National Safety and Quality Health Service Standards
Standard 5 Patient Identification and Procedure Matching - MEASUREMENT PLAN

Note: The measurement plan details the criteria / action and those question/s / responses that correspond to the action. Some questions may be used by the facility to demonstrate evidence for other actions, in addition to the action it has been aligned with.

Criteria	Rationale	This criterion will be achieved by:	Actions required	Audit Tool	Goal	Indicator	Question on Audit Tool	Response options	Numerator	Denominator	Exclusions
Identification of individual patients	At least three approved patient identifiers are used when providing care, therapy or services.	5.1 Developing, implementing and regularly reviewing the effectiveness of a patient identification system including the associated policies, procedures and/or protocols that: • define approved patient identifiers • require at least three approved patient identifiers on registration or admission • require at least three approved patient identifiers when care, therapy or other services are provided • require at least three approved patient identifiers whenever clinical handover, patient transfer or discharge documentation is generated	5.1.1 Use of an organisation-wide patient identification system is regularly monitored	Facility	Identify if the facility has a patient identification system policy, procedure and/or protocol	Evidence of a patient identification system policy, procedure and/or protocol	1.0 Is there evidence that the facility (or at service level) has a patient identification system policy, procedure and/or protocol? 1.1 If yes to 1.0: Do the policies, procedures and/or protocols define the approved patient identifiers for all clinical services? 1.2 If yes to 1.0: Do the policies, procedures and/or protocols define at least three patient identifiers to be recorded in the patient clinical records? 1.3 If yes to 1.0: Do the policies, procedures and/or protocols define the specifications for a standard patient identification band (as per national specifications)? 1.4 If yes to 1.0: Are the policies, procedures and/or protocols tabled at a governance committee/s or group meeting/s? 1.5 If yes to 1.4: If yes: Specify the committee/group. 1.6 If yes to 1.4: Do the terms of reference detail the overseeing of policies, procedures and/or protocols for patient identification systems? 1.7 If yes to 1.0: Do the policies, procedures and/or protocols define the audit process to be undertaken to assess against them? 1.8 If yes to 1.0: Do the policies, procedures and/or protocols reference the consultation processes or collaborative group/s involved in their development? 1.9 If yes to 1.0: Do the policies, procedures and/or protocols detail the date they became effective? 1.10 If yes to 1.0: Do the policies, procedures and/or protocols detail the date of the next revision? 1.11 If yes to 1.0: Do the policies, procedures and/or protocols reference the source documents (if applicable) particularly where they are represented as best practice? 1.12 If yes to 1.0: Does the workforce know the documents exist, can access them and know and use the contents? 1.13 If yes to 1.0: Outline details of the documents, where kept, review date/s and the 'owner'.	Yes ; No Yes; No Yes; No Yes; No Yes; No text box Yes; No Yes; No Yes; No Yes; No Yes; No Yes; No; N/A Yes; No text box			
			5.1.2 Action is taken to improve compliance with the patient identification matching system	Facility	Identify if the facility has an evaluation and quality improvement plan in place	Evidence the facility has an evaluation and quality improvement plan in place	3.0 Is there evidence that the facility (or at service level) has an evaluation and quality improvement plan/s in place to reduce patient identification incidents? 3.1 If yes: What sources of data/information led to the development of the plan e.g. PRIME, Queensland Bedside Audit, other data sources? 3.2 If yes to 3.0: Is there evidence that the plan/s record quality improvement action/s to be implemented? 3.3 If yes to 3.2: List the actions as per plan. 3.4 If yes to 3.0: Is there evidence that the plan/s include a risk register for the proposed quality improvement actions? 3.5 If yes to 3.4: Does the risk register include a scale to rate risks? 3.6 If yes to 3.4: Are the risks reviewed on a regular basis? 3.7 If yes to 3.0: Is there evidence that the plan/s includes mechanisms for evaluating the quality improvement actions? 3.8 If yes to 3.0: Is there evidence that the plan/s are tabled at a committee/group? 3.9 If yes to 3.8: Which committee/group? 3.10 If yes to 3.0: Who assisted in the development of the plan/s? 3.11 If yes to 3.0: Is there evidence the workforce know the plan/s exist? 3.12 If yes to 3.0: Outline who the 'owner' is, the clinical lead, where the plans are filed and how often they are reviewed.	Yes; No text box Yes; No text box Yes; No Yes; No Yes; No Yes; No text box text box Yes; No text box			
