departments/clinical units reporting that they have positive patient safety culture by LHD in NSW 2007/08 to 2013



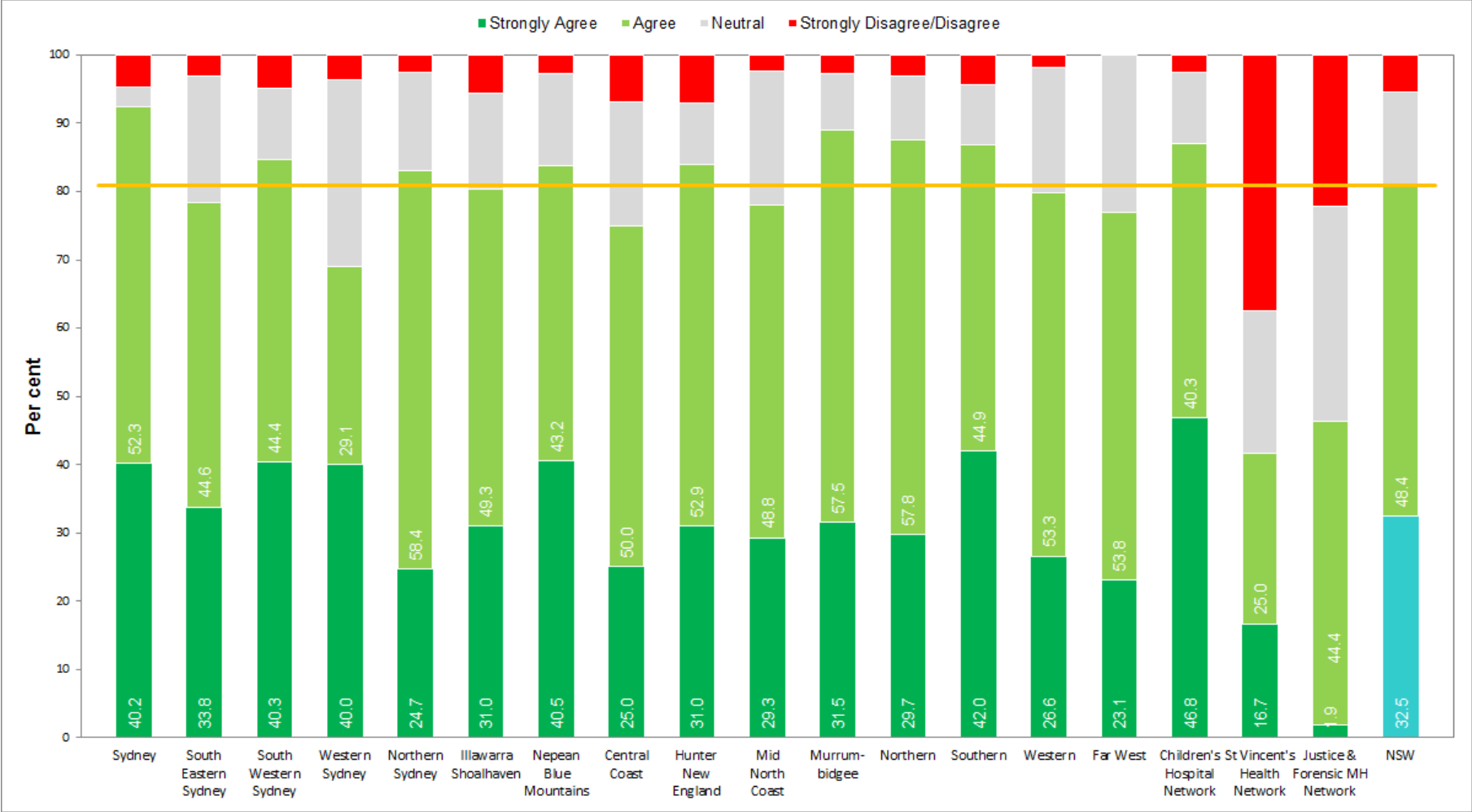
Source: Quality Systems Assessment, Clinical Excellence Commission.

PPS12c – Trend in percentage of departments/clinical units reporting that they have positive patient safety culture by LHD in NSW 2007/08 to 2013



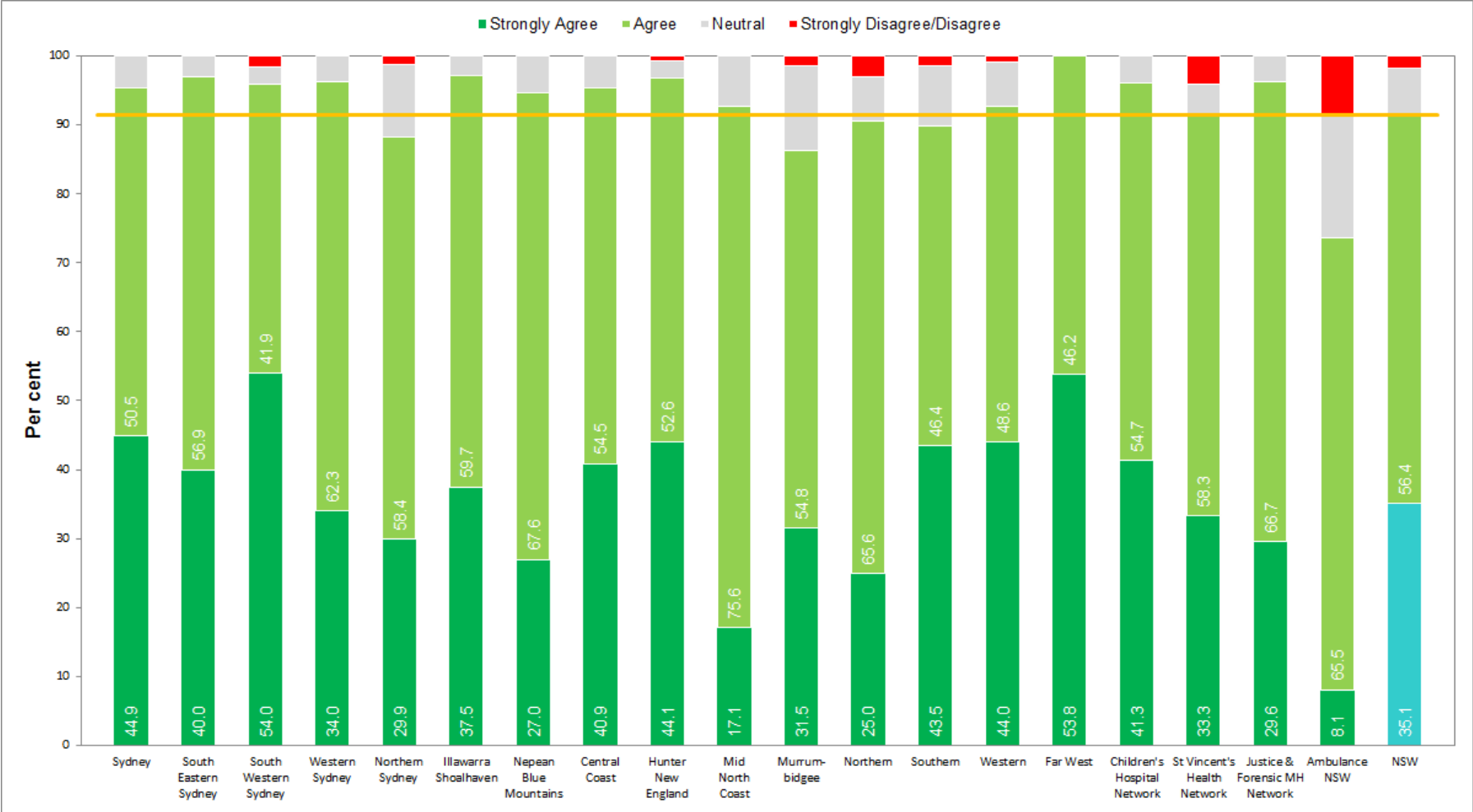
Source: Quality Systems Assessment, Clinical Excellence Commission.

