Key achievements of the Australian Council for Safety and Quality in Health Care

Supporting the workforce

National Standard for credentialling and defining the scope of clinical practice of medical practitioners (2004): The Council developed an agreed approach to credentialling and produced the National Standard. Support materials to assist in implementation were developed and distributed.

National Patient Safety Education Framework (2005): The National Patient Safety Education Framework sets out the required skills, knowledge and behaviour in regard to patient safety. It recognises education as a foundation element for redesigning systems and facilitating a sustainable culture of safety and quality in health care. Already there is great interest in the Framework from universities and the vocational education and training sector, as well as international organisations.

Measurement for improvement

Agreed National List of Core Sentinel Events (2003): Sentinel events are adverse events that cause serious harm to patients. A national core set of sentinel events has been agreed with all jurisdictions, and a national report is being developed to measure and learn from events that cause death or serious harm to patients.

Charting the safety and quality of health care in Australia (2005): This publication assembled data to provide health care providers, policy makers and consumers with a comprehensive overview of what is known about the safety and quality of the Australian health care system.

Measurement for Improvement Toolkit (2005): This is a practical toolkit of ways to measure the safety and quality of clinical services.

Patient Safety Risk Management Plans (2004): The Council worked with all jurisdictions to develop national specifications for incident reporting and management systems, including the use of root cause analysis. Each jurisdiction now has consistent incident management systems.

Working with consumers

10 tips for safer health care (2003): More than 100 000 copies of this booklet have been produced and distributed to help people understand health care safety and become more actively involved in their health care. It is also available in 15 community languages and is being widely distributed to patients at or before the time of admission. It has also been adopted by some private insurers.

Open Disclosure Standard: a National Standard for open communication in public and private hospitals, following an adverse event in health care (2003): The Open Disclosure Standard was produced in 2003. It aims to encourage greater openness around adverse events, through acknowledging when things go wrong, and providing reassurance to patients and their carers that lessons learned will help prevent a recurrence of the event.

Practice improvements

National Strategy to Address Health Care Associated Infections (2003): Health care-associated infections are a leading cause of adverse events. There is national agreement on key definitions regarding health care-associated infections, as well as surveillance templates, and production of clinical guides for health professionals to reduce harm.

High risk medication alerts (2003 and 2005): High risk medication alerts on intravenous potassium chloride (2003) and vincristine (2005) have been released, so that action is taken on known hazards with potentially catastrophic outcomes.

Ensuring Correct Patient, Correct Site, Correct Procedure Protocol (2004): The Protocol was developed in 2004 to help prevent procedures being carried out on the wrong patient or body part, an event that can cause serious harm and distress to patients. This is an evidence-based tool that is being widely used by the Royal Australasian College of Surgeons, and in a wide variety of settings around Australia.

Redesign and information technology

National Inpatient Medication Chart (2004): The National Inpatient Medication Chart was developed in consultation with a wide group of stakeholders to reduce harm resulting from error in the prescribing, supply and administering of medications. All jurisdictions have participated in the pilot of the chart, which precedes a national roll-out of this initiative.

Governance and investment

Centre for Research Excellence (2004): The Council has forged a partnership with the National Health and Medical Research Council to form a Centre of Research Excellence in Patient Safety, located at Monash University in Victoria. The Centre will provide the evidence base for sustainable and well researched improvements to the safety and quality of Australia's health system.

Australian Research Council Linkage Grant: The Council developed an industry partnership with ACT Health and the Australian National University, and was awarded an Australian Research Council Linkage Project Grant. This project aims to identify and develop promising regulatory strategies for improving safety and quality. *The governance of health safety and quality* discussion paper was published in July 2005 as the basis for the future directions of this project. ❑