				Facility		% of wards/units with an evaluation and quality improvement plan in place	7.0 What is the number of wards/units that have evaluation and quality improvement plan/s in place to reduce patient identification incidents? (PatID_Ward_Q1.0) 7.1 List the sources of data/information that led to the development of the plan/s. (PatID_Ward_Q1.1) 7.2 What is the number of wards/units where the plan/s record quality improvement action/s to be implemented? (PatID_Ward_Q1.2) 7.3 List the actions as per plan. (PatID_Ward_Q1.3) 7.4 What is the number of wards/units where the plan/s include a risk register for the proposed quality improvement actions? (PatID_Ward_Q1.4) 7.5 What is the number of wards/units that have a risk register that includes a scale to rate risks? (PatID_Ward_Q1.5) 7.6 What is the number of wards/units where risks are reviewed on a regular basis? (PatID_Ward_Q1.6) 7.7 What is the number of wards/units where the plan/s includes mechanisms for evaluating the quality improvement actions? (PatID_Ward_Q1.7) 7.8 What is the number of wards/units where the plan/s are tabled at a committee/group? (PatID_Ward_Q1.8) 7.9 List the committees/groups? (PatID_Ward_Q1.9) 7.10 List the persons who assisted in the development of the plan/s? (PatID_Ward_Q1.10) 7.11 What is the number of wards/units where the workforce know the plan/s exist? (PatID_Ward_Q1.11) 7.12 Outline who the 'owners' are, the clinical leads, where the plans are filed and how often they are reviewed.(PatID_Ward_Q1.12)	Number of wards/units who have; Total number of wards audited	Number of wards/units with an evaluation and quality improvement plan in place	Total number of wards/units audited	
				Ward		Evidence that the ward/unit has an evaluation and quality improvement plan in place	1.0 Is there evidence that the ward/unit has an evaluation and quality improvement plan/s in place to reduce patient identification incidents? (N/A for facility or service level responses and report at facility level) 1.1 If yes: What sources of data/information led to the development of the plan eg. PRIME, Queensland Bedside Audit, other data sources? 1.2 If yes to 1.0: Is there evidence that the plan/s record quality improvement action/s to be implemented? 1.3 If yes to 1.2: List the actions as per plan. 1.4 If yes to 1.0: Is there evidence that the plan/s include a risk register for the proposed quality improvement actions? 1.5 If yes to 1.4: Does the risk register include a scale to rate risks? 1.6 If yes to 1.4: Are the risks reviewed on a regular basis? 1.7 If yes to 1.0: Is there evidence that the plan/s includes mechanisms for evaluating the quality improvement actions? 1.8 If yes to 1.0: Is there evidence that the plan/s are tabled at a committee/group? 1.9 If yes to 1.8: Which committee/group? 1.10 If yes to 1.0: Who assisted in the development of the plan/s? 1.11 If yes to 1.0: Is there evidence the workforce know the plan/s exist? 1.12 If yes to 1.0: Outline who the 'owner' is, the clinical lead, where the plans are filed and how often they are reviewed.	Yes; No text box Yes; No text box Yes; No Yes; No Yes; No Yes; No text box text box Yes; No text box			
				Facility	Identify if the facility provides orientation and training to staff on patient identification and procedure matching and the reporting system	Evidence the facility provides orientation and training to staff on patient identification and procedure matching and the reporting system	4.0 Is there evidence that the facility (or at service level) provides orientation and training to staff on patient identification and procedure matching and the reporting system? 4.1 If yes: Is there evidence that attendance at the training sessions is recorded? 4.2 If yes to 4.0: Is there evidence that training is matched to staff training needs? 4.3 If yes to 4.0: Is there evidence that staff feedback reports of the sessions are evaluated and incorporated into the next revision? 4.4 If yes to 4.0: Provide comments on the training sessions and resources that are provided and when.	Yes; No Yes; No Yes; No Yes; No text box			