PBC13 – Percentage of departments/clinical units indicate level of agreement about family centred in healthcare by LHD in NSW 2012



Source: Quality Systems Assessment, Clinical Excellence Commission.

GVF14 –Percentage of departments/clinical units have clear and effective integrated framework for safety and quality by LHD in NSW 2012



Source: Quality Systems Assessment, Clinical Excellence Commission.

CLA15 – Percentage of departments/clinical units have standardised approach for clinical audit by LHD in NSW 2012



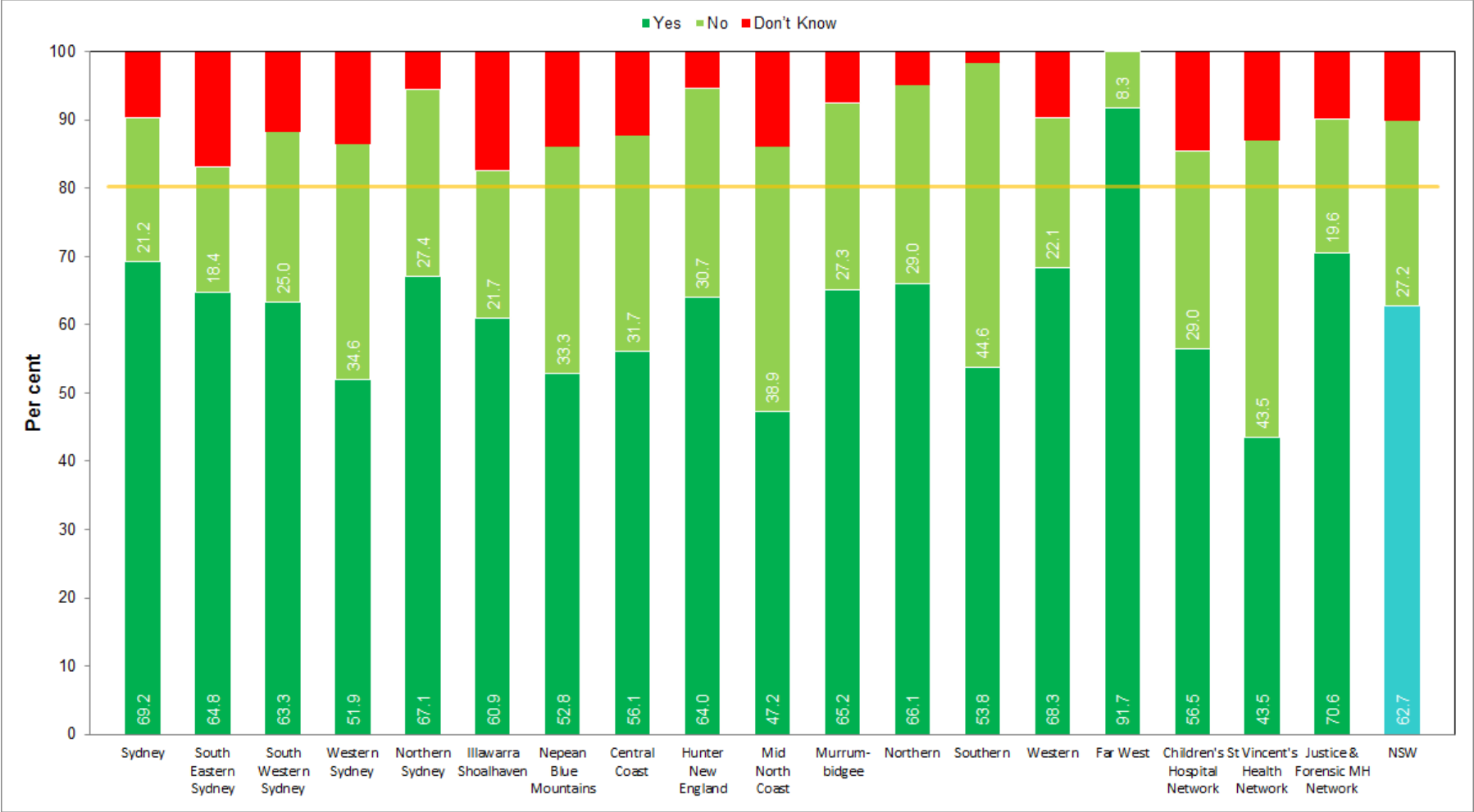
Source: Quality Systems Assessment, Clinical Excellence Commission.

CLA16 – Percentage of departments/clinical units have under taken clinical audit 12-18 months by LHD in NSW 2012



Source: Quality Systems Assessment, Clinical Excellence Commission

CLA17 – Percentage of departments/clinical units have lead manager to conduct clinical audit by LHD in NSW 2012



Source: Quality Systems Assessment, Clinical Excellence Commission.

