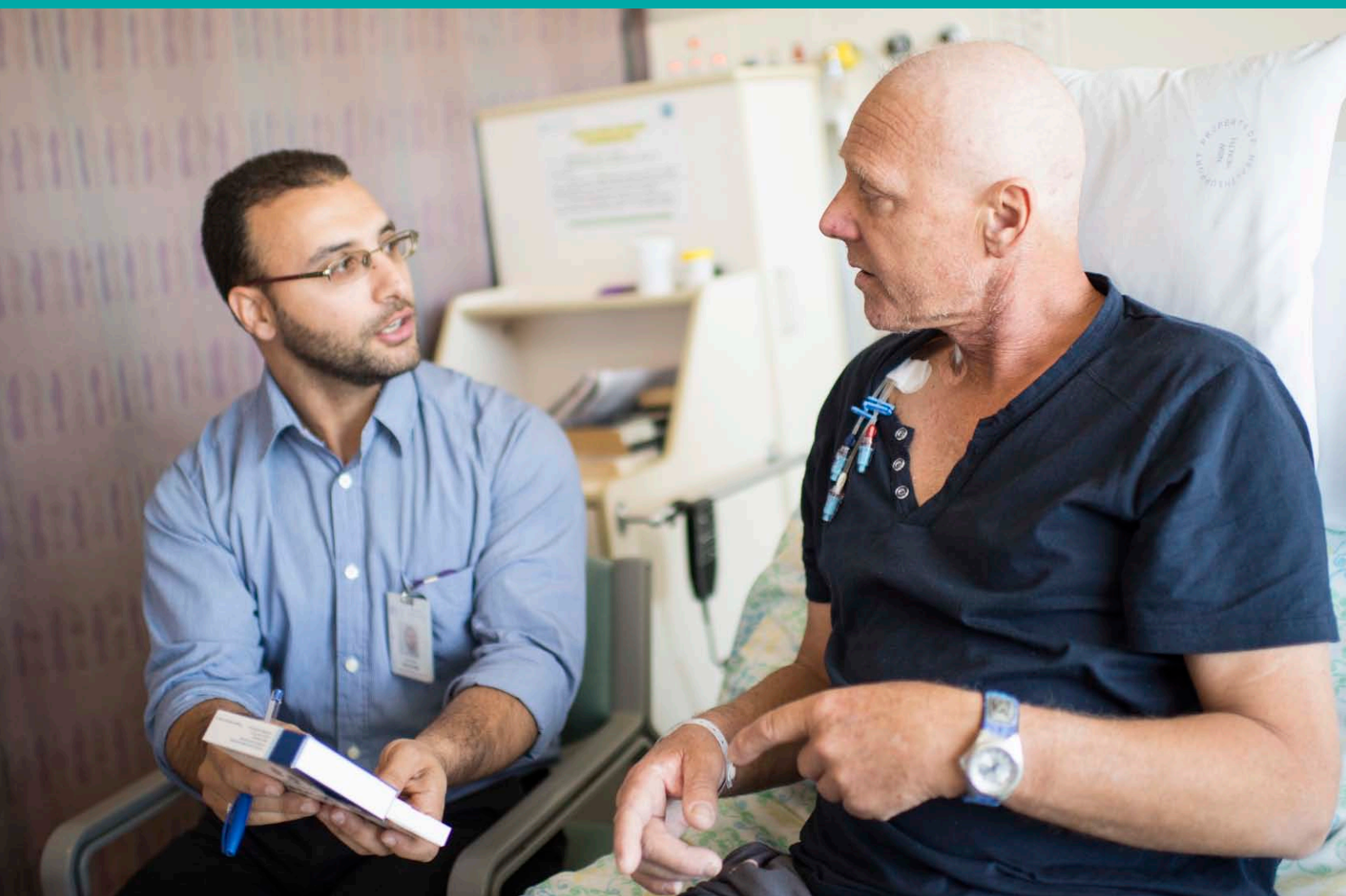




2013 QUALITY SYSTEMS ASSESSMENT



SAFER SYSTEMS BETTER CARE

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Clinical Excellence Commission

Board Chair: A/Prof Brian McCaughan, AM

Chief Executive Officer: Prof Clifford F Hughes, AO

Any enquiries about or comments on this publication should be directed to:

Clinical Excellence Commission

Locked Bag A4062

Sydney South NSW 1235

Phone: 02 9269 5500

Email: info@cec.health.nsw.gov.au

ABN: 79 172 068 820

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OVERVIEW

In August 2013, Don Berwick (Chair, National Advisory Group on the Safety of Patients in England) wrote:

“The most important single change in the NHS ...would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.”¹

NSW has an excellent health system that is committed to patients, their carers and our staff. In the 2013 NSW Patient Survey, 92 per cent of the 17,467 responses rated their overall care as “good” or “very good”.² Working together, we continually strive to make health care in NSW even better.