Criteria	Rationale	This criterion will be achieved by:	Actions required	Audit Tool	Goal	Indicator	Question on Audit Tool	Response options	Numerator	Denominator	Exclusions
				Facility	Identify if the facility has communication material on patient identification and procedure matching for staff, patients.carers	Evidence the facility has communication material on patient identification and procedure matching for staff, patients.carers	5.0 Is there evidence that the facility (or at service level) has communication material on patient identification and procedure matching? 5.1 If yes: Is there evidence the material is aimed at staff? 5.2 If yes to 5.0: Is there evidence the material is aimed at patients/carers? 5.3 If yes to 5.0: Is there evidence the workforce is aware of the communication? 5.4 If yes to 5.0: Is there evidence of processes in place for routinely distributing the material? 5.5 If yes to 5.0: Is there evidence that the needs of culturally and linguistically diverse populations are taken into consideration? 5.6 If yes to 5.0: Is there evidence the communication strategies are evaluated and modified accordingly? 5.7 If yes to 5.0: Specify the format of the communication material (eg. poster, website) and the 'owner'.	Yes; No Yes; No Yes; No Yes; No Yes; No Yes; No Yes; No text box			
				Facility	Identify if the facility undertake audits that observe staff completing the surgical safety checklist.	% of wards/units that undertake audits that observe staff completing the surgical safety checklist	8.0 What is the number of wards/units that have undertaken audits that observe staff completing the surgical safety checklist. (PatID_Ward_Q2.0) 8.1 Provide details of when the audits were undertaken and the results of those staff that met the 'sign in' and 'time out' requirements. (PatID_Ward_Q2.1, Q2.2 and Q2.3)	Number of wards that were audited. Insert text box.	Number of wards/units that undertake audits that observe staff completing the surgical safety checklist	Total number of wards/units audited	
				Ward		Evidence that the ward/unit has undertaken audits that observe staff completing the surgical safety checklist	For each staff member that is being observed in the completion of the surgical safety checklist when with the patient, look for the following checks: At 'Sign In': 8.0 Was the patient's identity confirmed verbally with the patient or carer? 8.1 Was the surgical registrar or surgical representative present during the identity confirmation? 8.2 Was there a visual check of the operative site and side markings? 8.3 Was the intended procedure checked with the patient or carer? 8.4 Was intended procedure confirmed with the patient's consent form and/or medical chart? 8.5 Were responses from team members audible? At 'Time Out' 9.0 Were all operating team members made aware of all relevant patient identification and procedure details prior to commencement of surgery?	 Yes; No Yes; No Yes; No; Internal Yes; No Yes; No Yes; No Yes; No			
							2.0 What is the number of staff that have been observed in completing the surgical safety checklist? (PatID_Ward_Q's 8.0 to 8.5 Table) 2.1 Provide details of when the audit was undertaken andwhere etc. 2.2 Number of staff that met the 'sign in' requirements ie: all 6 items were met (PatID_Ward_Q's 8.0 to 8.5) 2.3 Number of staff that met the 'time out' requirements ie: the item on awareness was met (PatID_Ward_Q9.0)		Number of staff who meet the requirements	Total number of staff who were observed	
				Facility	Identify if the facility has undertaken Quality Improvement activities for patient identification and procedure matching	Evidence of Quality Improvement activities for patient identification and procedure matching	6.0 Is there evidence that the facility (or at service level) has undertaken Quality Improvement activities for patient identification and procedure matching? 6.1 If yes: Give details of the quality improvement activities, when these were undertaken and the outcome/s.	Yes; No text box			
