

## NSQHS Standard 5 Comprehensive Care How to use the audit tools – Edition 2



### Comprehensive Care Audit Tools Instructions

Patient Safety and Quality Improvement Service, Clinical Excellence Queensland has developed audit tools for facilities and Hospital and Health Services (HHS) to use to collect data in support of evidence in meeting the National Safety and Quality Health Service (NSQHS) Standards. The audit tools have been updated to align to the second edition of the NSQHS Standards.

#### Purpose of the audit tools

The tools provide facilities and health services with additional supporting resources to use in conjunction with the existing NSQHS standards workbooks and guides to be able to:

- Demonstrate detailed evidence for an action by providing specific verification rather than noting the action has been met and listing the source, i.e. self-assessment
- Collect information and evidence to a further level of detail at a patient, ward and facility level, delving down into specific requirements that further support meeting the action
  - collect patient level data using a number of methods, i.e. chart documentation, observational and asking the patient/carer questions to demonstrate that the evidence has been met, and to what extent
  - observe ward/unit staff undertaking a process, e.g. clinical handover and recording individual results
- Determine actual performance results at a ward and patient level
- Clearly identify those detailed gaps/areas that need attention, in order to target improvements and build a robust action plan at the ward and facility level
- Track and monitor audit results at the three levels over time.

The tools can be used in conjunction with other resources and directly align to the criteria in the existing NSQHS Standards workbooks and guides. Depending on the size of the facility a number of audit questions may not be applicable, it is up to each facility/health service to determine the audit questions for review. Questions and responses can be adapted to suit the requirements of each facility/health service.

## The suite of documents include the following:

1. A 'how to' guide on using the tools (this document)
2. A definitions guide to assist in completing the tools
3. Three specific audit tools that allow the collection and collation of information are provided that can be adapted for local use. An Excel workbook consisting of tabs with the following:
  - *Facility Collection and Results*: collects facility level responses
  - *Ward/Unit Collection Audit Tool*: collects the ward/unit level responses, the Excel spreadsheet can be used to collect up to 15 wards/units
  - *Patient Collection Audit Tool*: collects patient level responses (at a ward/unit level), the Excel spreadsheet can be used to collect up to 20 patients
  - *Results for Ward/Unit*: collates the ward/unit level responses
  - *Results for Patient*: collates the patient level responses
  - *Results for Pressure Injuries*: collates the pressure injury data (collected at the patient level). Note – The number of pressures injuries is presented, not the number of patients. If a patient has more than one pressure injury, each pressure injury will be reported here.
4. A measurement plan for each standard that defines the goals, questions and responses in the audit tools. The plan details each audit question and its alignment to the action in the standard and can be adapted for local use. Some questions may be used by the facility to demonstrate evidence for other actions, in addition to the action it has been aligned with.

## Scope of the Comprehensive Care Audit tools

The audit tools at this stage incorporate audit questions on comprehensive care planning and delivery; comprehensive care at the end of life; preventing and managing pressure injuries; preventing falls and harm from falls; nutrition and hydration; preventing delirium and managing cognitive impairment; predicting, preventing and managing self-harm and suicide; predicting, preventing and managing aggression and violence; minimising restrictive practices: restraint; minimising restrictive practices: seclusion.

The indicators and questions in the audit tools directly align to the Queensland Bedside Audit (QBA) and other statewide audits wherever possible.

## How the tools were developed

### An example is provided below using Action 5.1 in Standard 5

1. The NSQHS standards workbooks and guides were used, i.e.
  - a. Guide for Hospitals (November 2017) – Key tasks and Strategies for improvement  
<https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Safety-and-Quality-Health-Service-Standards-Guide-for-Hospitals.pdf>

Example: Guide for Hospitals – Action 5.21 in Standard 5

### Action 5.21



The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines

#### Intent

Evidence-based guidelines are used for prevention and care for patients at risk of, or with, a pressure injury.

#### Key tasks

- Use information from screening and assessment processes to prevent and manage pressure injuries
- Develop or adapt a wound management system that is based on best-practice guidelines
- Identify individuals or groups with responsibility for overseeing this system.

#### Strategies for improvement

Use the screening processes in Action 5.10 to identify patients at risk of pressure injuries and plan for comprehensive care. Use Action 5.12 to ensure that the risk factors and a decision about the need for comprehensive and ongoing skin inspections are documented. Ensure that processes for preventing pressure injuries are based on best-practice guidelines and that details of prevention strategies are communicated to the team caring for at-risk patients.