‘Better’ can take on a number of meanings: caring; collaborative; efficient; innovative; respectful; dependable; connected; reduced waiting; equitable; open; empowering; reliable ...resilient.

Resilience means that a system stands up under pressure, recovers quickly and, most importantly, learns when it fails. A resilient system is one that must continually learn, improve and adapt to changes in its environment.

How does our system learn and act to reduce potential for patient harm now and in the future? Continuous learning and improvement is our key to system resilience. Health system resilience is the key to public confidence in better care.

The Quality Systems Assessment (QSA) is one vehicle that contributes to resilience in our health system. Working directly with local teams and local priorities, the QSA supports continuous learning and improvement to prevent and reduce patient harm.

This year’s QSA is the biggest ever. There were 1,745 responses to the Self-Assessment between August and October 2013 (97.6 per cent response rate), from right across the NSW health system. For the first time, community health units were included.

Between February and June 2014, the QSA visited 17 organisations, 48 hospitals and 30 community health services, to validate responses to the Self-Assessment and help identify local and system-level improvement

opportunities. During the visits, the QSA worked face-to-face with clinicians and managers, interviewing over 1,100 staff.

When comparing what is reported in the Self-Assessment with what is seen during site visits, a 97.7 percent accuracy rate was found. This gives confidence in the Self-Assessment findings.

In early 2014, local teams received their detailed local reports to consider and determine the most relevant improvement priorities.

In addition, seven system-wide recommendations have been identified for local health districts and specialty health networks to consider, relating to:

- Continuity of care transitions
- Embedding antimicrobial stewardship
- Action on venous thromboembolism prevention
- High safety for high-risk medications
- Good clinical care to prevent falls and harm from falls
- Community health: integrating care
- Ensuring excellence in environmental cleanliness.

Each of the recommendations has a headline statement, followed by several action points. These are the tangible improvement opportunities identified from the Self-Assessment results and validated during site visits.

They should be viewed as important challenges to all local teams, not as a quest for error-free performance, but to learn and build strength continually into the way we deliver patient care.

Thank you for your valued commitment to improving patient care continually in NSW.



Professor Clifford Hughes, AO
Chief Executive Officer



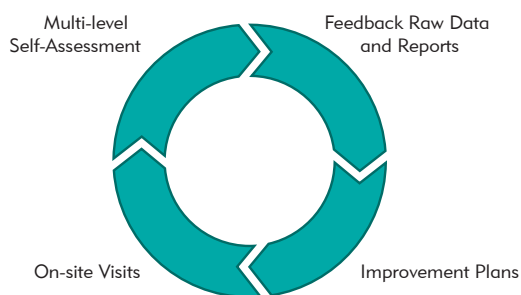
A marker of surgical excellence is not error-free performance, but rather the ability to manage errors and problems during an operation.³

THE QSA IN 2013

The QSA has been developed to provide clinicians and managers at all levels with information relevant to their local systems for clinical quality and patient safety.

Multi-level Self-Assessment

The QSA uses an online Self-Assessment and an organisational approach to assess local quality and safety systems. Teams receive detailed local data, analysis and reporting, to help them identify the highest priority local areas for improvement.



In 2013, the QSA focused on transitions of care, high-risk medications, antimicrobial stewardship, venous thromboembolism prevention and falls. Specific local focus was paid to environmental cleaning by the Ambulance Service of NSW (ASNSW); suicide risk management by Justice Health and Forensic Mental Health (JH+FMHN) and wound management in community health.

Between August and October 2013, 1,745 responses (2012=1,507) were received for the online Self-Assessment (97.6 per cent response rate).

On-site Visits

Visits for the 2013 Self-Assessment, started in February and finished in June 2014. On-site visit teams have four-five accredited assessors, most of whom are senior doctors, nurses and allied health staff.

In all, 17 organisations (including ASNSW), 48 hospitals, 36 clinical units/departments and 30 community health services were visited in four months to June 2014. The QSA team engaged with over 1,100 senior and junior clinicians and managers, to discuss a core set of questions from the 2013 Self-Assessment.

The opportunity to engage with other clinicians and managers about common issues and to share some of the excellent work they already do is valued by local teams as a benefit of the On-site Visits.

Previous visits have validated the responses recorded during the Self-Assessment as being highly accurate:

- ✓ 2011 Self-Assessment >97 per cent
- ✓ 2012 Self-Assessment >96 per cent
- ✓ 2013 Self-Assessment >97 per cent

This high accuracy and a tendency to underestimate, rather than overestimate local performance, gives confidence in the Self-Assessment findings.

Where appropriate, observations from the on-site visits have been used in this report to support the recommendations from Self-Assessment findings.

Reporting

This document is the QSA State-level report for the 2013 Self-Assessment. A series of more detailed and locally relevant data and reports has already been delivered. Raw local data was returned at the end of October 2013.

Facility/divisional level and community health reports were returned in December 2013. District-level reports were returned in January 2014.