DR18 – Percentage of departments/clinical units have reviewed all relevant deaths by LHD in NSW 2012



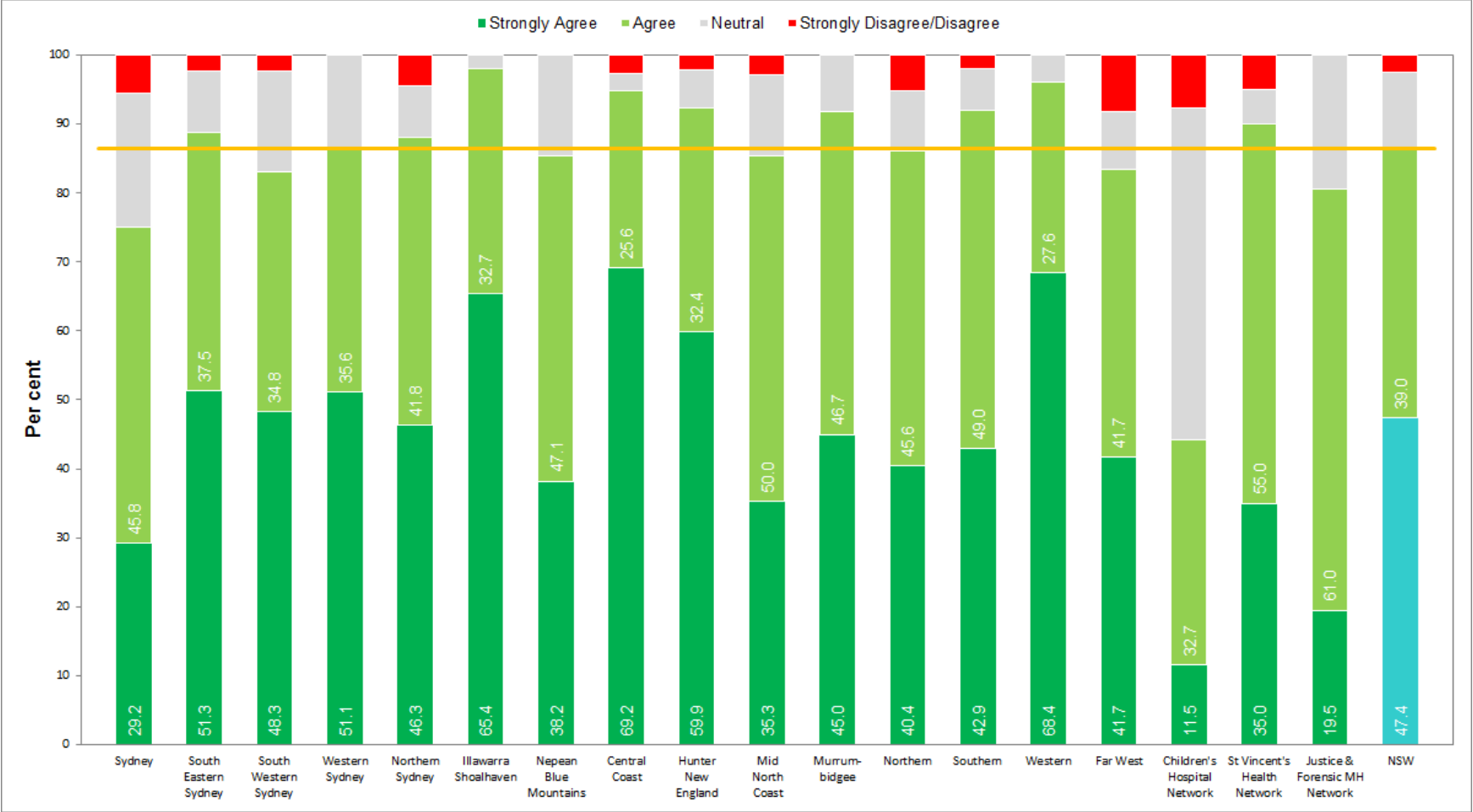
Source: Quality Systems Assessment, Clinical Excellence Commission.

DR19 – Percentage of departments/clinical units followed standardised frame work to review all relevant deaths by LHD in NSW 2012



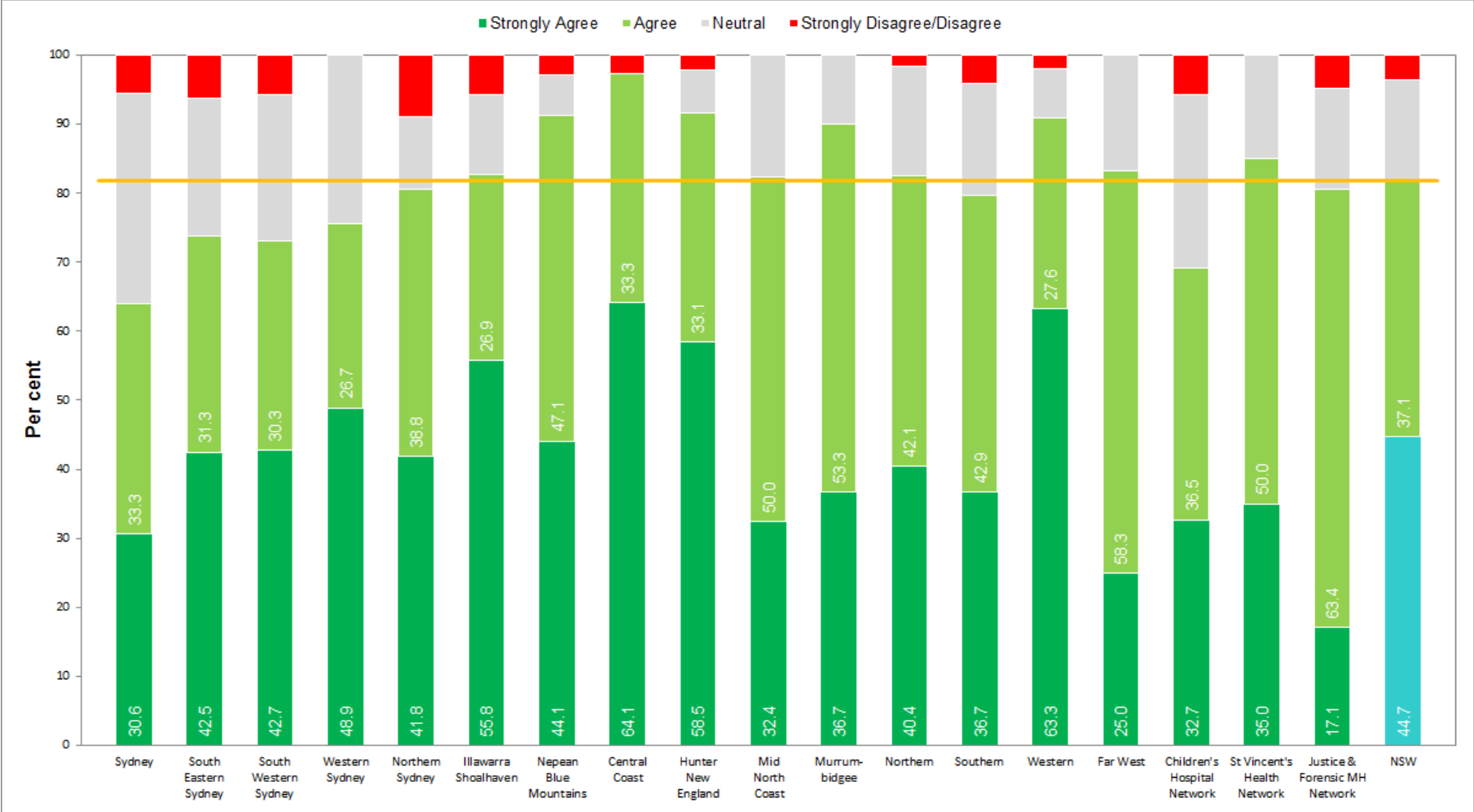
Source: Quality Systems Assessment, Clinical Excellence Commission.