		5.2 Implementing a robust organisationwide system of reporting, investigation and change management to respond to any patient care mismatching events	5.2.1 The system for reporting, investigating and analysis of patient care mismatching events is regularly monitored	Facility	Identify if the facility has an incident management system for reporting, investigating and analysing patient identification incidents	Evidence of an incident management system for reporting, investigating and analysing patient identification incidents	2.0 Is there evidence that the facility (or at service level) has an incident management system for reporting, investigating and analysing patient identification incidents? 2.1 If yes: Outline the system eg. PRIME 2.2 If yes to 2.0: Is this regularly monitored? 2.3 If yes to 2.2: when and by whom? 2.4 If yes to 2.0: Are reports developed using data in the system? 2.5 If yes to 2.4: Are the reports used to identify frequency and gaps? 2.6 If yes to 2.4: Are the reports tabled at a governance committee/group for review? 2.7 If yes to 2.6: Which governance committee/group?	Yes; No text box Yes; No text box Yes; No Yes; No Yes; No text box			
			5.2.2 Action is taken to reduce mismatching events	AS PER 5.1.2							
		5.3 Ensuring that when a patient identification band is used, it meets the national specifications for patient identification bands	5.3.1 Inpatient bands are used that meet the national specifications for patient identification bands	Patient	Identify patients in the ward/unit who had an identification band present.	% of patients with an identification band present	6.0 What method is used to identify the patient? Select only one method.	ID band ; Photo ID ; Other technology; None present	Number of patients with an identfcation band present	Total number of patients audited for method of patient identification	
				Ward			3.0 What is the number of patients that use IDband for the method of patient identification? (PatID_Patient_Q6.0)		Number of patients with an identfcation band present	Total number of patients audited for method of patient identification	
				Patient	Identify patients in the ward/unit who had a single patient identification band present only (white or red).	% of patients who had a single patient identification band present only (white or red)	7.0 If ID band: Is it a single ID band (one only)? 7.1 If a single ID band: Is it white or red?	Yes; No Yes; No	Number of patients who had a single patient identification band present only (white or red)	Total number of patients audited for identification band present	
				Ward			3.1 What is the number of patients who had a single patient identification band present only (white or red)? (PatID_Patient_Q7.0 & Q7.1)		Number of patients who had a single patient identification band present only (white or red)	Total number of patients audited for identification band present	
				Patient	Identify patients in the ward/unit who had all patient identification band details verified.	% of patients that had all patient identification band details verified	7.2 If a single ID band (white or red): Are the patient identification details correct?	Yes; No; Unable to verify at bedside	Number of patients that have all patient identification band details verified	Total number of patients audited with a single ID band (white or red)	
				Ward			3.2 What is the number of patients who had all patient identification details correct? (PatID_Patient_Q7.4)		Number of patients that have all patient identification band details verified	Total number of patients audited with a single ID band (white or red)	
				Patient	Identify newborns in the ward/unit who had identification documented in the neonatal pathway at the bedside as checked and correct within 24hr of birth	% of newborns who had identification documented in the neonatal pathway at the bedside as checked and correct within 24hr of birth	For maternity patients, 1.0 Is the newborn 'rooming in' (at the mother's bedside) on the ward with its mother? 1.1 If yes: Has the newborn's identification been checked and is correct within 24hr of birth as documented in the neonatal pathway at the bedside?	Yes ; No ; NA Yes ; No	Number of newborns who had identification documented in the neonatal pathway at the bedside as checked and correct within 24hr of birth	Total number of newborns 'rooming in' audited	
				Ward			3.3 What is the number of newborns who had identification documented in the neonatal pathway at the bedside as checked and correct within 24hr of birth? (PatID_Patient_Q1.1)		Number of newborns who had identification documented in the neonatal pathway at the bedside as checked and correct within 24hr of birth	Total number of newborns 'rooming in' audited	