As a State-level report, this document refrains from identifying specific local issues. It focuses on the key themes and findings to drive improvements in safety and quality across NSW.

Questions in the QSA are tailored to organisation, facility and clinical unit levels. They are also tailored to ensure relevance in the community health, JH+FMH and ASNSW settings.

One impact of the tailored questioning is that results presented in this State-level report often have different sample sizes. For simplicity, in this report n-values are not offered against individual findings.

If you have any questions regarding the QSA process, findings or data, please do not hesitate to contact the QSA team on 9269 5622 or via email qsa@cec.health.nsw.gov.au

Previous State-level Safer Systems Better Care reports are available on the [CEC website](#).



KEY FINDINGS AND ACTIONS

Continually building our patient safety culture

The annual QSA commitment to reviewing patient safety culture is important, because when leaders commit to and lead a culture of safety, outcomes for patients improve.

Research⁴ shows that facilities with a better climate for patient safety have relatively lower adverse safety incidents. Interestingly, it is shown that perceptions of patient safety among the frontline staff are very closely related to actual safety incidents, whereas the perceptions of senior management are less reliable.

All leaders are encouraged to actively and continuously seek the perceptions of their frontline staff regarding the local safety culture.

In the 2013 Self-Assessment 98 per cent of units *Strongly Agreed* or *Agreed* with the statement “There is a positive patient safety and quality culture in our department or clinical unit”. This maintains the steady return to 2007 levels seen since perceptions of a patient safety culture dipped in 2009 and 2010.

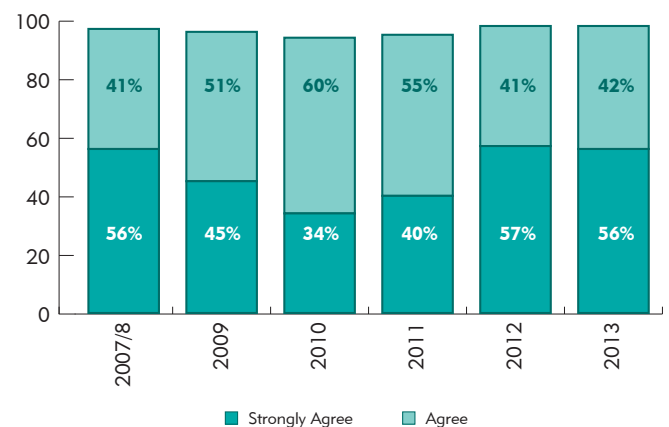
“There is a positive patient safety and quality culture in our department or clinical unit.”

The challenge now for NSW is to act in ways that continue to improve the share of Strongly Agree responses from our clinical units.

What we saw during on-site visits

There was strong local engagement with the visits by the clinical and executive leaders of all organisations. Commitment to shared discussions, involving senior executive and frontline clinicians around the same table, is an important contributor to patient safety culture.

The shared discussions are one way to help local leaders understand the perceptions and experiences of frontline clinicians and to align local strategy and resources accordingly.



Patient-based care: continuing the journey

Our patients tell us they want to be involved in their own care. Ninety-six per cent of respondents to the 2013 NSW Patient Survey indicated they wanted to be involved in decisions about their care and treatment, yet only 59 per cent felt that they were “Yes, definitely” involved as much as they wanted to be.

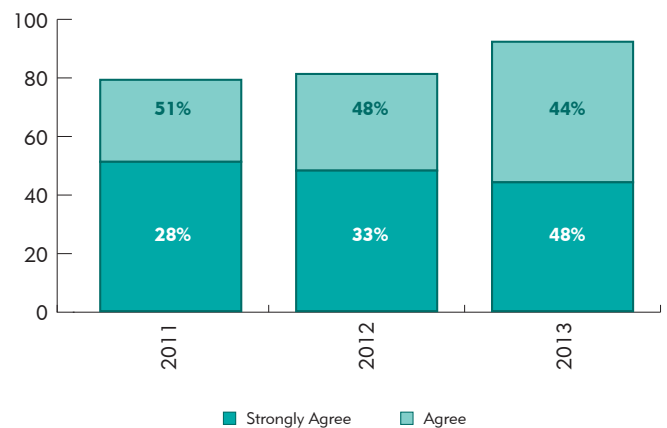
Research suggests that better health care experiences correlate with improved medical compliance, clinical outcomes, care continuity, reduced length of stay, medication errors,^{5,6} as well as malpractice litigation and costs.⁷ It has also been shown to link to higher employee satisfaction and retention rates and reduced operating costs.

There has been an increase in units responding “Strongly agree” or “Agree” to the statement “Patients and their families and/or carers are viewed as integral members of the health care team.”

“Patients and their families and/or carers are viewed as integral members of the health care team.”

Moving from ‘viewing’ to ‘actively involving’ patients is important. Positive responses in a number of examples of active involvement of patients, their carers and families show room for local and system improvement.

