Governance Audit Tools Definitions

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The following definition applies to the Governance Audit Tools:

1. **Open Disclosure Program**

   An Open Disclosure Program is a program that supports and encourages the open, effective and timely disclosure of an unintended outcome to the patient and/or their family. This is achieved through the training of all staff whose role requires them to undertake this form of disclosure and a defined process for initiating disclosure. For Hospital and Health Services, the minimum requirement is that a register of trained staff is kept; an offer of Formal Open Disclosure is made following every SAC 1 incident and an Open Disclosure Consultant (ODC) is used for all Formal Open Disclosure meetings.

Further information can be found at:

2. ACUTE Clinical Record Audit Tools

The following definitions and examples apply to the ACUTE Clinical Record Audit Tools:

Medico-legal:
1. Patient Registration Form/Patient Election Form
2. Nursing Assessment / Care Plan

Medication Safety:
1. National Inpatient Medication Chart (NIMC), Paediatric National Inpatient Medication Chart (PNIMC), Medication Action Plan (MAP) and Medication History
2. Allergies and Adverse Drug Reactions (ADR)
3. VTE Risk Assessment

Blood Products:
1. Crossmatch Report
2. Blood and blood products transfusion consent
3. Documentation of adverse reaction, blood prescription and transfusion observations

Maternity:
1. Intrapartum Record
2. Vaginal / Caesarean Pathway
3. Assisted Birth Record
4. Perinatal Morbidity Form

Surgical:
1. Surgical Safety Checklist
2. Perioperative Patient Record
3. Procedure Informed Consent
4. Intraoperative Record
5. Operation record
6. Sterility Validation Tracking and Prosthesis Used
7. Perioperative Count Record
8. Anaesthetic Record

Discharge:
1. Discharge Summary

Clinical Deterioration:
1. ADDS / CEWT or General Observation Chart

Pressure Injury / Falls / Malnutrition
1. Patient Risk Assessments
2. Patient Care Plans

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Medico-legal
Patient Registration Form / Patient Election Form

Patient Care Plan / Nursing Assessment
Medication Safety
National Inpatient Medication Chart (NIMC), Paediatric National Inpatient Medication Chart (PNIMC) and Medication Action Plan (MAP)

There are a number of questions on the audit tools targeted at documented evidence on the NIMC, PNIMC or MAP. Screen shots of each of the 3 documents are displayed below.
Medication History

Questions on the patient audit tool require evidence of a medication history. The Medication History can be documented in the Medicines Prior to Presentation to Hospital section located either at the bottom of page 1 of the NIMC OR, alternatively, in the Medication Action Plan (MAP) form.

NIMC - Medicines Prior to Presentation to Hospital section

MAP - Medicines Prior to Presentation to Hospital section

For the medication history section to be complete, the Medicines Prior to Presentation to Hospital section needs to be recorded on at least one medication chart or MAP form that is in current use.

A complete medication history requires:

- drug identification details (generic name, strength and form)
- dose and frequency
- duration of therapy, i.e. when started
- the person documenting the history has signed, printed their name and dated the entry
Allergies and Adverse Drug Reactions (ADR)

Questions 3.0 & 3.1 on the patient audit tool require evidence of medication allergies and adverse drug reactions.

The allergies and adverse drug reactions section is located in the top left corner of the NIMC.

For this section to be complete, either:

‘Nil Known’ box is ticked

OR the ‘Unknown’ box is ticked

OR the name of the drug / substance, the reaction details (e.g. rash, nausea) and the date the reaction occurred or approximate timeframe (e.g. “20 years ago”) is documented.

In the case where an adverse reaction is documented, an ADR alert sticker must also be attached on the front and back page of the NIMC and the person documenting the ADR status must have signed, printed their name and dated the entry on all NIMCs in use.
VTE Risk Assessment

Questions 7.0 & 7.1 on the patient audit tool require evidence of a Venous Thromboembolism (VTE) risk assessment. VTE comprises deep vein thrombosis (DVT) and pulmonary embolism (PE). It is a significant problem for medical and surgical patients, leading to an increased risk of morbidity and mortality. Options for thromboprophylaxis include anticoagulants and mechanical prophylaxis.

