The Australian Council on Healthcare Standards

MOCK ASSESSMENT | READINESS DIAGNOSTIC CONSULTANCY

ORGANISATION NAME:	Ambulance Tasmania

Utilising the PICMoRS Methodology *(Adapted from ACSQHC Fact Sheet 12: Assessment Framework for Safety & Quality Systems, December 2018)*

Process

This involves identifying who in the organisation is involved in the process and where the requirements for the process are documented. Assessors can then determine who should be interviewed. This information will enable an assessor to determine if actual practice matches practice described in the policy and procedures.

Improvement strategies

Then an assessor can determine if the organisation has reviewed the effectiveness of the process and if changes have been implemented. Where improvements have been introduced, you should seek to understand the rationale for change, how the workforce was made aware of the changes, implementation strategies used and how effective the changes are.

Consumer participation

You are evaluating consumer participation in safety and quality systems and processes, including clinical governance and in their own care. The form consumer participation takes will vary depending on the safety and quality process being evaluated. It may include involvement in design, monitoring or evaluation of services within a program, department or the organisation or being a member of a quality improvement and redesign team, providing input through focus groups, feedback mechanisms, surveys or social media.

Monitoring

The extent and type of monitoring a health service organisation conducts on its safety and quality processes should be considered and then how this information is used to plan, deliver and improve patient care. Effective monitoring enables organisations to understand day to day practice, evaluate the effectiveness of existing safety and quality processes, and respond to deviations from expected outcomes. Data is used to: Identify areas of under and high-performance; prioritise areas for improvement; measure changes over time; and evaluate the effectiveness of these changes.

Reporting

By tracking reporting the assessors can demonstrate evidence of the governance reporting system at work. Reporting on processes may occur at all levels and bilaterally within an organisation. You should confirm if information on a process is reported to the governing body, the workforce, consumers, the community and / or other health services / agencies.

Safety and quality systems

Safety and quality systems should be integrated and inform each other. For example, processes from a risk management system should inform policy and training systems, and the incident management system should inform the risk management system. Integrating these systems with the quality and safety system should be articulated and evident.

Overview

Ambulance Tasmania (AT) continues their journey, guided by the National Safety and Quality Health Service (NSQHS) Standards and the related Guide for Ambulance Health Services, in their preparation to meet the contemporary Australian standards for healthcare. Overall, there are eight Standards that form the NSQHS Standards (the National Standards) and the recently endorsed and released Guide for Ambulance Services. These standards are the same for other health streams and the Guide aids in the interpretation of these in the ambulance healthcare setting.

This report is designed to be a supportive companion in that process, serving as a formative assessment to guide improvement. While it highlights areas where systems are still developing to fully meet the Standards, it is intended as encouragement for further progress. The dedication of the AT Executive and Staff in pursuing significant improvements, all while managing ongoing operations with available resources, is noted and speaks towards the focus to improve the process and outcomes for this organisation.

It is anticipated that the National Standards will become mandatory for all ambulance services in the future, however the implementation of the National Standards remains optional for ambulance services (in Australia), and provide an excellent framework for strong governance, clinical safety, and quality improvement in delivery of care To assist in mapping their journey and provide ongoing support, AT engaged the Australian Council for Healthcare Standards (ACHS) in providing guidance to implement these Standards and by undertaking three Readiness Assessments.

At the request of AT, the original assessment plan was modified to remove the second planned assessment and replace it with a more comprehensive second on-site review. This revised approach was designed as a Mock Assessment to the National Standards Accreditation Assessment and cover services across the whole of Tasmania.

All assessments were conducted by a team of three highly experienced consultants, each with extensive and diverse backgrounds in healthcare. Two of the consultants participated in both the 2024 and 2025 reviews, ensuring consistency and continuity.

The **first assessment** focused exclusively on:

- **Standard 1 – Clinical Governance**, and
- **Standard 2 – Partnering with Consumers**

These two foundational standards underpin the remaining six clinical standards. It was agreed that the remaining six standards would be the focus of the **second assessment**, with the **third assessment** providing a comprehensive review across all eight NSQHS Standards. The initial plan intended for all major sites and a sample of smaller sites to be visited across the three assessments.

Following the revision, the **second visit** was expanded to include assessment against **all eight Standards**.Three consultants focussed on **Hobart**, **Launceston**, and **Burnie** during the first four days, allowing them to assess services within those respective geographic areas. On the final **Friday**, the Consultant team reconvened to consolidate findings and deliver an in-person feedback session to the Executive and staff. Comprehensive briefing was

provided at the end of each day to the Executive team, as well as a detailed briefing on the conclusion to the Executive and Staff about the main findings of the assessment as well as the opportunity for the internal stakeholders to give reciprocal feedback.

Consultancy service is designed to highlight areas of attention and clearly prioritise AT to focus their resources in areas that require a more immediate approach. While we note that there are multiple areas for improvement highlighted it is recognised that substantial work has been undertaken to date in an environment where dedicated resources have at times been limited.

It was noted by the Consultants that the resources to support the preparation for accreditation that may be seen in other health contexts, such as acute hospitals, is not apparent in AT. If AT are to continue their journey towards National Standards Accreditation, the resources allocated will need to be considered by the Governing Body to ensure that the work is completed in a timely manner. Standard areas, such as in Consumer Involvement, tare developing within the Tasmanian Health Department in strategic frameworks development, and this has meant that AT have had to wait until these frameworks are released before undertaking further work in these areas.

As the Readiness Assessment is a point in time review, the fact that broader organisational frameworks are being developed, does not impact on whether AT meets the requirements of a Standard or Action at the time of the assessment. This reflects what would occur inan formal assessment; however, the Consultants understand why AT is pragmatically waiting for these frameworks to be released before proceeding further in these areas to avoid re-work. AT have shown that the organisation and staff are committed to the journey and the many staff interviewed throughout the two visits were overwhelmingly positive about improving the services for the benefit of consumers. It is important to reiterate that as a functional document the areas highlighted and noted below are the findings that should be the focus to continue to best practice.