				Patient	Identify patients in the ward/unit who had a single identification band (white or red) that had all core patient identifiers present on the identification	% of patients with a single identification band (white or red) who had all core patient identifiers present on the identification band	8.0 If a single ID band (white or red): What core identifiers are present on the identification band ? Select all that are present.	MRN; Name; DOB; Other	Number of patients who had all core patient identifiers present on the identification band	Total number of patients audited with a single ID band (white or red)	
				Ward			3.4 What is the number of patients with a single identification band (white or red) who had all core patient identifiers (MRN, Name, DOB) present on the identification band? (PatID_Patient_Q8.0)		Number of patients who had all core patient identifiers present on the identification band	Total number of patients audited with a single ID band (white or red)	

Criteria	Rationale	This criterion will be achieved by:	Actions required	Audit Tool	Goal	Indicator	Question on Audit Tool	Response options	Numerator	Denominator	Exclusions
				Patient	Identify patients in the ward/unit who had a single identification band (white or red) that had the patient identifiers in black text on a white background	% of patients with a single identification band (white or red) who had the patient identifiers in black text on a white background	9.0 If a single ID band (white or red): Are the identifiers in black text on a white background? 9.1 If yes: Are the identifiers legible?	Yes ; No Yes - hand written; Yes - typed; No	Number of patients who had the patient identifiers in black text on a white background	Total number of patients audited with a single ID band (white or red)	
				Ward			3.5 What is the number of patients with a single ID band (white or red) who had identifiers in black text on a white background? (PatID_Patient_Q9.0) 3.6 Out of the number with a single band who had identifiers in black text on a white background, what is the number who had legible identifiers? (PatID_Patient_Q9.1) What is the number of patients with a single band who had identifiers in black text on a white background? 3.7 Out the number with a single band who had legible identifiers, what is the number who had handwritten identifiers? (PatID_Patient_Q9.1) 3.8 Out the number with a single band who had legible identifiers, what is the number who had typed identifiers? (PatID_Patient_Q9.1)		Number of patients who had the patient identifiers in black text on a white background	Total number of patients audited with a single ID band (white or red)	
Processes to transfer care	A patient's identity is confirmed using three approved patient identifiers when transferring responsibility for care.	5.4 Developing, implementing and regularly reviewing the effectiveness of the patient identification and matching system at patient handover, transfer and discharge	5.4.1 A patient identification and matching system is implemented and regularly reviewed as part of structured clinical handover, transfer and discharge processes	Patient	Identify patients in the ward/unit who had correct labelling documented on the Surgical Safety Checklist	% of patients who had correct labelling documented on the Surgical Safety Checklist	2.0 Has the patient been admitted for a surgical procedure? 2.1 If yes: Does the patient have a surgical safety checklist? 2.2 If yes to 2.0 & 2.1:Is there a patient label or are all of the patient details written legibly at the top of the form? 2.3 If yes to 2.0 & 2.1: In the 'sign in' section, - has the patients identity box been completed? - has the site/side box been completed? - has the procedure box been completed? - has the consent box been completed? 2.4 If yes to 2.0 & 2.1: In the 'sign in' section, has the site marked box (either yes or N/A) been completed? 2.5 If yes to 2.0 & 2.1: In the 'time out' section, - has the patient confirm box been completed? - has the site/side box been completed? - has the procedure box been completed?	Yes; No Yes; No Yes; No Yes; No Yes; No Yes; No Yes; No Yes; No Yes; No Yes; No Yes; No	Number of patients who had correct labelling documented on the Surgical Safety Checklist	Total number of patients audited who had a Surgical Safety Checklist	
				Ward			4.0 What is the number of patients who had correct labelling (ie: patient label) on the surgical safety checklist? (PatID_Patient_Q2.2)		Number of patients who had correct labelling documented on the Surgical Safety Checklist	Total number of patients audited who had a Surgical Safety Checklist	