For more information on *Patient-Based Care*, please contact CEC’s Patient-Based Care Directorate: patientbasedcare@cec.health.nsw.gov.au



84%

of units **Always** or **Often** obtained patient, family or carer consent prior to inter-facility transfer and included a discussion about the risks and benefits of transfer

66%

of units **Always** or **Often** used a process for patients, families or carers to escalate care and to request a clinical review or rapid response if they are worried or concerned about any change in the patient’s condition

62%

of units **Always** or **Often** involved patients and their family and/or carers in shared decision making and care planning about individualised falls prevention strategies

35%

of units **Always** or **Often** provided patients and family with information on VTE prophylaxis (both pharmacological and mechanical) as part of the admission process

Continuity of care transitions

A 2008/09 review of the NSW Incident Information Management System (IIMS) found 294 reported incidents related to retrieval and inter-hospital transfer.⁸ These included 11 Severity Assessment Code (SAC) 1 incidents and 44 SAC 2 incidents in the 12-month period.

Planning & care co-ordination

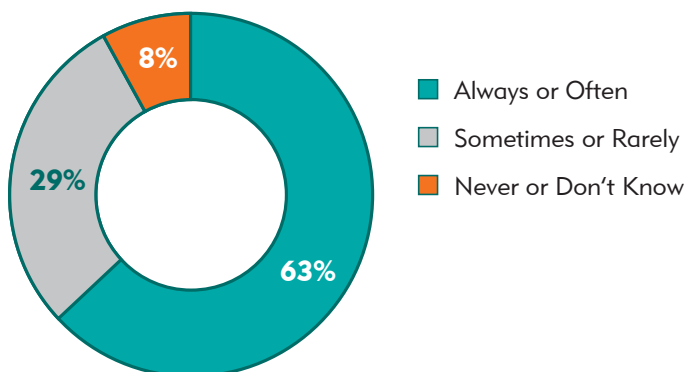
Most units reported using standardised processes to guide the patient's care co-ordination from admission (90 per cent) and to direct the care plan for discharge (82 per cent). In addition, 89 per cent of units responded that there was policy or guidelines in place for transfer of patients, based on Inter-facility Transfer Process for Adults Requiring Specialist Care – NSW Health PD2011_031.

Despite this consistency, there appears to be some disconnection in the implementation of patient care co-ordination processes.

Across nearly all local health districts, there was a consistent gap between the facility-level (overall NSW 66 per cent) and unit-level (overall NSW 49 per cent) responses to “A standardised transfer of care risk assessment (TCRA) is completed on initial presentation and whenever there is a change in status”.

The difference was most apparent in hospitals in **Peer Groups A** (facility 67, unit 43 per cent) & **B** (facility 80, unit 49 per cent).

Patients who require ongoing nutrition support on transfer of care have a formalised nutrition care plan which is provided to the patient and carer and forwarded to the receiving facility or service (unit level self-assessment.)



Recommendation 1

Local teams improve continuity in local systems that prioritise clinical need in transitions, specifically:

1. Clinical communication and collaboration enables safe, effective and efficient care transition
2. Monitoring, review and feedback of care transition outcomes drive improvement.

Seventy-six per cent of clinical units from facilities in **Peer Group A** reported that patients who require ongoing nutrition support on transfer of care “always” or “often” have a formalised nutrition care plan “which is provided to the patient and carer and forwarded to the receiving facility or service”, compared to 48 per cent of clinical units from facilities in **Peer Groups C, D or F**.

Medication errors are a risk for patients being transferred between care teams. **Reconciling medication is critical at any transfer point.** Variability exists in the implementation of standardised processes for reconciling a patient's medication.

Seventy per cent of units responded that this happens “on admission”, 66 per cent “on transfer between care teams or institution” and 73 per cent “on discharge”. Fifty-seven per cent of clinical units reported a standard process for reconciling patient medications in all three instances.

Patient-flow managers at receiving facilities “always” or “often” work co-operatively with clinicians to enable transfers according to clinical need rather than bed capacity.

66%

A common care plan is “always” or “often” developed through communication and collaboration between practitioners across settings, which includes both a physician-to-physician agreement and nurse-to-nurse agreement.

63%

Inter-facility transfer of care

In this area, about one-third of units identified barriers to providing good clinical care. Eighty-nine per cent indicated they had a policy or guideline in place for inter-facility transfer of patients. Around two-thirds indicated that they use a standardised inter-facility transfer form (67 per cent) or a list of the documentation required to be copied and transferred with the patient (65 per cent).

Seventy-seven per cent responded that there are escalation pathways available for clinicians when the transfer is delayed, or the patient is deteriorating.

What we saw during on-site visits

Consistent themes and recommendations arose across a number of organisations to improve continuity of care at transition points.

Local teams identified the need to:

- Improve the standardisation of medication reconciliation and consistency of occurrence
- Gain better oversight of care transfers, within and between facilities and to and from the community
- Improve sharing of information, monitoring and review between teams to improve the process, outcomes and efficiency of care transition.