Summary of Findings

AT journey towards National Standards Accreditation, demonstrates a strong commitment to ensuring their quality and safety systems align with contemporary National Standards. This report is designed to be a formative tool to assist in this journey, focusing on areas where existing systems may not yet fully meet the requirements of the Standards. It is important to emphasise that these observations are not a reflection on the dedication or efforts of the Executive and Staff of AT, who have undertaken significant improvement of work within current resources while supporting ongoing operations.

Where opportunities for improvement have been identified, it is acknowledged that considerable work has already been completed, often in circumstances where dedicated project resources have not been available. The Consultants recognise that, compared to other healthcare contexts such as acute hospitals, dedicated resources to support accreditation preparation are limited for AT. To continue progressing towards National Standards Accreditation, it will be important for the Governing Body to consider the resources needed to complete this significant work in a timely manner.

In areas such as Consumer Involvement, AT's progress is also linked to broader developments within the Tasmanian Health Department, where strategic frameworks are underway. AT has chosen to wait these frameworks before proceeding further, in order to align efforts and avoid unnecessary rework. The Readiness Assessment, as a point-in-time review, reflects the status of Standards or Actions at the time of assessment, which is consistent with how an actual accreditation would be conducted. The Consultants appreciate AT's practical approach in these circumstances.

Although there are areas that require further development, it was clear throughout both visits that AT's staff and organisation are highly committed to continuous improvement and to providing the best possible service for consumers. Staff interviewed expressed a strong sense of positivity and engagement with the improvement journey.

Overview of Readiness Assessment 17th to 21st March 2025

The Consultants visited a range of AT sites including Volunteer and Paramedic Stations, the Critical Care and Retrieval (CCR) Base, the Communication Centre, and RHH, Launceston, and Bernie Hospitals. They also observed care provision firsthand by accompanying AT teams, and conducted interviews with National Standards sponsors and other staff involved in systems and processes related to the Standards. Briefings were conducted daily for the AT Executive, particularly highlighting areas for improvement, and all Executive members attended most days during the five-day assessment.

As with the previous visit, Consultants had the opportunity to meet and observe many dedicated staff who are eager to contribute to safe, high-quality services and to meet service requirements. Supporting staff in this important work will be essential for ongoing progress. Embracing effective risk management and the Quality Cycle will further facilitate success and help maintain staff engagement and enthusiasm.

While some recommendations from the previous report remain to be fully addressed, this is understood to be influenced by the resourcing challenges outlined previously. There have been positive developments in areas like governance, including the endorsement of the AT Strategic Plan by the Governing Body. However, some aspects—such as risk management systems and the Clinical Governance Plan—continue to evolve. The Consultants note that progress is ongoing and that the intent is to use this formative assessment to guide ongoing improvement.

For Standard One Governance, two Actions were assessed as Met, with 14 rated as Not Met and 14 rated as Met with Recommendation. This current level of compliance may trigger a Mandatory Reassessment (see the Australian Commission for Safety and Quality in Healthcare – Fact Sheet Three), which would require follow-up actions. This assessment's formative nature provides a chance to proactively address these areas.

Additionally, some delays in responding to SAC 1 and Coroner's Recommendations, combined with the number of Not Met Actions across several Standards, may in the future require notification to the Commission and the Governing Body, in line with the Commission's Advisory AS18/09: Notification of significant risk. Developing a comprehensive plan to address identified risks will help maintain community confidence in AT and support the best outcomes for both the service and the Tasmanian Department of Health as the Governing Body.

It is also noted that risks are not always being reported transparently or effectively as possible through current management systems or regular reporting. Ensuring that the AT Executive and Governing Body have clear information about these risks will support informed decision-making and risk management going forward.

Addressing the issues outlined in this report will require a substantial investment of time (potentially 1-3 years) and resources. A Project Management approach, prioritising work based on clinical, reputational, and financial risk, is recommended. Clear briefings to the Governing Body will help ensure the necessary resources are considered and allocated appropriately.

This is also an opportune time to ensure that the forthcoming AT Business Plan, informed by the recently endorsed Strategic Plan, clearly articulates safety and quality priorities. Taking the time to integrate the recommendations from this report into the Business Plan will help position AT for success.

Given the number of Actions with High Priority Recommendations, those where it is suggested that they be addressed within 90 days are highlighted in red for clarity and emphasis.

Limitations

As with any external review, this report presents a snapshot in time and place, influenced by the number of sites, travel distances, Consultants involved, and days allocated. The report may not capture improvements made prior to the assessment, and it is possible that some systems have already progressed further than reflected here.

The following priority action items | suggested improvements were identified by the consultants:

	High Priority (H)	Medium Priority (M)	Low Priority (L)
Standard 1	**1.01, 1.02, 1.03, 1.04, 1.06, 1.07, 1.08, 1.10, 1.11, 1.16, 1.21, 1.23, 1.25, 1.26**	**1.13, 1.14, 1.15, 1.20, 1.22, 1.24, 1.27, 1.29, 1.20**	
Standard 2	**2.01, 2.02, 2.04, 2.08, 2.09**	**2.03, 2.05, 2.06, 2.07, 2.10, 2.12, 2.13, 2.14**	
Standard 3	**3.03, 3.08, 3.10, 3.13, 3.14, 3.15**	**3.01, 3.02, 3.04, 3.05, 3.07, 3.09, 3.11, 3.12, 3.18, 3.19**	**3.06, 3.17**
Standard 4	**4.15**	**4.01, 4.02, 4.03, 4.04, 4.05, 4.06, 4.07, 4.08, 4.11, 4.13, 4.14**	
Standard 5	**5.34, 5.35**	**5.01, 5.02, 5.04, 5.08, 5.10, 5.11, 5.12, 5.13, 5.14, 5.15, 5.16, 5.17, 5.18, 5.19, 5.21, 5.24, 5.25, 5.26, 5.29, 5.30, 5.31, 5.33**	**5.03, 5.05, 5.06, 5.07, 5.09, 5.20, 5.22, 5.23, 5.27, 5.28, 5.32**
Standard 6	**6.02**	**6.01, 6.03, 6.04, 6.07, 6.08, 6.09, 6.10, 6.11**	
Standard 7			**7.01**