Prevention and Treatment of Pressure Ulcers: Clinical practice guideline<sup>151</sup> is the relevant best-practice guidelines. These guidelines outline the components of, and techniques for, comprehensive skin and tissue inspections.

Implement a comprehensive wound management system that describes the protocols and processes for patient care when a patient's pressure injury has been identified. Include the assessment, treatment, monitoring and documentation of pressure injuries.

Ensure that assessment of pressure injuries incorporates:

- The use of a validated risk assessment tool
- The use of a pressure injury classification system
- Assessment of pain using validated self-reporting tools such as verbal descriptor, visual analogue or numerical scales
- Ongoing assessment that evaluates the effectiveness of the wound management plan.

Ensure that treatment addresses:

- Pain management
- Wound management
- Adjunctive treatment options such as heel elevation, prophylactic dressings or electrotherapy

Example of Key tasks for 5.21 'Use information from screening and assessment processes to prevent and manage pressure injuries'

2. The questions in the audit tools (patient, ward, facility) assess and ask for verification of the examples of evidence and outputs to collect the detailed information necessary to meet that evidence. In addition, other examples of evidence may be used. The questions may directly ask if there is supporting evidence, or may be broken down into a series of questions to delve deeper into whether the evidence has been met.

Questions and responses have been developed in consultation with content area experts.

*Example: Patient audit tool questions for Action 5.21 in Standard 5*

		Pt 1	Pt 2
		URN:	
<b>Preventing and managing pressure injuries</b>			
<b>Documentation audit - Patient</b>			
1.0	Is there documented evidence that a pressure injury risk assessment was undertaken on admission to the ward?		
1.1	If yes to 1.0, what is the patient's documented category of risk?		
1.2	If yes to 1.0, within what timeframe from ward admission was the pressure injury risk assessment undertaken? <i>N/A for aged care in MPHS patient. May not be applicable for long stay patient</i>		
2.0	If the LOS is greater than 7 days, is there documented evidence of a pressure injury risk assessment that is current? <i>Current is within the past week or on change of condition; within the past 3 months for aged care in MPHS patient; as defined by your local policy/procedure for long stay patient.</i> <i>N/A for LOS &lt;7 days</i>		
2.1	If yes to 2.0, what is the patient's most recent documented category of risk?		
3.0	Is there documented evidence of a pressure injury prevention plan? <i>Plan includes interventions to reduce risk of pressure injury. Ccomplete for all patients</i>		
4.0	Is there documented evidence that a comprehensive skin inspection was undertaken on admission to the ward?		
4.1	If yes to 4.0, within what timeframe from ward admission was the comprehensive skin inspection undertaken? <i>N/A for aged care in MPHS patient. May not be applicable for long stay patient</i>		
5.0	Is there documented evidence of a comprehensive skin inspection that is current? <i>Current is within the past day for 'At risk' patient; within the past week or on change of condition for 'Not at risk' patient; on transfer; or as defined by your local policy/procedure for long stay patient</i>		

In addition to the collection of information, the Excel spreadsheet collates data at the patient and ward/unit levels. The tab *Results for Ward/Unit* shows the number of wards/units that met the indicator and the total number audited, which are then used to calculate the percentage of wards/units that met that indicator. Subsequently, the tab *Results for Patient*, displays the percentage of patients that met the indicator. Details of the indicators can be found in the measurement plan.

- The measurement plan details the actions and those question(s)/responses that correspond to the action.

Note: Some questions may be used by the facility to demonstrate evidence for other actions, in addition to the action it has been aligned with.