Relevant NSW Health policies in this section

PD2011_015 – Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals

PD2011_031 – Inter-facility Transfer Process for Adults Requiring Specialist Care

The CEC’s [In Safe Hands program](#) offers useful tools and information aimed at improving team collaboration and care planning. For more information please contact: insafehands@cec.health.nsw.gov.au

Embedding antimicrobial stewardship

The emergence and spread of antimicrobial resistance is a major and escalating public health concern.⁹ Demonstrating the scale of opportunity, we know that up to 50 per cent of antimicrobial use in hospitals is inappropriate.¹⁰ With limited new antimicrobials in development, immediate action and long-term commitment are required to preserve the effectiveness of existing antimicrobials.

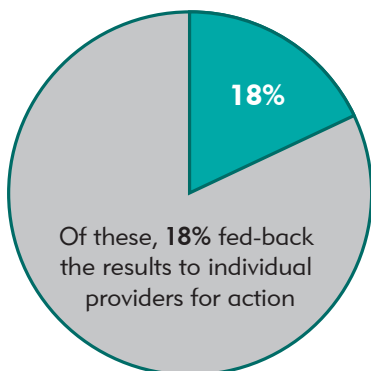
Governance of antimicrobial stewardship (AMS) is maturing, with 81 per cent of local health districts indicating they have a multi-disciplinary committee to oversee AMS.

At the unit level, 67 per cent of respondents indicated they have a **standardised approach for antimicrobial prescribing and review**. Sixty-five per cent indicated they used standardised antimicrobial prescribing protocols and clinical pathways. Fifty-two per cent ensured that use of formulary restricted antimicrobials is discussed with a senior member of the team and/or the AMS team prior to initiation.

Monitoring and analysis of antimicrobial usage is critical to understanding local opportunities to reduce antimicrobial resistance and improve patient outcomes.

Continuous surveillance of the **appropriateness of antimicrobial prescribing** should be the ultimate aim of any stewardship program. Any local investment in surveillance should be matched by feedback, analysis and action.

59% of units reported undertaking an activity to monitor and assess outcomes of antimicrobial stewardship.



Recommendation 2

Local teams demonstrate that they have effective antimicrobial stewardship programs in place that:

1. Promote and support antimicrobial prescribing.
2. Improve the quality of care delivered to patients receiving antimicrobial therapy.

What we saw during on-site visits

It is clear through the visits that there is significant variability across NSW in the maturity and formality of local AMS programs. They need to be tailored to meet local needs and ensure that continuous surveillance of appropriate antimicrobial use is the ultimate aim.

OPPORTUNITY

Patients and carers have a real impact in their antimicrobial use. Only 18 per cent of clinical units indicated they have a formalised procedure or policy to inform patients about their antimicrobial therapy.

*For more information regarding **Antimicrobial Stewardship**, please contact CEC's Quality Use of Antimicrobials in Healthcare team: hai@cec.health.nsw.gov.au*

Action on venous thromboembolism prevention

Venous thromboembolism (VTE) can have a catastrophic impact, yet is highly preventable. A 2008 multinational study¹¹ of 68,183 patients across 358 hospitals in 32 countries, found that 64.4 per cent of surgical patients and 41.5 per cent of medical patients were assessed to be at risk of developing VTE.

Despite this, only 58.5 per cent of the at-risk surgical patients and 39.5 per cent of the at-risk medical patients received recommended VTE prophylaxis strategies.

Results from the 2013 QSA indicate there is an opportunity to improve uptake of VTE risk screening and prophylaxis in NSW. Seventy-one per cent of units indicated that they have a standardised approach for VTE assessment and management.

Using a standardised or best practice tool, 44 per cent of clinical units, including those assessing patients in pre-admission clinic (PAC), always assess for VTE and bleeding risk on admission.

In addition, 74 per cent of units indicated that “patients assessed at risk are offered VTE prophylaxis, based on their assessment”.

VTE is highly preventable. A new occurrence is considered an adverse incident, not a standard clinical complication. Reporting of VTE in a non-blaming and continuous learning culture is essential to drive the improvements necessary to prevent patient harm.

All incidents of patients being diagnosed with Deep Vein Thrombosis or Pulmonary Embolus during admission are reported in IIMS.

25%

All incidents of VTE are reviewed at Morbidity & Mortality or team meeting or comparable forum and improvement actions implemented.

26%

Relevant NSW Health policies in this section
PD2010_077 – Prevention of Venous Thromboembolism

Recommendation 3

Local teams improve local processes to reduce patient risk from venous thromboembolism (VTE), specifically:

1. Improve uptake of timely VTE risk assessment
2. Ensure that prophylaxis matches the patient's clinical risk.

What we saw during on-site visits

Systems for VTE risk assessment and prophylaxis were reviewed at organisational, facility and clinical unit levels. There was variability in practice across and within organisations.

The need to develop, or implement and review, the use of a VTE risk-assessment tool was a common recommendation in local reports following the on-site visits.