The NIMC facilitates the prescribing of these prophylaxis methods by providing:

- an area to document that the patient’s VTE risk has been assessed and to record contraindications to VTE prophylaxis as relevant
- a designated section for prescribing of anticoagulants for VTE prophylaxis
- a designated section for the prescribing of mechanical prophylaxis such as graduated compression stockings or intermittent pneumatic compression devices

For this section to be complete:

1. The VTE risk assessed box is signed and dated on the NIMC/medication chart
2. OR
   - The VTE risk assessment is clearly documented on a site specific chart.

An example of a site specific chart for documenting VTE risk assessment
Further information can be found at:


**Blood and Blood Products Crossmatch Report**

![Blood and Blood Products Crossmatch Report Image]

**Blood and blood products transfusion consent**

![Blood and Blood Products Transfusion Consent Images]
Documentation of adverse reaction, blood prescription and transfusion observations

Example of a document used by Metro South that includes prescription, observations and adverse reactions
IV and SC Fluid Order form.

Q-ADDS form
Example of an Observation Record – used by The Townsville Hospital

Further information can be found at:

- BloodSafe eLearning Australia: [https://www.bloodsafelearning.org.au/](https://www.bloodsafelearning.org.au/)
The state-wide neonatal clinical pathway is used in all Hospital and Health Service birthing facilities. This clinical pathway is a standardised, evidenced-based multidisciplinary management plan, which identifies an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for the baby.
The section ‘Baby Identification is checked and correct’ is complete at 2-24hr in the pathway when:
1. The pathway is signed by minimum two staff and if variance, the variance noted.
   OR
2. The pathway is signed by one staff member and a witness to birth i.e. partner.

On transition to the ward area staff from the birth suite hand over responsibility of care to ward staff – baby is identified by both members of the staff at this clinical handover of care.

**Perinatal Morbidity Form**

**Surgical Safety Checklist**

The tools incorporate key questions to audit patient identification in the surgical safety checklist, as highlighted below.

For Queensland Health staff, please go to QHEPS for further information on the Surgical Safety Checklist and the 3C’s.
Perioperative Patient Record
The tools incorporate key questions to audit patient identification in the perioperative patient record, as highlighted below.

For Queensland Health staff, please go to QHEPS for further information on the Perioperative Patient Record Pathway.

Procedure Informed Consent Form
The tools incorporate key questions to audit patient identification in the informed consent form, as highlighted below.

**Intraoperative Record**
Operation Record

**Paper – written record**

**Example – ORMIS printed record**

**Sterility Validation Tracking and Prosthesis Used**
Clinical Deterioration Observation Chart

Ensuring that patients who deteriorate receive appropriate and timely care is a key safety and quality challenge. All patients should receive comprehensive care regardless of their location in the hospital or the time of day. Even though a range of systems have been introduced to better manage clinical deterioration, this area needs to remain a high priority while patients continue to experience preventable adverse events because their deterioration is not identified or properly managed.

The **objective of an observation chart is to present the most important vital signs for detecting deterioration** in most patients in a user-friendly manner. One of its specific aims is to detect deterioration rather than being a general observation chart.

One of the factors that can contribute both to poor recording of observations and failure to interpret them correctly is the way in which observation charts are designed and used. The use of human factors principles in their design supports accurate and timely recognition of clinical deterioration, and prompts action when deterioration is observed.

Many types of general observation charts exist. Examples of the various types of tools are shown here to assist you in determining which tool your facility/ward uses.

a) **Single parameter tool (track and trigger)** - Vital signs are compared with a simple set of criteria with predefined thresholds, with a **response algorithm being activated when any criterion is met**. The main vital signs are graphed so that trends can be easily ‘tracked’. There are also colour coded zones to indicate when patient observations are likely to represent deterioration, where a response is ‘triggered’. Incorporating call criteria in observation charts is an effective way in which to highlight possible deterioration and assist clinicians with making decisions as to when to ‘trigger’ a response, whether that be for a clinical review or rapid response call.
b) Aggregate scoring system - Core observations attract a weighted Score. “Weighted scores are assigned to physiological values and compared with predefined trigger thresholds. The main vital signs are collected and points are allocated. The points for each observation are added to give a score that helps identify patients with subtle signs of deterioration. A supporting Action Plan triggers certain actions when certain scores are reached.

c) Combination system - Single or multiple parameter systems used in combination with aggregate weighted scoring systems.