	High Priority (H)	Medium Priority (M)	Low Priority (L)
Standard 8	**8.01, 8.02, 8.04, 8.05**	**8.03, 8.06, 8.09, 8.11**	**8.07, 8.12**
TOTAL	33	72	16

STANDARD 1: CLINICAL GOVERNANCE

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Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
1.01	The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance.	The development and release of the Ambulance Tasmania Our Future 2024-2028 Strategic Plan has clarified to some degree the Governing Body for Ambulance Tasmania (AT). The plan outlines the key strategic objectives for AT for this period; however, it relies on the Ambulance Tasmania Annual Business Plan which cascades each year from the Strategic Plan for the translation of, "... the strategic priorities into annual actions aligned to budget cycles." Further, the Strategic Plan requires AT to provide quarterly reports to be submitted to the Department of Health "for oversight." This implies that the Department of Health, and the Commissioner of Ambulance Services are the governing entities for AT as defined in the National Safety and Quality Health Service Standards (NSQHSS) ("*… highest level of governance*			**H**	1. Clearly document the roles and responsibilities of the AT Governing Body and how they relate to the requirements of Action 1.01 in the revised AT Clinical Governance Plan. 2. Develop and implement regular and standardised reports to the Governing Body that include risk, incident, complaint and relevant safety and quality KPIs which reflect the priorities endorsed by the Governing Body. 3. Obtain the Governing Body's endorsement of the AT Clinical Governance Plan once the revision is complete. 4. Ensure that the development of AT's Annual Business Plan which cascades from the endorsed Strategic Plan articulates the key safety and quality priorities for AT and is endorsed by the Governing Body.

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	Not Met	(individual or group of individuals) that has *ultimate responsibility* for strategic and operational decisions affecting safety and quality in a health service organisation." Author's italics). The role and functions of the 'Governing Body' as required by this Action have not been clearly articulated by AT in the current AT Clinical Governance Plan 2024-2026. Due to the absence of clearly articulated safety and quality priorities (endorsed by the Governing Body), there is an absence of organisational alignment and a lack of clarity about what the priorities are. This creates confusion and improvement initiatives across AT which are not aligned.				
1.02	The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people **Not Met**	AT do not currently have the capacity or capability to annotate in their information systems whether a consumer is an Aboriginal and/or Torres Strait Islander person. This gap in the system's capability does not allow the analysis of data on access, activity, outputs, or outcomes to determine whether there are particular risks for Aboriginal and Torres Strait Islander people when compared with non-Aboriginal and Torres Strait Islander people. This means that AT have not developed or implemented safety and quality priorities to address the specific health needs of Aboriginal and Torres Strait Islander people.			**H**	1. Implement and evaluate a system to capture whether an AT consumer identifies as an Aboriginal and Torres Strait Islander person. 2. In the interim, liaise with local First Nations Community Organisations to develop initial improvement plans for Aboriginal and Torres Strait Islander people receiving services from AT. 3. Use the systems in place which identify whether a consumer is an Aboriginal and Torres Strait Islander person to analyse access, activity, outputs, and outcomes. This will enable the development of safety and quality

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		Not only is this a significant risk for the successful accreditation of AT, it also does not reflect contemporary priorities to close the gap between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander people in terms of their access to and outcomes from healthcare. There have been systems and priorities developed at the Departmental level which may be utilised by AT to develop safety and quality priorities to address the specific health needs of Aboriginal and Torres Strait Islander people. However, these higher-level plans and priorities needs to be assessed as to their applicability in the AT context.				priorities to address the specific risks apparent.
1.03	The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality **Not Met**	The current AT Clinical Governance Plan has only recently been developed and released. Following the previous Readiness Assessment Report, AT have been re-developing the Plan based on the feedback provided. Action 1.03 requires that the Governing Body has endorsed the Clinical Governance Framework, but the current AT Clinical Governance Plan is signed by two AT Executives who co-Chair the AT Clinical Governance Committee. Further, the AT Clinical Governance Plan outlines a number of 'Improvement Opportunities' and 'Measures of Success' but these are broad in nature			**H**	1. Clarify the roles, responsibilities, and accountabilities of the AT Executive regarding safety and quality and the National Standards allocated. 2. Review the role and intent of the AT Clinical Governance Plan and evaluate its effectiveness against that intent. 3. Ensure that the revised AT Clinical Governance Plan is endorsed by the AT Governing Body. 4. Utilise a project management approach to implement and oversee the implementation of the Clinical Governance Plan. 5. Align the improvement opportunities and measures of success in the AT Clinical

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		and do not outline specific initiatives with related SMART key performance indicators (KPIs) as would be expected in a safety and quality improvement plan. Further, the AT Clinical Governance Plan does not articulate the roles of the AT Executive with regard to safety and quality or their responsibilities and accountabilities in relation to the National Standards. Standards are currently allocated to various Director level staff, and this is not appropriate.				Governance Plan with the Business Plan when it has been developed.
1.04	The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people **Not Met**	See the comments in Action 1.02.			H	Use the Commission's guideline for implementing the Aboriginal and Torres Strait Islander Actions to guide actions necessary to meet this, Action.
1.05	The health service organisation considers the safety and quality of health care for patients in its business decision-making, **Met with Recommendation**	See comments and the recommendations made at Action 1.01 about the opportunity to utilise the development of annual Business Plans which cascade from the AT Strategic Plan that clearly articulate the annual safety and quality priorities for AT.				See Recommendation 4 at Action 1.01.
1.06	Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients	The AT Clinical Governance Plan does outline the key roles and responsibilities for AT Executive staff in relation to safety and quality.			H	See Recommendation 1 at Action 1.03 in relation to the role of the AT Executive staff.