OPPORTUNITY

Patients and carers have a real impact in effective VTE prophylaxis. Only 35 per cent of units responded that they “always” or “often” provide patients or family with information on VTE prophylaxis (both pharmacological and mechanical) as part of the admission process.

For more information regarding Venous Thromboembolism, please contact CEC's Medication Safety and Quality team: stopclots@cec.health.nsw.gov.au

High safety for high-risk medications

A review of the NSW Incident Information Management System (IIMS) shows that in 2013, 22,171 clinical incidents with a principal incident type of “medications” and “IV fluids” were reported. Improvements can be made to the way medications are managed in NSW public hospitals.

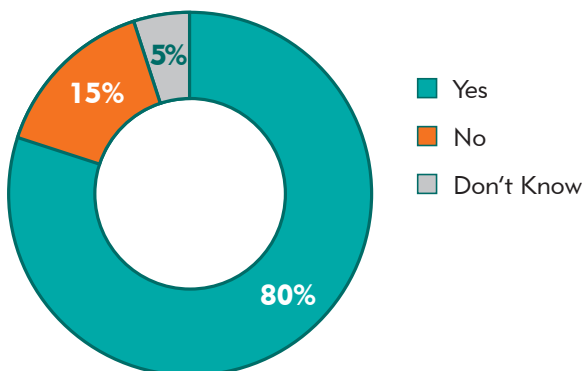
Seventy-seven per cent of units completing the 2013 QSA indicated that they “prescribe or manage patients with high-risk medications”. Analgesics, antithrombotic agents and drugs used in diabetes and psycholeptics were commonly identified in the top three high-risk medications used in the department or clinical unit.

A number of units that did not identify that they prescribe or manage high-risk medications were categorised as surgery, general medical, mental health, emergency; and aged care/geriatrics. There may be opportunity to improve high-risk medication identification in these units.

The NSW Health High-Risk Medicines Management policy (PD2012_003) states that all high-risk medicines must be recorded on an up-to-date register.

There is also opportunity for gains in monitoring and feedback processes that drive improvement. Of the clinical units that do identify local high-risk medicine usage, 48 per cent have an internal audit program to monitor and assess their usage. Of those who audit, seven per cent have no feedback process, 66 per cent present the results at a clinical meeting and 41 per cent discuss the results directly with the individual prescribers.

Has the department or clinical unit developed and implemented a standardised process or protocol to manage use of the above identified medications?



Recommendation 4

Local teams ensure high safety local management of high-risk medications, specifically:

1. Identification of local high-risk medicine usage.
2. Standard processes are developed for the use and review of high-risk medicines that are frequently or infrequently used.

What we saw during on-site visits

Most sites manage high-risk medications extremely well. Local innovations demonstrate that local clinical teams invest significant effort to develop and implement protocols for usage. Common themes identified for improvement relate to facility and organisation-level governance, support and consistency for protocols and processes, auditing, improvement strategies and education.

OPPORTUNITY

Medication safety walk-round checklists are used in some facilities to provide a snapshot of a unit's processes and to track improvements in the handling of high-risk medicines.

For more information or useful resources on [High-Risk Medicines](#), please contact CEC's Medication Safety and Quality team: medicationsafety@cec.health.nsw.gov.au

Good clinical care to prevent falls and harm from falls

While the overwhelming majority of serious falls among older people occur in the community, the risk of patient falls during a hospital stay should be reduced. Inside our health services, 27,591 fall incidents were reported to have occurred in 2013. Of these, 461 were critical Severity Assessment Code (SAC) 1 and SAC 2 incidents.

Engagement with falls prevention strategies is widespread across the NSW public hospital system, with 90 per cent of clinical units indicating that they have a standardised approach for management of patients at risk of falls.

The theme for the [NSW April Falls Day in 2014](#) was “Medicate right to stay upright”. It provided a focus on improving awareness of the role of medication management in reducing the risk of falls. Fifty-six per cent of units reported that they review patient medications with the goal of eliminating or replacing any unnecessary drugs or those that increase the risk of falls or severity of fall-related injury.

Clinical units are “always” or “often” providing relevant targeted clinical assessments as part of local falls risk screening and assessment processes, including malnutrition screening (61 per cent), cognitive assessment (64 per cent) and delirium assessment (56 per cent).

Patients who have a fall during the admission “always” or “often” have a standardised approach or protocol implemented around assessment and management.

83%

Following a fall, the patient is rescreened and a new management plan developed.

78%

Relevant NSW Health policies in this section

PD2011_029 – Prevention of falls and harm from falls among older people

Recommendation 5

Local teams continue improvements to prevent falls and harm from falls, including:

1. Embedding targeted clinical risk assessments
2. Standardising protocols that ensure patients are rescreened and new management plans are developed following falls
3. Optimising medication management.

More work can be done to ensure that medication reviews and complex clinical assessments are included in standard falls risk-management processes.