				Patient	Identify patients in the ward/unit who, in the 'sign in' section of the surgical safety checklist, were documented as having been confirmed	% of patients who, in the 'sign in' section of the surgical safety checklist, were documented as having been confirmed	In the same questions as above		Number of patients who, in the 'sign in' section of the surgical safety checklist, were documented as having been confirmed ie: had all four boxes completed.	Total number of patients audited who had a Surgical Safety Checklist	
				Ward			4.1 What is the number of patients who, in the 'sign in' section of the surgical safety checklist, were documented as having been confirmed? ie: had all four boxes completed. (PatID_Patient_Q2.3)		Number of patients who, in the 'sign in' section of the surgical safety checklist, were documented as having been confirmed ie: had all four boxes completed.	Total number of patients audited who had a Surgical Safety Checklist	
				Patient	Identify patients in the ward/unit who, in the 'sign in' section of the surgical safety checklist, were documented as having the site marked	% of patients who, in the 'sign in' section of the surgical safety checklist, were documented as having the site marked	In the same questions as above		Number of patients who, in the 'sign in' section of the surgical safety checklist, were documented as having the site marked.	Total number of patients audited who had a Surgical Safety Checklist	
				Ward			4.2 What is the number of patients who, in the 'sign in' section of the surgical safety checklist, were documented as having the site marked? (PatID_Patient_Q2.4) What is the number of patients who had a surgical safety checklist and were audited?		Number of patients who, in the 'sign in' section of the surgical safety checklist, were documented as having the site marked.	Total number of patients audited who had a Surgical Safety Checklist	
				Patient	Identify patients in the ward/unit who, in the 'time out' section of the surgical safety checklist, were documented as having been confirmed	% of patients who, in the 'time out' section of the surgical safety checklist, were documented as having been confirmed	In the same questions as above		Number of patients who, in the 'time out' section of the surgical safety checklist, were documented as having been confirmed ie: had all three boxes completed.	Total number of patients audited who had a Surgical Safety Checklist	
				Ward			4.3 What is the number of patients who, in the 'time out' section of the surgical safety checklist, were documented as having been confirmed? ie: had all three boxes completed. (PatID_Patient_Q2.5)		Number of patients who, in the 'time out' section of the surgical safety checklist, were documented as having been confirmed ie: had all three boxes completed.	Total number of patients audited who had a Surgical Safety Checklist	
				Patient	Identify patients in the ward/unit who had correct labelling documented on the Perioperative Patient Record	% of patients who had correct labelling documented on the Perioperative Patient Record	3.0 Has the patient been admitted for a surgical procedure? 3.1 If yes, has the patient a Perioperative Patient Record? 3.2 If yes to 3.0 & 3.1: Is there a patient label or are all of the patient details written legibly at the top of the form? 3.3 If yes to 3.0 & 3.1: Has 1. full name, DOB and ID band matching box been completed for ALL checks 1, 2 and 3? - if no to above, has it been partially completed ie: for 1 or 2 checks? 3.4 If yes to 3.0 & 3.1: Has 2. procedure consent box been completed for ALL checks 1, 2 and 3? - if no to above, has it been partially completed ie: for 1 or 2 checks? 3.5 If yes to 3.0 & 3.1: Has 3. procedure stated box been completed for ALL checks 1, 2 and 3? - if no to above, has it been partially completed ie: for 1 or 2 checks? 3.6 If yes to 3.0 & 3.1: Has 4. surgical site marked box been completed for ALL checks 1, 2 and 3? - if no to above, has it been partially completed ie: for 1 or 2 checks?	Yes; No Yes; No Yes; No Yes; No Yes; No Yes; No Yes; No Yes; No Yes; No Yes; No	Number of patients who had correct labelling documented on the Perioperative Patient Record	Total number of patients audited who had a Perioperative Patient Record	
				Ward			5.0 What is the number of patients who had correct labelling on the Perioperative Patient Record? (PatID_Patient_Q3.2)		Number of patients who had correct labelling documented on the Perioperative Patient Record	Total number of patients audited who had a Perioperative Patient Record	