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	Not Met	Monitoring of safety and quality KPIs is occurring but at the time of the review many of these were outside target (e.g., closure of SAC 1 and Coroner's recommendations, and complaints). Further, there is no link to clearly articulated priorities or objectives against which evaluation can occur. Further, the role of audit in assuring AT that staff were operating within the parameters set by policies, procedures, and clinical practice guidelines (CPGs) is not clear. Staff described that clinical audit processes were not currently occurring as they did previously due to resource constraints and competing priorities.				See recommendation made at Action 1.08 for the quality system to establish the systems necessary to monitor performance and outcomes against safety and quality priorities.
1.07	The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements **Not Met**	The document management systems across AT are not well maintained and there are a variety of policy, procedure, and CPGs which are in place. The majority of these are outside of their review date. This is a significant governance failure and reflects poorly on senior management. The role of any document management system is to develop, implement and maintain a group of documents which establish the rules by which the organisation conducts its business. The documents are controls as part of the wider risk management system. If the risk that is to be controlled by the document is significant enough to warrant the control, then compliance monitoring is necessary to ensure that the control is effective.			**H**	1. Review the document management systems to: a) Ensure that the intent of each document is clear and that that intent is evaluated. b) Clarify how AT documents are developed and implemented as a component of the DoH's document management systems. c) Identify the clinical and compliance audit programs necessary to assure compliance with documented requirements. 2. Allocate a single point accountable AT Executive who is responsible (and held accountable) for ensuring that AT documents

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						are maintained, current and effective (links with Recommendation 1 at Action 1.03).
1.08	The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems **Not Met**	As outlined in Actions 1.01 and 1.06, clarity is required in relation to the strategies for safety and quality improvement, as well as the systems in place for the monitoring of compliance and performance. In the absence of clear strategies and related SMART KPIs, AT will not be able to allocate scant resources in the areas of greatest clinical risk. It will also prevent the evaluation of the strategies and initiatives employed which will not be able to be effectively evaluated. Using a rational and risk-based approach to establishing priorities, with input from AT consumers, will assist in ensuring that the resources necessary to implement and evaluate safety and quality initiatives will objectively reduce clinical risk and/or improve the outcomes for AT consumers.			**H**	1. Develop a sustainable clinical and compliance audit program which drives safety and quality improvements. 2. Review the quality systems in place to ensure that they are clearly: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies 3. Involve consumers and the workforce in the review of safety and quality performance and systems. 4. Develop and implement a monitoring and accountability framework and ensure that regular safety and quality reports are provided internally, to the Governing Body, and to the community.
1.09	The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations **Not Met**	Currently, the systems of reporting to the AT Clinical Governance Committee are in their infancy and are being developed as the system matures. There is a lack of regular safety and quality reporting form AT to the Governing Body. Further, the absence of clearly articulated safety and quality strategies and SMART KPIs makes it				See the recommendations at Actions 1.01, 1.03 and 1.08.

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		difficult to evaluate and report in any systematic way. Compliance reporting is difficult where there is no clinical and compliance audit program in place which is appropriately resourced and sustainable.		
1.10	The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters **Not Met**	AT have a risk management system in place which is consistent with the DoH Tasmania's risk management framework. The role and function of risk management as part of the AT Clinical Governance Plan is not well articulated and the risks reviewed on the current risk register were broad in nature and the actual risk to be managed was not clear. Of the 20+ risks outlined on the current AT risk register, many were not risk rated and all of them were not being effectively or transparently managed. Many of the clinical and reputational risks outlined in this report were absent from the register and the Governing Body is not receiving risk reporting to make the risks apparent and transparent to them.	**H**	1. Allocate a single point accountable AT Executive staff member who will be responsible for the development and maintenance of the AT risk management system (links with Recommendation 1 at Action 1.03). 2. Review the role of risk management as part of the systems review of the AT quality improvement systems. 3. Eliminate the artificial separation of clinical and non-clinical risk management. 4. Evaluate the effectiveness of the current risk management processes in acting as a dynamic system to identify, assess, manage, and monitor risk. 5. Link the issues identified in the incident, complaint, and audit programs with the risk management systems.
1.11	The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents	AT have an incident reporting system known as the Safety Reporting and Learning System (SRLS) which is used to report and act on incidents utilising a severity classification system from SAC 1 to SAC 3. Specific timeframes for investigation and action are	**H**	1. Ensure that timeframes established for the resolution of significant incidents (including Coroner's Recommendations) are monitored and acted upon, especially if the timeframes are likely to be breached.

Action		Comment	Priority			Recommended Action or Improvement Strategy
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	c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems **Met with Recommendation**	mandated by the incident reporting framework documents according to the SAC level. As part of the development of safety and quality KPIs as recommended in Action 1.08, monitoring of the requirements on the incident reporting systems should be included in the suite of indicators. Caution should be used in the selection and use of incident reported data as a performance indicator as it reflects the reporting culture rather than a true representation of the incidence of adverse events. Staff interviewed indicated that confidence in the system to resolve issues reported was low and that feedback to reporters of incidents did not routinely occur. Staff indicated that the reporting culture was poor and that many incidents go unreported.				2. Review the processes in place to feedback to incident reporters on the outcomes of their incident reports.
1.12	The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework b. Monitors and acts to improve the effectiveness of open disclosure processes **Met**	An open disclosure program is in place which is consistent with the Australian Open Disclosure Framework and the incident reporting framework outlines where a formal open disclosure is to occur.				
1.13	The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their	Development of consumer experience is occurring, and results have been used to develop improvements. However, there is a lack a systematic approach in place to include this data as		M		See the recommendations made at Action 1.08.