Scores for all physiological parameters are summed up to obtain a total score.
Scores for all physiological parameters are summed up to obtain a total score.
d) Non track and trigger - Other observations charts may include the collection of vital signs with no scoring or no criteria for a response

**Acute Observation Chart**


Further information can be found at:

- Hospital and Health Services can access information on Recognition and Management of the Deteriorating Patient via the Patient Safety Unit intranet website.

**Pressure Injury / Falls / Malnutrition**

**Pressure Injury Risk Assessment**

Each patient is assessed for Pressure Injury Risk upon pre-admission and/or admission to hospital and within a minimum of eight hours. The use of the Waterlow tool is recommended for adults and the Glamorgan for paediatric patients. The results of Pressure Injury Risk assessment shall be documented in the appropriate admission form/nursing care plan or chart. Patients/residents shall be re-assessed at a minimum:

- weekly in hospital, subacute or rehabilitation and
- monthly in residential care settings or earlier if there is a change in status or in accordance with the needs of the resident as per their Geriatric Medical Assessment Care Plan and the requirements of the Aged Care Accreditation Standards Agency and
- when there is a change in the patient’s environment, health or functional status
- upon discharge.

A risk assessment tool is a formal scale or score used to help determine the degree of pressure injury risk. The tool identifies the risk of developing a pressure injury based on a score of rating scale to weight the severity of risk into categories of - no risk, low, medium or high risk. The use of the Waterlow tool is recommended for adults, others include Braden Scale and Norton Scale, these tools are validated and reliable scales for assessing pressure injury risk in adults. The Glamorgan scale can be used for paediatric patients and some facilities have integrated these tools into a comprehensive risk screening and assessment tool.
**WATERPROOF PRESSURE ULCER RISK ASSESSMENT TOOL**

1. Circle each score. Several scores per category can be calculated. Add totals to obtain risk score.

<table>
<thead>
<tr>
<th>Surface</th>
<th>Wound/Weight for Height</th>
<th>Special Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stable</td>
<td>Average Weight</td>
<td>Body mass index</td>
</tr>
<tr>
<td>Unstable</td>
<td>Low or high weight</td>
<td>Lower limb edema</td>
</tr>
<tr>
<td>Malnourished</td>
<td>Underweight</td>
<td>Paraplegia</td>
</tr>
<tr>
<td>Malnourished</td>
<td>Weight Loss</td>
<td>Amputee</td>
</tr>
<tr>
<td>Malnourished</td>
<td>Ustainable weight</td>
<td>Sensory impairment</td>
</tr>
<tr>
<td>Malnourished</td>
<td>Weight loss</td>
<td>Prolonged intubation</td>
</tr>
<tr>
<td>Malnourished</td>
<td>Weight loss</td>
<td>Impaired bowel function</td>
</tr>
<tr>
<td>Malnourished</td>
<td>Weight loss</td>
<td>Severe motor impairment</td>
</tr>
<tr>
<td>Malnourished</td>
<td>Weight loss</td>
<td>Severe sensory impairment</td>
</tr>
<tr>
<td>Malnourished</td>
<td>Weight loss</td>
<td>Severe cognitive impairment</td>
</tr>
<tr>
<td>Malnourished</td>
<td>Weight loss</td>
<td>Severe respiratory impairment</td>
</tr>
</tbody>
</table>

**MOBILITY**

- Limited mobility
- Bedridden
- In wheelchair
- Limited ability to move
- Unable to move

**COMORBIDITIES**

- Cardiovascular disease
- Respiratory disease
- Cancer
- Chronic neurological disease
- Chronic renal disease
- Chronic liver disease

**MAJOR SURGERY OR TUMOR**

- Major surgery or tumor
- Major burn
- Major trauma

**Total Score**

- 0 = No risk
- 1 = Low risk
- 2 = Moderate risk
- 3 = Very high risk

**DOCUMENT THE RISK ASSESSMENT IN THE MEDICAL RECORD CHART**

Waterproof Tool: modified and reproduced with permission of Judy McLean in 2001.

**BRADEN Q SCALE**

A risk assessment to be completed on admission and each 24 hours for patients with decreased level of mobility in relation to developmental age. Evidence of pressure ulcers will be defined using the classification system (stage 1 to 4).