Example: Measurement plan for Action 5.21 in Standard 5

Action	Actions required	Goal	Indicator	Audit Tool	Question on Audit Tool	Response options	Numerator	Denominator
5.21	The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines	Identify the extent to which patients are being risk assessed for pressure injuries and how timely	<p>% of patients with documented evidence that a pressure injury risk assessment was undertaken on admission to the ward</p> <p>% of patients with a pressure injury risk assessment undertaken on admission to the ward who were At risk</p> <p>% of patients with a pressure injury risk assessment undertaken on admission to the ward who were at High risk</p> <p>% of patients with a pressure injury risk assessment undertaken on admission to the ward who were at Very high risk</p> <p>% of patients with a pressure injury risk assessment undertaken on admission to the ward who were Not at risk</p> <p>% of patients with a pressure injury risk assessment undertaken on admission to the ward who were Not risk assessed</p> <p>% of patients with a pressure injury risk assessment undertaken in &lt;2hr from ward admission</p> <p>% of patients with a pressure injury risk</p>	Patient	<p>1.0 Is there documented evidence that a pressure injury risk assessment was undertaken on admission to the ward?</p> <p>1.1 If yes to 1.0, what is the patient's documented category of risk?</p> <p>1.2 If yes to 1.0, within what timeframe from ward admission was the pressure injury risk assessment undertaken? N/A for aged care in MPHS patient</p>	<p>Yes; No</p> <p>At risk; High risk; Very high risk; Not at risk; Not risk assessed</p> <p>&lt;2hr; &lt;4hr; &lt;8hr; &lt;12hr; &lt;24hr; &gt;24hr; Not available</p>	<p>Number of patients with documented evidence that a pressure injury risk assessment was undertaken on admission to the ward (Yes to 1.0)</p> <p>Number of patients with a pressure injury risk assessment undertaken on admission to the ward who were At risk (Yes to 1.0 and At risk to 1.1)</p> <p>Number of patients with a pressure injury risk assessment undertaken on admission to the ward who were at High risk (Yes to 1.0 and High risk to 1.1)</p> <p>Number of patients with a pressure injury risk assessment undertaken on admission to the ward who were at Very high risk (Yes to 1.0 and Very high risk to 1.1)</p> <p>Number of patients with a pressure injury risk assessment undertaken on admission to the ward who were Not at risk (Yes to 1.0 and Not at risk to 1.1)</p> <p>Number of patients with a pressure injury risk assessment undertaken on admission to the ward who were Not risk</p>	<p>Total number of eligible patients (Yes or No to 1.0)</p> <p>Total number of eligible patients that were risk assessed on admission to the ward (Yes to 1.0 and 1.1 is not null)</p> <p>Total number of eligible patients that were risk assessed on admission to the ward (Yes to 1.0 and 1.2 is not null)</p>



## Using the Excel tools

The audit tools are in different worksheets in the Excel document and these are accessed by the tabs at the bottom of the workbook or by clicking on the links in the Contents page.



## National Safety and Quality Health Service (NSQHS) Standards Standard 5 Comprehensive Care - Edition 2

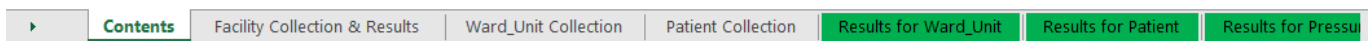


The Clinical Excellence Division has developed audit tools for facilities and Hospital and Health Services (HHS) to use to collect data in support of evidence in meeting Edition 2 of the NSQHS Standards. There are a number of tools in the workbook. The tools provide the ability to collect a number of patient's and ward's, and display combined results for each indicator. In addition, the measurement plan provides a high level view of the NSQHS actions and their alignment to each audit question.

### Audit Tools to audit against Edition 2 of the NSQHS Standards

#### Contents

- [Facility Collection & Results](#) This audit tool collects Facility level data, and the results can be printed directly from this sheet
- [Ward\\_Unit Collection](#) This audit tool collects Ward/Unit level data
- [Patient Collection](#) This audit tool collects Patient level data
  
- [Results for Ward\\_Unit](#) This tab presents the results of the Ward/Unit level data (that were collected on the Ward\_Unit Collection tab)
- [Results for Patient](#) This tab presents the results of the Patient level data (that were collected on the Patient Collection tab)
- [Results for Pressure Injuries](#) This tab presents the results of the Pressure injury data (that were collected on the Patient Collection tab)
  
- [Measurement Plan](#) The measurement plan outlines the NSQHS Standards Actions and the audit questions and indicators aligned to them



In addition, we recognise that each facility will define when the audit will take place, how often, how many patients to audit and who will perform the audit.

Queensland Health facilities have the ability to enter their audit data online using an existing secure, electronic web-based system, Measurement, Analysis and Reporting System (MARS), available via the Queensland Health intranet. Please email [mars@health.qld.gov.au](mailto:mars@health.qld.gov.au) for further information.

We recognise and appreciate that there may be gaps in the scope and questions included in these tools, however, as the audit tools are a constant '**Work in Progress**', future versions will build upon the existing scope and questions, and incorporate staff feedback and suggestions for improvement.

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

**Please email Patient Safety and Quality Improvement Service on [mars@health.qld.gov.au](mailto:mars@health.qld.gov.au) for feedback or comments.**

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