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	understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems **Met with Recommendation**	part of the suite of regular safety and quality indicators reported and used within AT and for reporting of performance to the Governing Body.				
1.14	The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of e. complaints and actions taken f. Uses information from the analysis of complaints to inform improvements in safety and quality systems g. Records the risks identified from the analysis of complaints in the risk management system h. Regularly reviews and acts to improve the effectiveness of the complaints management system **Met with Recommendation**	There is a complaints management system in place across AT for the reporting and action necessary to respond to complaints. The complaints framework outlines timeframes for the response to complaints as well as the targets for completion of the complaint. AT are struggling to meet these timeframes, and the resources required to meet and sustain the timeframes will continue to be a challenge. Evidence was viewed that some complaints may be prematurely closed without due regard to the complaint and the feedback provided to the complainant. Some complaints that should have been actioned were classified as 'rejected.'		M		1. Review the systems in place to ensure that AT achieves and sustains the targets set for the response to, and finalisation of, complaints. 2. Ensure that complaints cannot be 'rejected' or closed in the system without due regard to the complaint and the feedback provided to the complainant.
1.15	The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm	See the comments at Actions 1.02 and 1.04 for Aboriginal and Torres Strait Islander consumers.		M		Develop the systems available to capture the diversity of the community that AT serves to enable the identification of groups who are at higher risk of harm and use that information in the planning and delivery of care (refer to Action 1.02).

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			L	M	H	
	c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care **Met with Recommendation**	There are many diverse communities across Tasmania and the capacity of the AT information systems to capture this diversity is limited. Local knowledge in the communities outside the metropolitan areas is very good and this knowledge is used by local teams to identify groups where there may be a higher risk of harm				
1.16	The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used **Met with Recommendation**	AT are in the process of re-developing the information systems for the healthcare record which is currently used. At present, the information systems in place do not allow the record to be available at the point of care and most of the documentation occurs post patient care. The new systems will provide specific AT owned devices which will allow the record to be accessed more readily. As stated previously, the clinical audit programs that were in place previously have not been sustained and the current IT systems use a narrative approach which is not standardised in terms of what is documented across the service. This means that even if an audit program is reconstituted, it is difficult to audit systematically if documentation is not standardised.			H	AT review the systems in place for specifying what and how a patient episode is to be documented in the VACIS record to eliminate unwarranted variation and enable the systematic audit of the record content.
1.17	The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that:	The current Not Applicable is supported for this Action.			N/A	

STANDARD 1: CLINICAL GOVERNANCE

Leaders of a health service organisation have a responsibility to the community for continuous improvement of the safety and quality of their services, and ensuring that they are person centred, safe and effective.

Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
	a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies **Not Applicable**					
1.18	The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system **Not Applicable**	The current Not Applicable is supported for this Action.		N/A		
1.19	The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation. **Not Met**	Orientation is provided to members of AT. See the comments and recommendations made at Action 1.20.		M		
1.20	The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards	AT have an Essential Skills Maintenance (ESM) program which evolves annually depending on an analysis of the incident and complaints systems, as well as other monitoring programs. At the review there was a focus on airway management.		M		1. Allocate a single point accountable AT Executive responsible for the development and maintenance of AT education and training systems (links with Recommendation 1 at Action 1.03). 2. Determine the AT requirement to comply with any training mandated by DoH Tasmania.

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			L	M	H	
	c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training **Not Met**	This program is further to the orientation and new graduate programs which are very comprehensive and designed to equip new staff with the knowledge and skills necessary to be effective members of the AT workforce. DoH Tasmania have also mandated training which requires some clarification from AT as to whether compliance to these mandated requirements is required by AT staff, and to what degree. The HR and education systems did not appear to support the timely and accurate provision of information on training status of the AT workforce across the ESM and other mandated training requirements. Line managers across the regions were keeping local records of their staff to ensure that they were aware of their training status.				3. Develop, articulate, and maintain a list of mandated training (including once off, periodic, and ESM training) for all categories of AT staff. 4. Develop and implement monitoring systems and processes to the AT Clinical Governance Committee to ensure that mandated training is occurring as specified.
1.21	The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients **Met with Recommendation**	Currently the cultural awareness program is minimal with a short online program which all new staff are required to complete on orientation. Compliance with this requirement is not actively monitored nor is there any evidence it meets the needs of the local communities.			H	See the recommendations made at Action 1.20 in relation to the monitoring and reporting of mandated training.
1.22	The health service organisation has valid and reliable performance review processes that:	There is a Performance Review (PR) system in place but unfortunately is not routinely completed on an annual basis. Some staff report that they have never				1. Allocate a single point accountable AT Executive responsible for the development and maintenance of the Performance Review systems and processes.

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Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
	a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system **Met with Recommendation**	had a review whilst others indicate that they have only had one in past the 4 years. In addition, there is no systematic process for managers to capture/monitor the data of who has had a review undertaken and when their next one is due. The current target of 100% is admirable but it is unrealistic due to a number of factors such as the nature of the work and particularly the various types of leave when staff will be away for extended periods. It is suggested that if there was a compliance of 85% plus it is anticipated that this would meet the intent of this Action.		M		2. Review the Performance Review policies and procedures to ensure they are current and meet the requirements of the service. 3. Establish a realistic target for compliance. 4. Establish systems to easily monitor compliance by Line Managers and above. 5. Establish routine and trended compliance reporting to the Clinical Governance Committee.
1.23	The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered **Met with Recommendation**	The newly developed Ambulance Tasmania Capability Framework is an excellent starting point in defining service delivery in the various services. The Scope of Practice is defined in the individual's position Statement of Duties, but not all staff have received one or are aware of it. The Scope of Practice (SOP) Matrix is an excellent document that clearly outlines who is able to do what. It is suggested that as a quality improvement activity that there be a that short audit be			**H**	1. Develop the systems necessary to ensure that all medical staff who work for AT or are seconded to AT have their credentials and scope of practice allocated and approved by AT. 2. Undertake an audit to verify all staff have a Statement of Duties. 3. Review the process on how the organisation monitors clinical practice to ensure staff are working within their SOP.

Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
		undertaken as to the effectiveness of the tools and closer of the quality cycle. The systems in place to monitor compliance with training and mandatory competencies is difficult to navigate and compliance with requirements is unclear (see Action 1.20). Medical staff from RHH and Launceston Hospitals, and any others who may work in AT from time-to-time are required to be credentialled and allocated a scope of practice by AT. This may be done through a mutual recognition of scope across these services and AT; however, no such arrangement was apparent at the time of the consultation.				
1.24	The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process **Met with Recommendation**	The current credentialling process, definitions and framework is unclear including who is required to be credentialled. The medical staff are credentialled through the Department of Health (DoH) process and Royal Hobart Hospital. AT are currently reviewing their credentialling process and who needs to be credentialled. It will be important to ensure that those requiring credentialling are practicing at an advanced practice level and that definitions are in line with other jurisdictions, APHRA and the Commissions Guide		M		1. Progress the review, development, implementation, and evaluation of the new Credentialling Framework and in line with national standards. 2. Clearly define who the credentialling process applies to and use language and definitions that are aligned with the broader health environment.

STANDARD 1: CLINICAL GOVERNANCE

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Action		Comment	Priority L M H	Recommended Action or Improvement Strategy
		'Credentialing health practitioners and defining their scope of clinical practice: A guide for managers and practitioners' Each position needs to have a clearly defined Scope of Clinical Practice (SoCL) that is clearly aligned with the Credentialling process.		
1.25	The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff **Not Met**	As outlined in Action 1.03 there is a lack of clarity in relation to the roles, responsibilities, and accountabilities of the AT Executive staff in relation to safety and quality and the requirements of the National Standards. This is particularly apparent between the Ops and Clinical Services roles. This lack of clarity cascades down through the organisation and leads to a lack of alignment not only around what the safety and quality priorities are, but also how all staff are responsible for the safety and quality of the services they provide.	**H**	1. Review all positions at all levels to ensure their Statement of Duties articulates their safety and quality responsibilities and their duties which relate to the National Standards. 2. Review the terminology used in other Department of Health jurisdictions to ensure that the AT Statements of Duties aligns with those used across the Department of Health.
1.26	The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate **Met with Recommendation**	There are good systems in place to support new graduates which includes various competencies at different points throughout their graduate program. The supervision provided to new staff transferred from other jurisdictions on commencement was not clear. There are a number of paramedics, and some volunteers, who work either in a single branch station or by themselves on the road. There is	**H**	Develop a comprehensive clinical supervision framework and system across AT which reflects the risks associated with the various roles and levels of staff providing services, with particular attention to digital posts.

Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
		limited evidence of supervision for a number of individuals. There is a need to review the protocols/guidelines for these positions to ensure there are robust systems and processes in place to monitor their practice. This includes any variations in practice as well as their wellbeing by providing support and guidance.			
1.27	The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care **Met with Recommendation**	There are a number of systems and processes for staff to access best practice guidelines including EPOCH on their mobile devices.		M		Review all the Clinical Care Standards developed by the Australian Commission on Safety and Quality in Health Care to ensure that any that are relevant to AT are considered in the review of practice
1.28	The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice	Unfortunately, there are limited systems in place, that are monitored or evaluated, to facilitate review of clinical practice of all clinicians unless there is an incident or an RCA undertaken for a significant adverse event. There is an annual process in place to benchmark a set of high-level broad key Indicators (ROGS) against other Ambulance services across Australia.				See the recommendations at Action 1.01, 1.03, and 1.08.

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			L	M	H	
	e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system **Not Met**	There is a need to develop Indicators that managers can use on a monthly/quarterly basis to explore variation in practice across the Regions and service. This will need a set of local indicators to be developed that reflect the operational environment and add value to the local managers.				
1.29	The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose **Met with Recommendation**	There is a need to check that the current policy and procedure for the 'Single person response' is current and that there are regular audits to monitor safety of these practices and the suitability of the designated environments. Processes be developed that provide the receiving paramedic on a roadside handover some form of documented handover regarding medications that may have been given to the patient prior to transfer of care.		M		1. Review the Policy and Procedures associated with "Standbys" and "Rendezvous" to ensure a safe and appropriate environment for handover. 2. A safety audit of designated sites for clinical handover on the side of the road is undertaken on at least an annual basis. 3. Review the current practice of clinical handover of the medications administered to a patient on a roadside handover. 4. Review the business continuity plans at the Hobart helicopter base to ensure there is a clear analysis of the impact of the loss of any utilities and a plan is in place to maintain services (this may inform the plans in place for the reallocation of these services as part of the new tender).
1.30	The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce	The actual nature of the Ambulance service response, as first responders to a case, makes it automatically a high-risk environment and includes unpredictable behaviours of both the patient and bystanders. There are a number of strategies in place to manage these situations in the field, at the		M		Ensure reporting of all SLRS behaviour incidents and summary of any learnings be tabled at the AT CGC on a routine basis.

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			L	M	H	
	b. Provides access to a calm and quiet environment when it is clinically required **Met with Recommendation**	hospital and for the general workforce. Overall, the intent of this Action appears to be met but will be important to check that the Single officer response policy is current and up to date.				
1.31	The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose **Met**	The process of how to access Ambulance services are very clear to the community using the 'Triple Zero' number. Signage in each community where there is Ambulance Services is clear and visible.				
1.32	The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so **Not Applicable**	Not applicable as AT do not have overnight admissions.				N/A
1.33	The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people **Not Met**	There was no evidence of a formalised process or strategy to address the welcoming environment for Aboriginal and Torres Strait Islander peoples. Despite this it was noted that a number of staff work badges with relevant flags and in some entrances, there were some small Aboriginal and Torres Strait flags.				Refer to Actions 1.2, 1.4, 1.33, 2.13, and 5.8.

STANDARD 2: PARTNERING WITH CONSUMERS

Leaders of a health service organisation develop, implement, and maintain systems to partner with consumers. These partnerships relate to the planning, design, delivery, measurement, and evaluation of care. The workforce uses these systems to partner with consumers.

Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
2.01	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers. b. Managing risks associated with partnering with consumers. c. c. Identifying training requirements for partnering with consumers **Not Met**	AT is in the developmental stage of establishing an AT Consumer Engagement Framework to guide the strategic direction of community partnerships. Currently there is little to no engagement of consumers to offer support and feedback on current safety and quality systems. There is a framework being re-developed by the Tasmanian Department of Health and AT have suspended any work until this revised framework is released. If both AT and the Department are using the National Standards as a guide, alignment should be a natural consequence. As a result of the suspension of work in relation to community and consumer involvement, little work has been undertaken to address the recommendation made at the previous Readiness Assessment. Consequently, the report and recommendations made previously are extant and only new issues will be highlighted. The vast majority of the Standard Two report for this on-site review will remain unmodified from the previous report.			**H**	1. An AT Consumer Engagement Framework be developed and implemented. 2. A single point accountable AT Executive is allocated responsibility for the requirements of Standard 2. 3. The Framework be used to manage risks associated with partnering with consumers and to identify training requirements.
2.02	The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers. b. Implementing strategies to improve processes for partnering with consumers.	The lack of dedicated resources to support the quality improvement system results in poor monitoring and reporting processes. Trended and themed analysis does not occur for feedback currently received.			**H**	1. AT scope, the project work required to deliver Standard Two outcomes. 2. Consider sustainable support to allow current reporting and monitored KPI's to be met as per policy.

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			L	M	H	
	c. Reporting on partnering with consumers **Not Met**					
2.03	The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families, and consumers **Met with Recommendation**	AT has a plan to implement a process that will ensure consumer access to information on health care rights. The plan is robust but needs to be implemented and evaluated prior to accreditation assessment. Consultants viewed the Charter in some ambulances; however, this was not consistent across the service.		M		Standardise consumer access to the Charter across all AT assets.
2.04	The health service organisation ensures that its informed consent processes comply with legislation and best practice. **Met with Recommendation**	Policies for consent processes are currently under review at AT and clinical practice guidelines for capacity assessment are being developed and improved. Feedback from clinicians indicated under the current process there is little to no appetite to not transport patients (even if this is requested) due to concern about: a) limited capacity assessment and b) fear of limited support should there be adverse outcomes.			H	1. Further support and training are provided to encourage a consumer-focused mindset based on capacity of the individual to make decisions. 2. Develop a process to regularly monitor consumer feedback that does not rely on the complaint and compliment feedback process, this could provide a regular 'pulse' on community feedback.

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2.05	The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care. b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves **Met with Recommendation**	AT has recognised a current service deficit in this domain and is in the process of developing a new CPG on assessment of patient capacity to make decisions.		M		1. Following the review a robust education process is established to ensure the CPG translates into practise. 2. Consideration is given to the use of validated rapid assessment tools such as the 4AT to support assessment of capacity.
2.06	The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care. **Met with Recommendation**	During consultation it appeared from both Executive discussion and clinicians that the development and use of advanced care directives is limited. New relationships that have formed with palliative care services will strengthen supported decision making in this area.		M		AT scope, their role and involvement in how consumers can be supported to develop goals of care and how this can be documented through the Compar and other extended care spaces.
2.07	The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care. **Not Met**	Refer 2.05. AT need to develop the training and educational packages and tools to support the workforce to encourage consumer partnerships, once this is implemented it should be evaluated for effectiveness.		M		A robust project plan with clear deliverables be developed to ensure timely implementation monitoring and evaluation.
2.08	The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community. **Not Met**	It is currently difficult to ascertain any CALD (inclusive of Aboriginal and Torres Strait Islander) demographics through data capture. It is envisaged that the new AePCR software will aid capture and improve reporting. Without the demographic data it is difficult to understand where AT needs to focus its attention to improve communication mechanisms with consumers. The interpreter hotline is used for the 000-call line and on scene, but it is perceived that this is poorly utilised.			H	1. AT capture accurate demographic information. 2. Use the information to tailor communication to CALD clients. 3. Monitor trends of interpreter usage to demonstrate improvement when quality projects are implemented.

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			L	M	H	
2.09	Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review. **Not Met**	AT does not currently have access to a Consumer Advisory Board; there is a discussion around the formation of a Department of Health board that would provide a service AT. How AT accesses consumers for regular feedback should be outlined in the consumer engagement framework that is under development.			H	1. Ensure the process for consumer input is outlined in the consumer engagement framework. 2. AT could access consumer volunteers (or in a paid capacity) through an EOI process. Alternatively, the current complaints and complement feedback process could provide a pool of willing community members that could provide ongoing support and feedback to AT. These consumers could meet quarterly or be available on an ad hoc basis to support patient information review.
2.10	The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families, and consumers. b. Information provided is easy to understand and use. c. The clinical needs of patients are addressed while they are in the health service organisation. d. Information needs for ongoing care are provided on discharge. **Met with Recommendation**	See 2.08 summary.		M		1. Assess demographic data to ensure communication tools and mediums are fit for purpose and age and literacy appropriate, particularly considering the ageing population. 2. Review of the Patient not transported, and Refusal of treatment/ transport policies to generate appropriate patient information to support ongoing safe care.
2.11	The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care. b. Has processes so that the consumers involved in these partnerships reflect	AT acknowledge a consumer engagement framework is required to outline how the partnership model will be governed, developed implemented and monitored. This framework is the foundation and cornerstone of all consumer				See the recommendations at Action 2.01.