BTF20 – Percentage of departments/clinical units agreed that BTF DETECT program has contributed to improve knowledge and skills of staff by LHD in NSW 2012



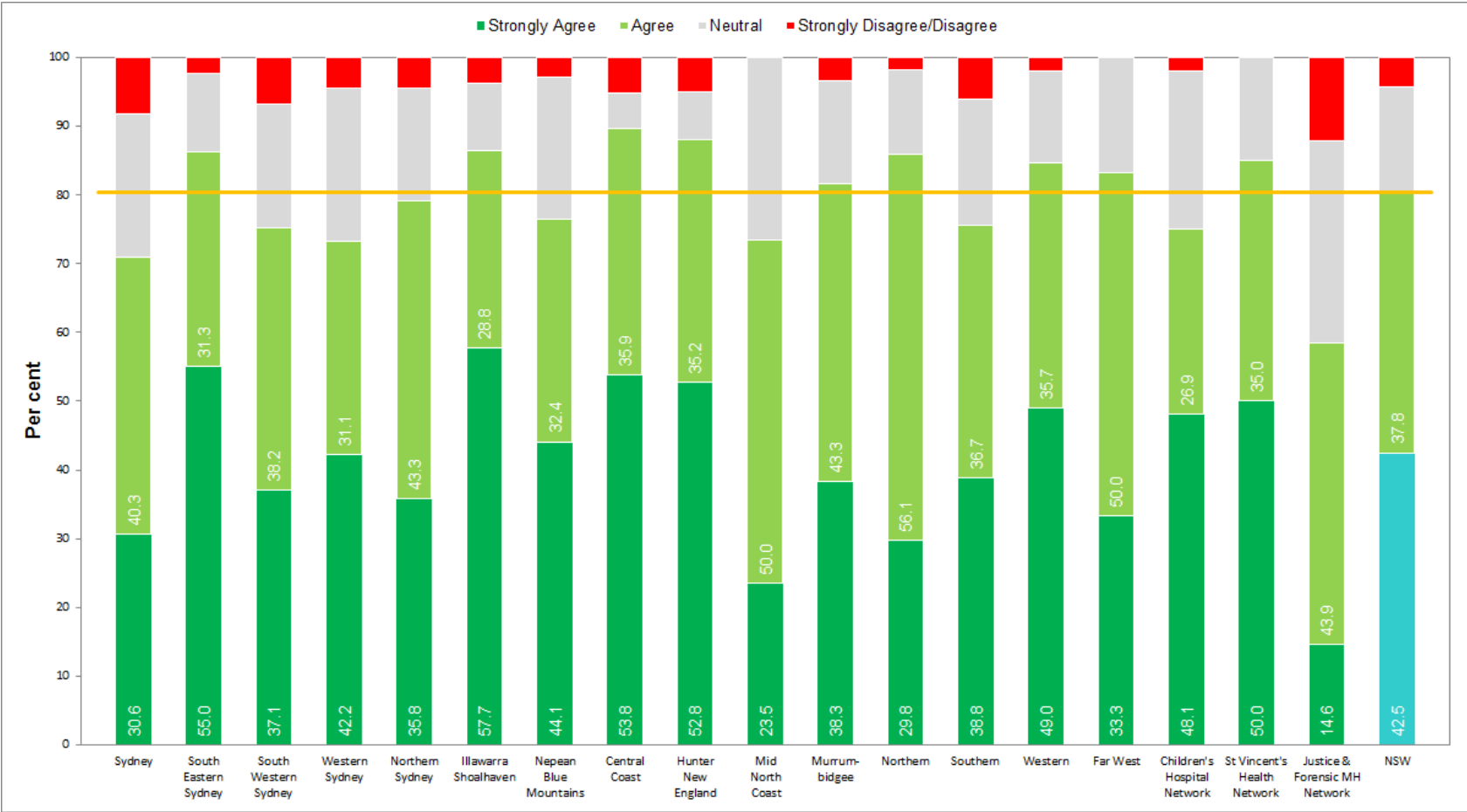
Note: DETECT - Detecting Deterioration, Evaluation, Treatment, Escalation and Communicating in Teams
 Source: Quality Systems Assessment, Clinical Excellence Commission.

BTF21 – Percentage of departments/clinical units agreed that BTF program has benefitted patient safety by LHD in NSW 2012