What we saw during on-site visits

Evidence from the site visits mirrored the Self-Assessment findings, in that falls prevention strategies are highly evolved across most of NSW. Where local recommendations were identified, they were most commonly aimed at optimising medications to reduce falls risks and increasing the uptake of cognitive, delirium and malnutrition screening.

For more information regarding [Falls Prevention](#), please contact CEC’s Falls Prevention team: falls@cec.health.nsw.gov.au

Community health: integrating care

Generally, patients/clients spend far more time within their community than they do within the acute hospital setting.

In this first year of inclusion with the QSA, questions tailored to community health focused on clinical review meetings and wound management.

Most Community Health units indicated there is a regularly scheduled meeting, with the purpose of reviewing patient safety and quality issues. Sixty-one per cent of units indicated that meetings are attended by staff from more than one discipline. Forty-three per cent responded that reports/minutes of meetings are forwarded to the district's clinical governance committee or equivalent, to identify issues that need to be addressed across the services. This suggests that there is scope to improve the conduct and governance of the meetings to ensure the best outcomes for patients.

The capacity for more complex care to be provided in the home, or in community health settings, has increased.

Wound management is one example of health care that is now delivered primarily outside the acute hospital setting.

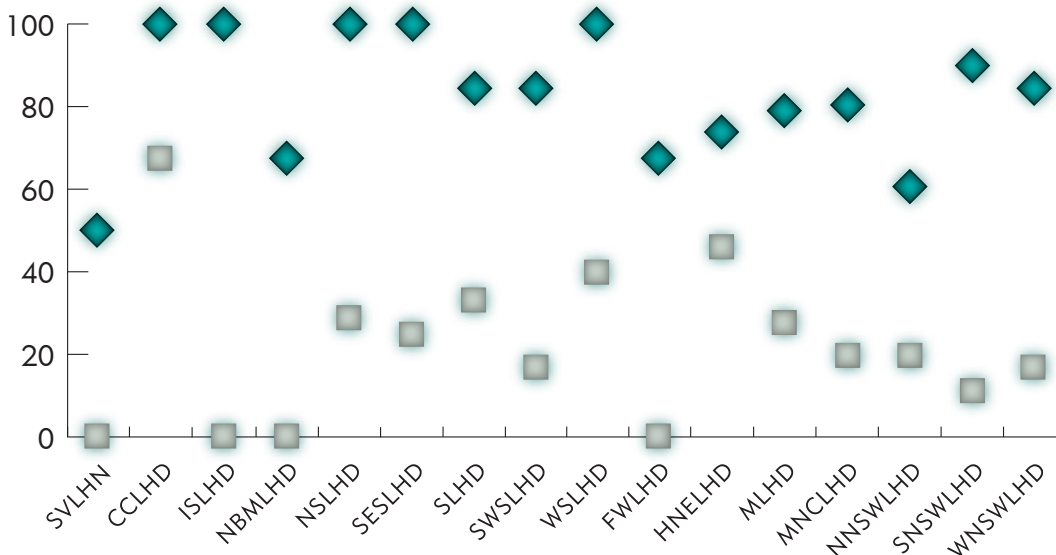
Recommendation 6

Local teams improve systems for patient care, with appropriate local integration of planning, monitoring and improvement processes between acute and community health, including:

1. Integration of relevant clinical governance systems.
2. Escalating and accessing wound management expertise at the time it is needed.

The Self-Assessment results demonstrate a commitment to striving for wound management best-practice protocols, yet there remains an opportunity to improve use of review processes and available wound management expertise.

Community health units identify that they have access to wound management experts when required, but show lower implementation of processes to escalate care to the experts when needed.



- ◆ % of units with best practice guidelines and/or local protocols in place or available in relation to the overarching wound management model of care
- % of units with a formalised process in place to monitor the length of time a client remains on the "books" without referral to a wound management expert or escalating client management

Ensuring excellence in environmental cleanliness

The Ambulance Service of NSW (ASNSW) proactively reviewed the topic of environmental cleanliness as part of a tailored QSA Self-Assessment in 2013.

While these findings are specific to ASNSW, they are relevant for consideration across all care settings in the NSW health system.

Paramedics and emergency retrieval teams have very little control of the cleanliness of the environment when they provide clinical care at the scene of an incident (eg: they could be providing care at an industrial scene, under a train, or at the scene of a motor vehicle accident).

Information on the past history, or infectious status of the patient, may also be unavailable if the patient is unconscious or otherwise incapacitated.

Thirty-eight per cent of respondents indicated that they have a policy or guideline in place that provides a standardised approach for environmental cleaning for all ambulance stations or vehicles. Effective environmental cleaning approaches may vary across ambulance zones and stations, due to the changing environments in which they work.

Healthcare associated infections (HAIs) are one of the most common adverse events impacting patients in our health system. They number around 200,000 incidents in Australian health facilities each year, causing great suffering to patients and costing an estimated two million bed days each year. A HAI is a potentially preventable adverse event, rather than an unpredictable complication in health. The prevention of HAIs is a key commitment of NSW Health for patients and aligns with the National Safety and Quality Health Service Standards.