				Patient	Identify patients in the ward/unit who, on the Perioperative Patient Record had 1. full name, DOB and ID band matching box completed for ALL checks 1, 2 and 3.	% of patients who, on the Perioperative Patient Record had 1. full name, DOB and ID band matching box completed for ALL checks 1, 2 and 3.	as per questions above		Number of patients who, on the Perioperative Patient Record had 1. full name, DOB and ID band matching box completed for ALL checks 1, 2 and 3.	Total number of patients audited who had a Perioperative Patient Record	
				Ward			5.1 What is the number of patients who had 1. full name, DOB and ID band matching box completed for ALL checks 1, 2 and 3 on the Perioperative Patient Record? (PatID_Patient_Q3.3) What is the number of patients who had 1. full name, DOB and ID band matching box partially completed for 1 or 2 checks on the Perioperative Patient Record? (PatID_Patient_Q3.3)		Number of patients who, on the Perioperative Patient Record had 1. full name, DOB and ID band matching box completed for ALL checks 1, 2 and 3.	Total number of patients audited who had a Perioperative Patient Record	

Criteria	Rationale	This criterion will be achieved by:	Actions required	Audit Tool	Goal	Indicator	Question on Audit Tool	Response options	Numerator	Denominator	Exclusions
				Patient	Identify patients in the ward/unit who, on the Perioperative Patient Record had 2. procedure consent box completed for ALL checks 1, 2 and 3.	% of patients who, on the Perioperative Patient Record had 2. procedure consent box completed for ALL checks 1, 2 and 3.	as per questions above		Number of patients who, on the Perioperative Patient Record had 2. procedure consent box completed for ALL checks 1, 2 and 3.	Total number of patients audited who had a Perioperative Patient Record	
				Ward			5.2 What is the number of patients who had 2. procedure consent box completed for ALL checks 1, 2 and 3 on the Perioperative Patient Record? (PatID_Patient_Q3.4) What is the number of patients who had 1. full name, DOB and ID band matching box partially completed for 1 or 2 checks on the Perioperative Patient Record? (PatID_Patient_Q3.4)		Number of patients who, on the Perioperative Patient Record had 2. procedure consent box completed for ALL checks 1, 2 and 3.	Total number of patients audited who had a Perioperative Patient Record	
				Patient	Identify patients in the ward/unit who, on the Perioperative Patient Record had 3. procedure	% of patients who, on the Perioperative Patient Record had 3. procedure stated box completed for ALL checks 1, 2 and 3.	as per questions above		Number of patients who, on the Perioperative Patient Record had 3. procedure stated box completed for ALL checks 1, 2 and 3.	Total number of patients audited who had a Perioperative Patient Record	

Criteria	Rationale	This criterion will be achieved by:	Actions required	Audit Tool	Goal	Indicator	Question on Audit Tool	Response options	Numerator	Denominator	Exclusions
				Ward	stated box completed for ALL checks 1, 2 and 3.		5.3 What is the number of patients who had 3. procedure stated box completed for ALL checks 1, 2 and 3 on the Perioperative Patient Record? (PatID_Patient_Q3.5) What is the number of patients who had 1. full name, DOB and ID band matching box partially completed for 1 or 2 checks on the Perioperative Patient Record? (PatID_Patient_Q3.5)		Number of patients who, on the Perioperative Patient Record had 3. procedure stated box completed for ALL checks 1, 2 and 3.	Total number of patients audited who had a Perioperative Patient Record	
				Patient	Identify patients in the ward/unit who, on the Perioperative Patient Record had 4. surgical site marked box completed for ALL checks 1, 2 and 3.	% of patients who, on the Perioperative Patient Record had 4. surgical site marked box completed for ALL checks 1, 2 and 3.	as per questions above		Number of patients who, on the Perioperative Patient Record had 4. surgical site marked box completed for ALL checks 1, 2 and 3.	Total number of patients audited who had a Perioperative Patient Record	