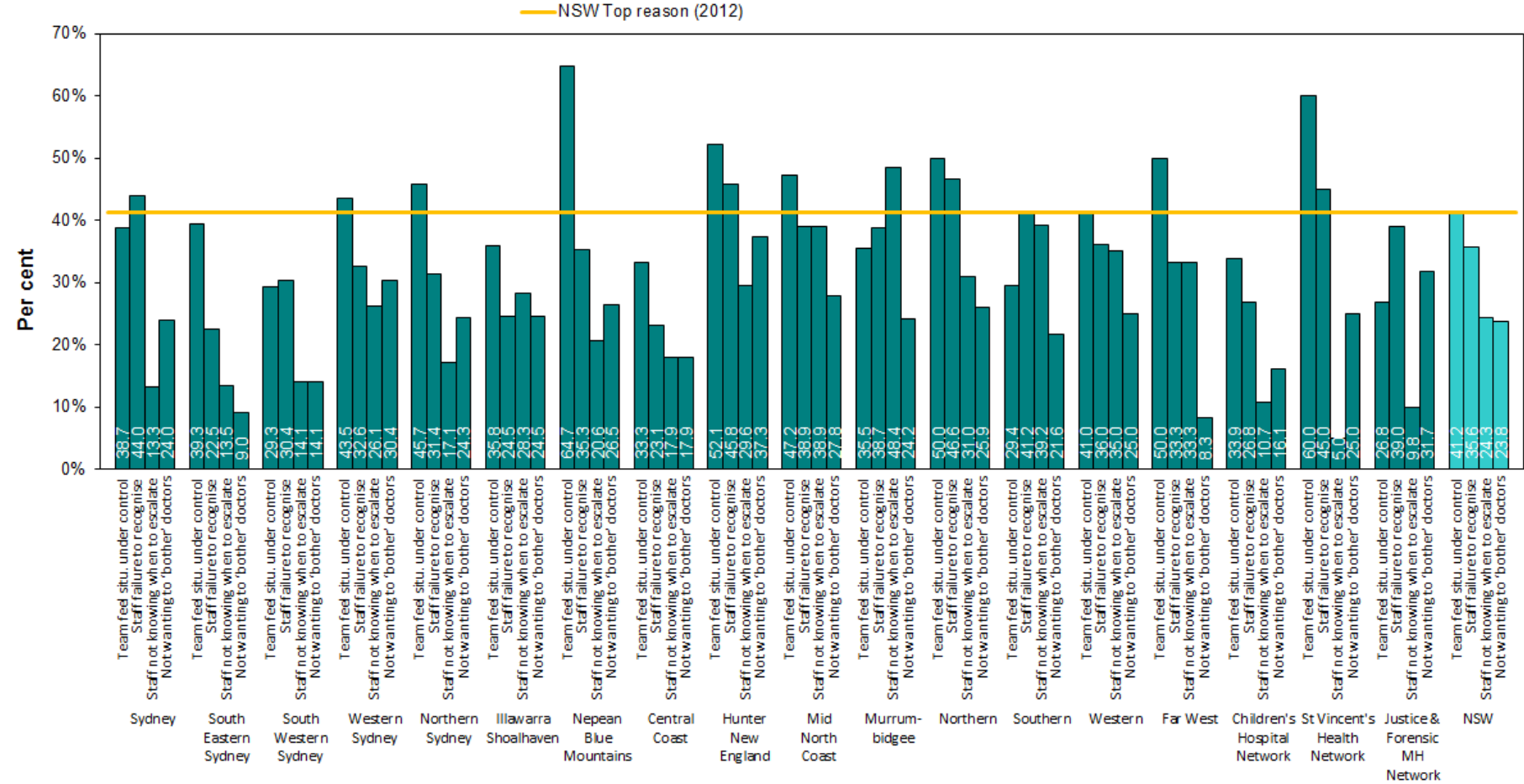
Source: Quality Systems Assessment, Clinical Excellence Commission.

BTF22 – Percentage of departments/clinical units agreed that Clinical Emergency Response Systems (CERS) has improved the system to assist deteriorating patients by LHD in NSW 2012



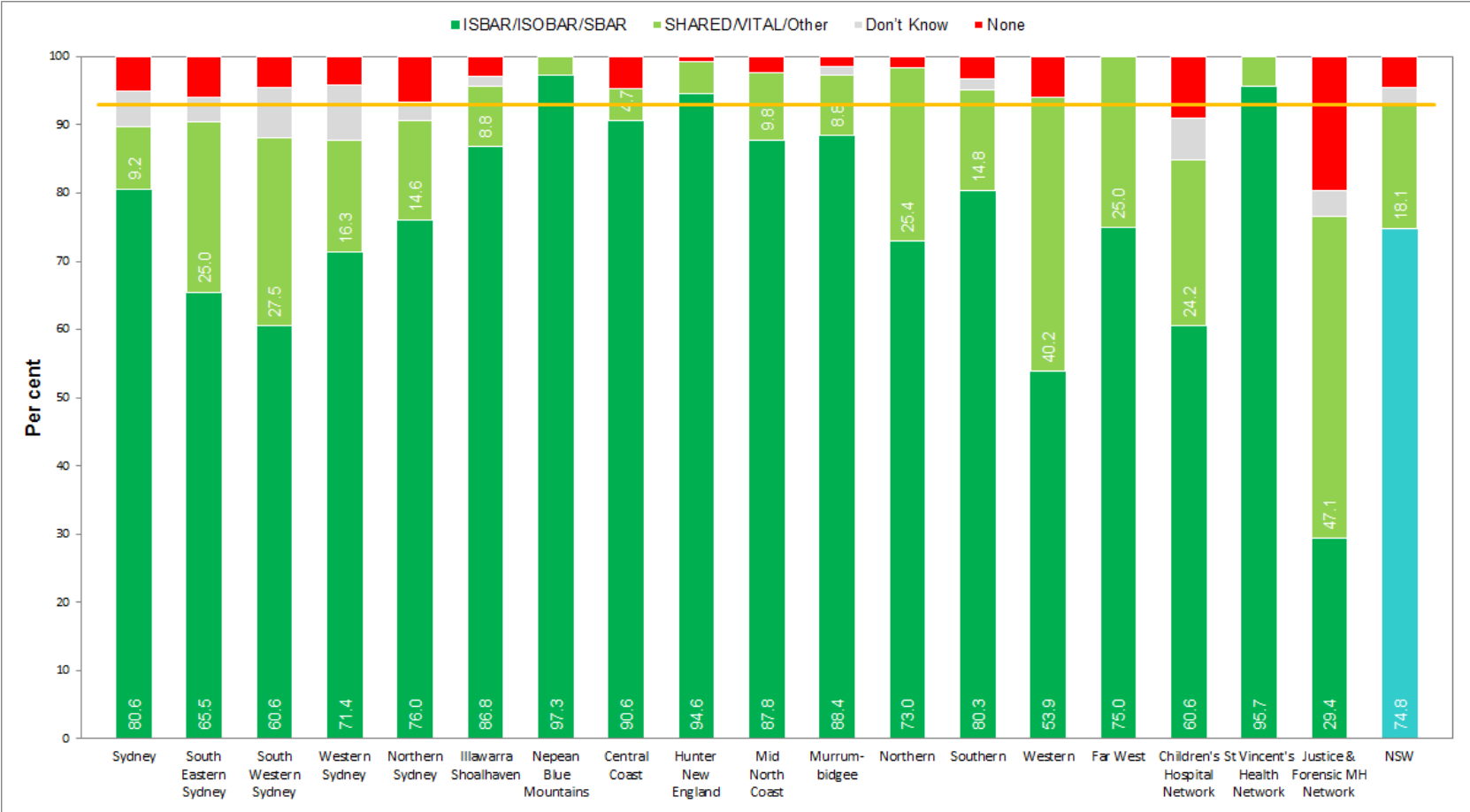
Source: Quality Systems Assessment, Clinical Excellence Commission.

BTF23 – Percentage of departments/clinical units have reported barriers or challenging the care of the deteriorating patients by LHD in NSW 2012



Source: Quality Systems Assessment, Clinical Excellence Commission.