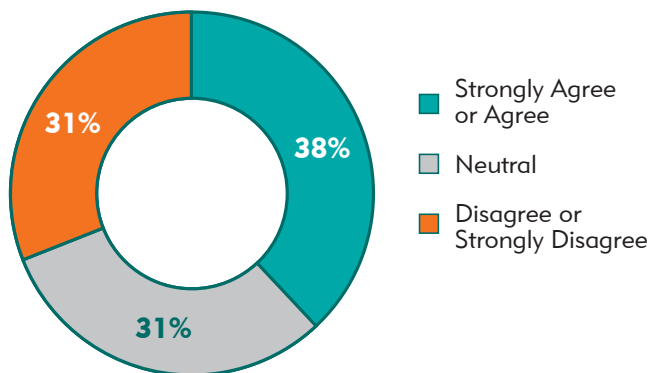
Environmental cleaning is an important component of a systems approach to reducing HAIs. NSW Health policy ([PD2012_061](#)) acknowledges that all public health organisations and their staff have a duty of care under common law, to take all reasonable steps to safeguard patients, visitors and staff from infection.

Relevant NSW Health policies in this section
[PD2012_061](#) – NSW Environmental Cleaning Policy

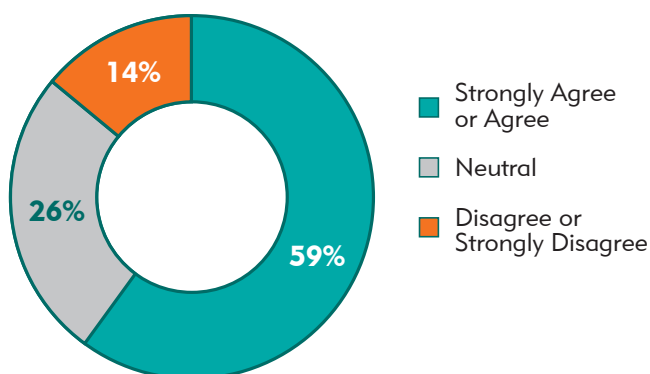
Recommendation 7

The Ambulance Service of NSW should review existing local environmental cleaning processes, to identify and implement improvements that minimise the risk of infection to patients and staff.

Patients are treated in physical environments that minimise the risk of infection



The cleanliness of ambulance vehicles in our station or zone meets necessary standards



For more information regarding *Healthcare Associated Infections*, please contact CEC's HAI team: hai@cec.health.nsw.gov.au

Alignment with national standards

It is important that local efforts to learn, spread, share and improve upon the results of the QSA in 2013 align, wherever possible, with existing local work portfolios. Local efforts to meet the National Safety and Quality Health Service Standards (national standards) is one such important factor to consider.

Each of the commitments and recommendations in this report has a primary alignment with one of the national standards.

The QSA team continues to work with local teams to ensure that QSA effort, processes and outcomes support local efforts for accreditation against each national standard, criterion and required action.

Depending on local QSA results and priorities for actions, efforts to address the commitments and recommendations can also contribute to a number of other national standards.

For example, where a local team improves medication reconciliation at transitions of care, they will also be able to align that effort with National Standard 4.8 (Medication Safety). The clinical workforce reviewing the patient's current medication orders against his or her medication history and prescriber's medication plan, and reconciling any discrepancies.

The primary purpose of the QSA is to identify and reduce risk that may cause patient harm. This is done through a vehicle that embraces collaborative efforts to learn, spread, share and improve upon the excellence that already exists within the NSW health system.

While direct alignment with national standards accreditation efforts is not the primary outcome of QSA, this is understandably an important consideration for local teams when determining their priority areas for action, based on local results.

Primary alignment of 2013 QSA state-level recommendations against the National Safety and Quality Health Service Standards



	Patient Safety Culture	Patient-Based Care	Rec 1 – Transition of Care	Rec 2 – Antimicrobial Stewardship	Rec 3 – Venous Thromboembolism	Rec 4 – High-Risk Medications	Rec 5 – Falls Prevention	Rec 6 – Community Integration	Rec 7 – Environmental Cleaning
	✓	✓	✓	✓	✓	✓	✓	✓	✓
	✓	✓	✓	✓	✓	✓	✓	✓	✓
			✓					✓	
				✓	✓				
			✓						
							✓		
						✓			

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Thank you for your care.

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- The directors of clinical governance and all staff in their clinical governance units
- The QSA co-ordinators who support and manage the QSA at the local level
- The staff who volunteer to be assessors in the on-site visit program
- The clinicians who assisted the QSA team in the self-assessment tool development and data analysis.

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NOTES



Clinical Excellence Commission
Level 13, 227 Elizabeth St
SYDNEY NSW 2000
02 9269 5500

www.cec.health.nsw.gov.au



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