<table>
<thead>
<tr>
<th>Immobility and Duration of Pressure</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>No = Duration of pressure is 0 days</td>
<td>50</td>
</tr>
<tr>
<td>1 day</td>
<td>40</td>
</tr>
<tr>
<td>2 days</td>
<td>30</td>
</tr>
<tr>
<td>3 days</td>
<td>20</td>
</tr>
<tr>
<td>4 days</td>
<td>10</td>
</tr>
<tr>
<td>5 days</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tolerance of the Skin and Supporting Structure</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>No = Tolerance of skin and supporting structure is intact</td>
<td>50</td>
</tr>
<tr>
<td>1 = Tolerance of skin and supporting structure is intact but there is a loss of subcutaneous tissue</td>
<td>40</td>
</tr>
<tr>
<td>2 = Tolerance of skin and supporting structure is intact but there is a loss of subcutaneous tissue and bone</td>
<td>30</td>
</tr>
<tr>
<td>3 = Tolerance of skin and supporting structure is intact but there is a loss of subcutaneous tissue, bone, and muscle</td>
<td>20</td>
</tr>
<tr>
<td>4 = Tolerance of skin and supporting structure is intact but there is a loss of subcutaneous tissue, bone, muscle, and skin</td>
<td>10</td>
</tr>
<tr>
<td>5 = Tolerance of skin and supporting structure is intact but there is a loss of subcutaneous tissue, bone, muscle, and skin</td>
<td>0</td>
</tr>
</tbody>
</table>

**Patient on Risk:**

- Low Risk
- Medium Risk
- High Risk
- Very High Risk

Notes:...

NSQHS Standard 1 Governance – Definitions sheet
V3.0 8/12/2014
Falls Screen and Risk Assessment

A falls risk screen determines which people are at greatest risk of falling. A minimum falls risk screen would be a single item question ‘Have you had a fall in the last 12 months?’. Typically the screen consists of a small number of items (up to five) based on presence or absence of a risk factor. When the threshold on a falls screening is exceeded it would prompt a more detailed falls risk assessment. A falls risk screen should be undertaken when a change in health or function status is evident or when the patient’s environment changes e.g. on admission. It should be noted that falls risk screening does not provide a framework for planning interventions, it merely tries to measure the level of risk an individual has for future falls within a particular time period or setting.

Falls risk screening is not necessary in cohorts of patients already known to be at risk of falls, e.g. in high care residential aged care facilities.

A falls risk assessment is a more detailed process than screening and is used to identify modifiable risk factors for falling, appropriate interventions and referral pathways. An assessment systematically and comprehensively identifies factors contributing to a patient’s increased risk of falling. Falls risk assessment tools vary in the number of risk factors they include, and how each risk factor is assessed.

Note: Interventions should systematically address the risk factors identified. You will need to look at the assessment tools and compare the risk factors identified to what strategies are recorded in the care plan and/or on the assessment tool.
Falls Prevention Plan (FPP)

A falls prevention plan documents interventions that systematically address the risk factors identified. Note: You will need to look at the assessment tools and compare the risk factors identified to what strategies are recorded in the care plan and/or on the assessment tool.

Actions in a FPP are located on the right of the Plan. For the FPP to be complete, the date and signature are required for ALL risks or as actions documented in the nursing care plan.

Select YES if there is evidence at the bedside that all risk factor/s identified in the falls assessment have a relevant strategy or strategies identified in the care plan. Select NO if one or more risk factor/s identified on the falls assessment does not have at least one relevant strategy identified in the care plan.

Further information can be found at:


For Queensland Health staff, please go to QHEPS for further information on Pressure Injury Prevention.
We recognise and appreciate that there may be gaps in the scope and questions included in these tools, however, as this is a ‘Work in Progress’, future versions will build upon the existing scope and questions, and incorporate staff feedback and suggestions for improvement.

The Patient Safety and Quality Improvement Service, Clinical Excellence Division, welcomes feedback on the audit tools and the measurement plans, to ensure the tools meet the needs of Hospital and Health Services. We appreciate any feedback you can provide for the next version.

Please email Patient Safety and Quality Improvement Service on PSQIS_Comms@health.qld.gov.au for feedback or comments.