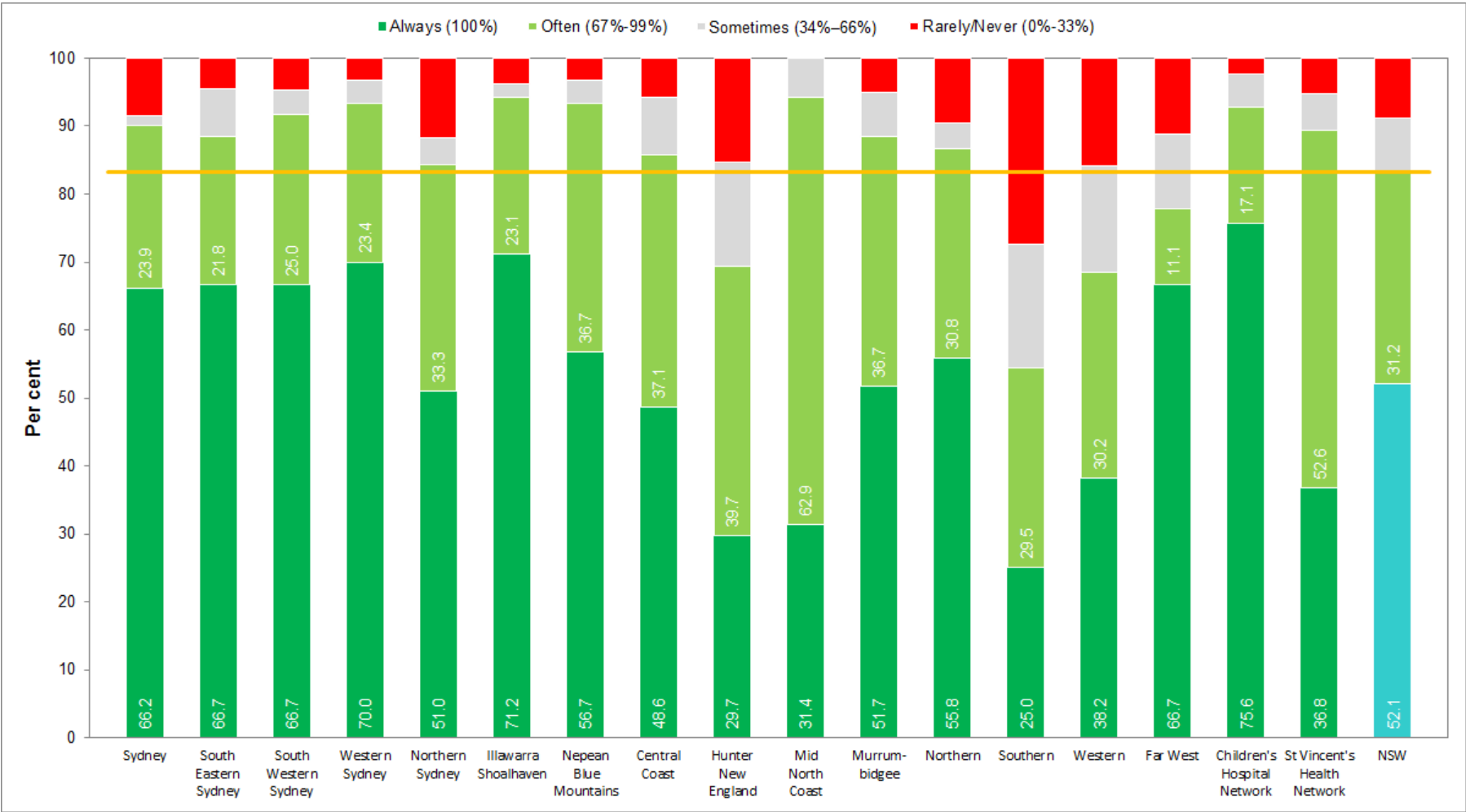
CH24 – Percentage of departments/clinical units used standardised tool for effective clinical handover by LHD in NSW 2012



Note: ISBAR (Introduction, Situation, Background, Assessment and Recommendation / Request); ISOBAR (Introduction, Situation, Observation, Background, Assessment and Recommendation/Request) SBAR (Situation, Background, Assessment, Recommendation); SHARED (S-situation H-history A-assessment R-risks E-expectation D-documentation); and VITAL (V- vital signs/observation I - input/output T - Treatment = Diagnosis A - Ambulation & patient safety L - legal & patient learning).

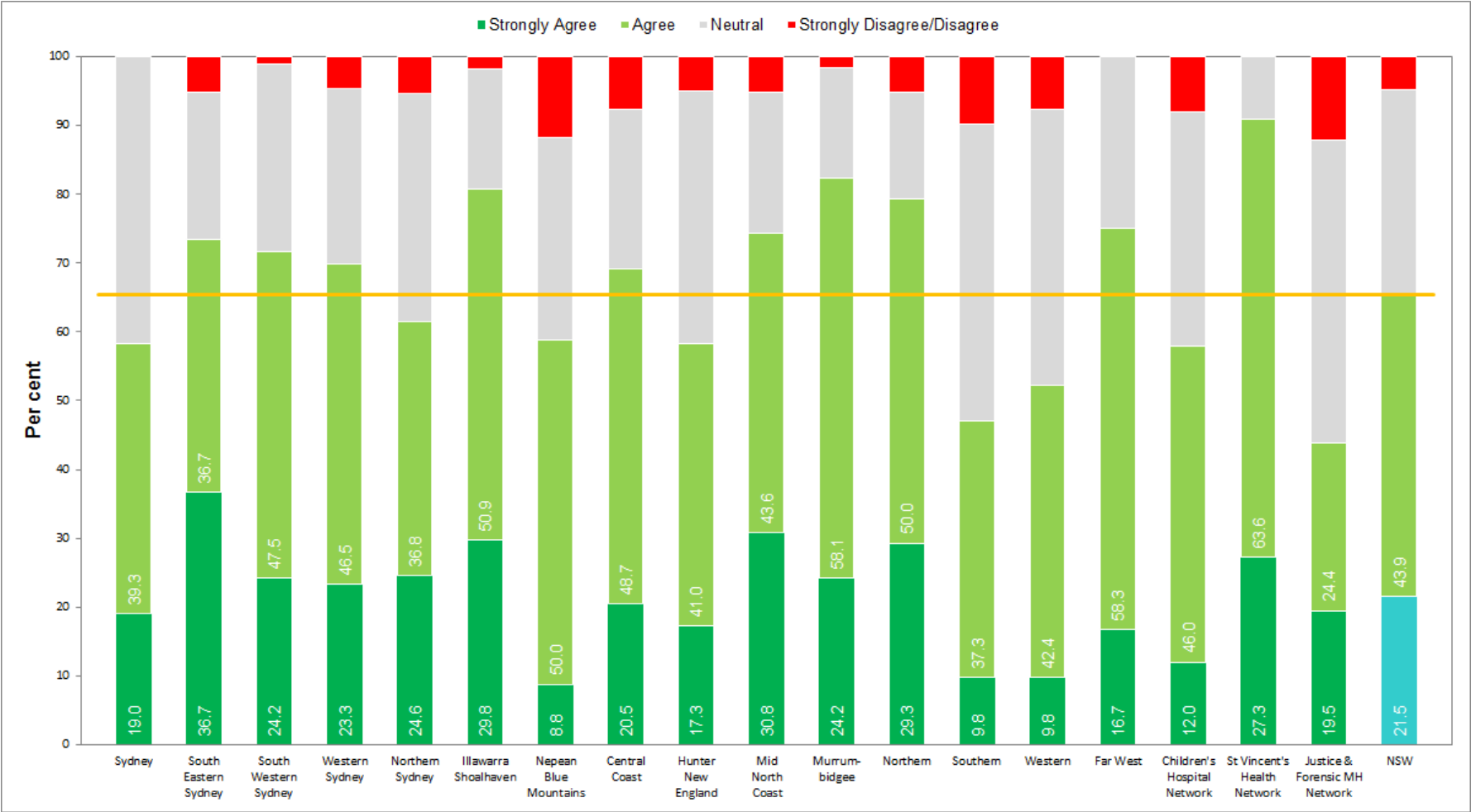
Source: Quality Systems Assessment, Clinical Excellence Commission.