				Ward			5.4 What is the number of patients who had 4. surgical site marked box completed for ALL checks 1, 2 and 3 on the Perioperative Patient Record? (PatID_Patient_Q3.6) What is the number of patients who had 1. full name, DOB and ID band matching box partially completed for 1 or 2 checks on the Perioperative Patient Record? (PatID_Patient_Q3.6)		Number of patients who, on the Perioperative Patient Record had 4. surgical site marked box completed for ALL checks 1, 2 and 3.	Total number of patients audited who had a Perioperative Patient Record	
				Patient	Identify patients in the ward/unit who had correct labelling documented on the procedure consent form	% of patients who had correct labelling documented on the procedure consent form	4.0 Has the patient been admitted for a procedure? 4.1 If yes: Is there a written and signed consent form? 4.2 If yes to 4.0 & 4.1: Does the patient have the capacity to provide consent ie: the 'patients who lack capacity box is not completed? 4.3 If yes to 4.0, 4.1 & 4.2: is there a patient label or are all of the patient details written legibly at the top of each page of the form? 4.4 If yes to 4.0, 4.1 & 4.2: Has the patient consented to the procedure by completing their name and signed and dated? 4.5 If yes to 4.0, 4.1 & 4.2: Has the doctor/delegate section been completed with name and designation and signature and date?	Yes; No Yes; No Yes; No Yes; No Yes; No Yes; No	Number of patients who had correct labelling documented on the procedure consent form	Total number of patients audited who had a written consent form	
				Ward			6.0 What is the number of patients who had correct labelling on the procedure consent form? (PatID_Patient_Q4.3)		Number of patients who had correct labelling documented on the procedure consent form	Total number of patients audited who had a written consent form	
				Patient	Identify patients in the ward/unit who, on the procedure consent form, had corrent patient and staff consent.	% of patients who, on the procedure consent form, had corrent patient and staff consent.	as per questions above		Number of patients who, on the procedure consent form, had corrent patient and staff consent ie: the patient has completed their name and signed and dated AND the doctor/delegate section been completed with name and designation and signature and date.	Total number of patients audited who had a written consent form	
				Ward			6.1 What is the number of patients who had corrent patient and staff consent on the procedure consent form? (PatID_Patient_Q4.4 and Q4.5)		Number of patients who, on the procedure consent form, had corrent patient and staff consent ie: the patient has completed their name and signed and dated AND the doctor/delegate section been completed with name and designation and signature and date.	Total number of patients audited who had a written consent form	
				Patient	Identify patients in the ward/unit who had the patient identification complete on all pages of the medication chart	% of patients who had the patient identification complete on all pages of the medication chart	5.0 Is the patient identification (minimum of name, DOB, MRN, address) complete on all pages of the medication chart? (N/A for patients with no evidence of medication chart at the bedside)	Yes; No; N/A	Number of patients who had the patient identification complete on all pages of the medication chart	Total number of patients audited who had a medication chart at the bedside	
				Ward			7.0 What is the number of patients who had the patient identification complete on all pages of the medication chart? (PatID_Patient_Q5.0)		Number of patients who had the patient identification complete on all pages of the medication chart	Total number of patients audited who had a medication chart at the bedside	
Processes to match patients and their care	Health service organisations have explicit processes to correctly match patients with their intended care.	5.5 Developing and implementing a documented process to match patients to their intended procedure, treatment or investigation and implementing the consistent national guidelines for patient procedure matching protocol or other relevant protocols	5.5.1 A documented process to match patients and their intended treatment is in use	AS PER 5.4.1							
			5.5.2 The process to match patients to any intended procedure, treatment or investigation is regularly monitored	AS PER 5.4.1							
			5.5.3 Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation	AS PER 5.1.2 and 5.2.2							

Criteria	Rationale	This criterion will be achieved by:	Actions required	Audit Tool	Goal	Indicator	Question on Audit Tool	Response options	Numerator	Denominator	Exclusions

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.