CH25 – Percentage of departments/clinical units conduct shift to shift clinical handover at patient's bedside at least once every 24 hours by LHD in NSW 2012



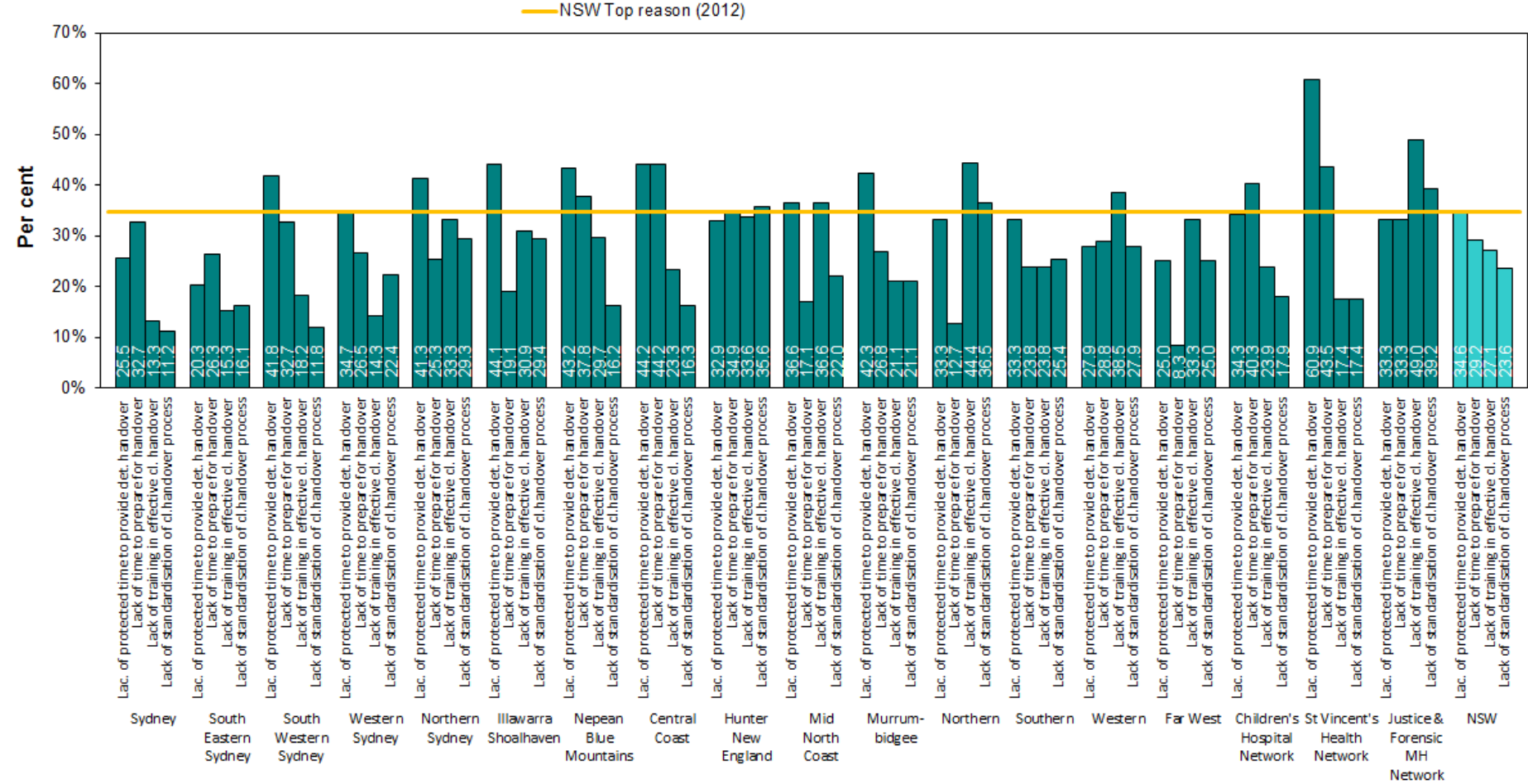
Source: Quality Systems Assessment, Clinical Excellence Commission.

CH26 – Percentage of departments/clinical units agreed that the Statewide Safe Clinical Handover program has improved and reinforced clinical handover processes by LHD in NSW 2012



Source: Quality Systems Assessment, Clinical Excellence Commission.

CH27 – Percentage of departments/clinical units have reported barriers to effective clinical handover by LHD in NSW 2012



Source: Quality Systems Assessment, Clinical Excellence Commission.

Data Definitions

Chart:	EOL01-EOL11
Admin Status:	Current
Indicator Name:	QSA Survey 2012: End of Life care management
Description:	QSA Survey 2012: End of Life (EOL) care management related indicators (does the unit follow a standardised approach for EOL patients; what are the most challenging issues to manage EOL patients; access to specialist palliative care services; co-ordination of care; and involvement with patients and their families) by local health districts and special health networks
Dimension:	Patient safety
Clinical Area:	Initiatives in safety and quality health care
Data Inclusions:	Total number of respondents in QSA survey by responses
Data Exclusions:	None
Numerator:	Total number of units/facilities in QSA survey by responses
Denominator:	Total number of respondents by local health districts
Standardisation:	None (crude rate per 100 was calculated)
Data Source:	QSA data, Clinical Excellence Commission and NSW Ministry of Health
Comments:	Not Applicable

Chart:	PPS12-PPS12c
Admin Status:	Current
Indicator Name:	QSA Survey 2012: Patient safety and quality culture
Description:	QSA Survey 2012: Trend in existence/practice of positive patient safety (PPS) and quality culture by local health districts and special health networks
Dimension:	Patient safety
Clinical Area:	Initiatives in safety and quality health care
Data Inclusions:	Total number of respondents in QSA survey by responses
Data Exclusions:	None
Numerator:	Total number of units/facilities in QSA survey by responses
Denominator:	Total number of respondents by local health district
Standardisation:	None (crude rate per 100 was calculated)
Data Source:	QSA data, Clinical Excellence Commission and NSW Ministry of Health
Comments:	Not Applicable

Chart:	PBC13
Admin Status:	Current
Indicator Name:	QSA Survey 2012: Patient based care (PBC)
Description:	QSA Survey 2012: Percentage of departments/clinical units indicate level of agreement about family centred in healthcare team (patients and their families and/or carers are viewed as integral members of the health care) by local health districts and special health networks
Dimension:	Patient safety
Clinical Area:	Initiatives in safety and quality health care
Data Inclusions:	Total number of respondents in QSA survey by responses
Data Exclusions:	None
Numerator:	Total number of units/facilities in QSA survey by responses
Denominator:	Total number of respondents by local health district
Standardisation:	None (crude rate per 100 was calculated)
Data Source:	QSA data, Clinical Excellence Commission and NSW Ministry of Health
Comments:	Not Applicable

Chart:	GVF14
Admin Status:	Current
Indicator Name:	QSA Survey 2012: Clinical Governance
Description:	QSA Survey 2012: Percentage of departments/clinical units have clear and effective integrated effective governance framework for safety and quality (including risk management and clinical incident management systems) by local health districts and special health networks
Dimension:	Patient safety
Clinical Area:	Initiatives in safety and quality health care
Data Inclusions:	Total number of respondents in QSA survey by responses
Data Exclusions:	None
Numerator:	Total number of units/facilities in QSA survey by responses
Denominator:	Total number of respondents by local health district
Standardisation:	None (crude rate per 100 was calculated)
Data Source:	QSA data, Clinical Excellence Commission and NSW Ministry of Health
Comments:	Not Applicable

Chart:	CLA15- CLA17
Admin Status:	Current
Indicator Name:	QSA Survey 2012: Clinical Audit
Description:	QSA Survey 2012: Clinical audit related indicators [does the unit have a program or system in place that provides a standardised approach for clinical audit; has the unit undertaken any audit in relation to clinical outcome/patient management over the last 12-18 months; is there a nominated clinical audit lead/manager who is responsible for facilitating clinical audit in the facility (e.g. training/development of staff)?] by local health district and special health networks
Dimension:	Patient safety
Clinical Area:	Initiatives in safety and quality health care
Data Inclusions:	Total number of respondents in QSA survey by responses
Data Exclusions:	None
Numerator:	Total number of units/facilities in QSA survey by responses
Denominator:	Total number of respondents by local health district
Standardisation:	None (crude rate per 100 was calculated)
Data Source:	QSA data, Clinical Excellence Commission and NSW Ministry of Health
Comments:	Not Applicable

Chart:	DR18- DR19
Admin Status:	Current
Indicator Name:	QSA Survey 2012: Death Review
Description:	QSA Survey 2012: Death review related indicators (how often the death review occur for relevant deaths in the department/ clinical unit; does the department/clinical unit follow a standardised framework or guideline for review of all deaths) by local health districts and special health networks
Dimension:	Patient safety
Clinical Area:	Initiatives in safety and quality health care
Data Inclusions:	Total number of respondents in QSA survey by responses
Data Exclusions:	None
Numerator:	Total number of units/facilities in QSA survey by responses
Denominator:	Total number of respondents by local health district
Standardisation:	None (crude rate per 100 was calculated)
Data Source:	QSA data, Clinical Excellence Commission and NSW Ministry of Health
Comments:	Not Applicable

Chart:	BTF20- BTF23
Admin Status:	Current
Indicator Name:	QSA Survey 2012: Between the Flags (BTF)
Description:	QSA Survey 2012: Between the Flags (BTF) related indicators [which of the following observations charts namely: SAGO (Standard Adult General Observation), SMOC (Standard Maternity Observation Chart) and SPOC (Standard Paediatric Observation Chart) have been fully implemented; level of agreement about following statements: 'the DETECT (detecting deterioration, evaluation, treatment, escalation and communicating in teams) program has contributed to improving the knowledge and skills of staff in recognising and responding to the deteriorating patient', 'overall the BTF program has benefitted patient safety at unit level', and 'the Clinical Emergency Response Systems policy has improved the system for obtaining urgent assistance when a patient is clinically deteriorating'; and top 3 barriers or challenges to escalating the care of the deteriorating patient] by local health districts and special health networks.
Dimension:	Patient safety
Clinical Area:	Initiatives in safety and quality health care
Data Inclusions:	Total number of respondents in QSA survey by responses
Data Exclusions:	None
Numerator:	Total number of units/facilities in QSA survey by responses
Denominator:	Total number of respondents by local health district
Standardisation:	None (crude rate per 100 was calculated)
Data Source:	QSA data, Clinical Excellence Commission and NSW Ministry of Health
Comments:	Not Applicable

Chart:	CH24- CH27
Admin Status:	Current
Indicator Name:	QSA Survey 2012: Clinical Handover
Description:	QSA Survey 2012: Clinical handover related indicators [which of the standardised tool for clinical handover/communication is used; what are the top 3 barriers to effective clinical handover in your department/clinical unit?; how regularly does the unit conduct shift to shift clinical handover at patient's bedside at least once every 24 hours; level of agreement about the statement 'the statewide Safe Clinical Handover program has improved and reinforced our clinical handover processes'] by local health districts and special health networks.
Dimension:	Patient safety
Clinical Area:	Initiatives in safety and quality health care
Data Inclusions:	Total number of respondents in QSA survey by responses
Data Exclusions:	None
Numerator:	Total number of units/facilities in QSA survey by responses
Denominator:	Total number of respondents by local health district
Standardisation:	None (crude rate per 100 was calculated)
Data Source:	QSA data, Clinical Excellence Commission and NSW Ministry of Health
Comments:	Not Applicable