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Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
	the diversity of consumers who use the service or, where relevant, the diversity of the local community. **Not Met**	participation and engagement. It is strongly suggested that AT take advantage of the numerous frameworks already developed by other services and adapt and align them to suit AT purpose. The annual report on consumer engagement that is proposed by AT is an excellent idea.				
2.12	The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement, and evaluation of the organisation. **Not Met**	Induction and orientation to ensure that consumers engaged with AT are adequately informed and educated to value add to any subcommittees, training positions or advisory committees is essential. Tokenistic appointments of consumers will not result in quality involvement and are likely to be disclosed in the accreditation process when the involved consumers are interviewed. It is acknowledged that AT currently engage consumers in the position/ design of new infrastructure.		M		Consumer induction packages are designed and tailored to the specific roles that consumer representatives are appointed to.
2.13	The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs. **Not Met**	Once demographic data is available, AT should consider developing robust partnerships with aboriginal stakeholders.		M		Stakeholder consideration be given to (but is not limited by) aboriginal health providers, advocacy agencies and connections through aboriginal health worker liaison services at health/hospital organisations.
2.14	The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce. **Not Met**	There are many ways and avenues to involve consumers in education and training. Patient stories can be a powerful educational tool. How consumers are involved in this domain should be outlined in the consumer engagement framework.		M		AT consider that complaints and compliment feedback offer a conduit to allow patient stories to be told and videoed. These can provide a collective resource to be used for educational purposes.

STANDARD 3: PREVENTING AND CONTROLLING INFECTIONS

The leaders of a HSO develop, implement and monitor systems to prevent, manage and control infections and antimicrobial resistance; reduce harm for patients, consumers and members of the workforce; and achieve good health outcomes for patients. The workforce uses these systems to minimise and manage risks to patients and consumers.

Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
3.01 **Met with Recommendation**	The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for infection prevention and control b. Identifying and managing risks associated with infections c. Implementing policies and procedures for antimicrobial stewardship d. Identifying and managing antimicrobial stewardship risks	There are gaps in the documentation to support infection prevention practices at AT. There was no risk register available which outlined the risks associated with infections. There is no obvious antimicrobial stewardship program in place. Only one antimicrobial medication is used, in limited clinical situations, one requires a doctor consult the other does not leading to opportunity for missed administration or confusion.		M		1. Review the AT infection prevention procedures to ensure that they cover all aspects of preventing and controlling infections such as assessment of patient risk of infection, screening practices, auditing, PPE use, hand hygiene, managing immunisation and infection risk to the workforce, storage of stock and cleaning. 2. Develop a risk register which outlines the risks associated with implementing the requirements of Standard 3 at AT and the action to address the gaps identified. 3. Undertake a risk assessment which considers the approach to antimicrobial stewardship and the limited scope of use. Consider making both situations 'doctor consult' and then section the AMS to the Critical Care and Retrieval service in the same way Blood Management occurs. 4. If the approach at point 3 is adopted, apply to the Commission for Quality & Safety for not applicable in all other parts of AT.
3.02	The health service organisation: a. Establishes multidisciplinary teams to identify and manage risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems. b. Identifies requirements for, and provides the workforce with access to	There is limited evidence of the approach of risk identification and management at AT. There is no obvious hierarchy of controls documented to support staff decision making.		M		1. Develop a risk register which outlines the risks associated with implementing the requirements of standard 3 at AT and the action to address the gaps identified. 2. Define a controls hierarchy at AT 3. Undertake a risk assessment which considers the approach to antimicrobial stewardship and

Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
	training to prevent and control infections c. Has processes to ensure that the workforce has the capacity, skills and access to equipment to implement systems to prevent and control infections d. Establishes multidisciplinary teams, or processes, to promote effective antimicrobial stewardship e. Identifies requirements for, and provides access to, training to support the workforce to conduct antimicrobial stewardship activities f. Has processes to ensure that the workforce has the capacity and skills to implement antimicrobial stewardship activities g. Plans for public health and pandemic risks **Met with Recommendation**	The App provides paramedics with a quick reference guide for the use of PPE for which type of infectious risk. There is no data available to understand how often the infection control section of the App is used to guide practice. There is no antimicrobial stewardship program in place. Paramedics were observed to use masks when attending a respiratory case. There is an overuse of gloves when hand hygiene would be sufficient. There was some infection prevention education provided to the workforce with the appointment of the Infection Prevention Nurse Consultant. The training appears ad hoc rather than part of a risk-based education program. The nurse consultant role is vacant at time of review. There is mandatory training on THEO however staff training rates were not available during assessment. The package was not available for viewing to consider if the content met the intent of the standard in workforce training.				the limited scope of use. Consider making both situations 'doctor consult' and then section the AMS to the Critical Care and Retrieval service in the same way Blood Management occurs. 4. If the approach at point 3 is adopted, apply to the Commission for Quality & Safety for not applicable in all other parts of AT. 5. Develop expertise in the management of Infection Prevention either through partnership or appointment of Infection Control Nurse Consultant. 6. Develop a training program which ensures the workforce has the skills they need to identify and respond to infection risks, keeping patients and themselves safe.

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Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
		There is a state-wide plan for pandemics and public health emergencies which AT has a role.				
3.03	The health service organisation applies the quality improvement systems from the Clinical Governance Standard when: a. Monitoring the performance of infection prevention and control systems b. Implementing strategies to improve infection prevention and control systems c. Reporting to the governance body, the workforce, patients, and other relevant groups on the performance of infection prevention and control systems d. Monitoring the effectiveness of the antimicrobial stewardship program e. Implementing strategies to improve antimicrobial stewardship outcomes f. Reporting to the governance body, the workforce, patient and other relevant groups on antimicrobial stewardship outcomes g. Supporting and monitoring the safe and sustainable use of infection prevention and control resources **Met with Recommendations**	There is some evidence of monitoring of infection prevention and control systems at various levels of the organisation however the information is reviewed at 7 committees making accountability and decision making difficult. There is an action plan to improve infection prevention and control systems however evidence of progress against the actions was difficult to determine.			**H**	*Consider the approach to antimicrobial stewardship described in 3.01* 1. Review the structure to ensure that a single AT Executive is accountable for the infection prevention and control system and there is a committee responsible for monitoring the outcomes and improvement actions. 2. Ensure at least annually, the governing body receives an update on the status of Standard 3 actions, risks, and improvement actions.
3.04	Clinicians use organisational processes consistent with the Partnering with Consumers Standard when assessing risks and preventing and managing infections, and	There is no evidence of partnering with consumers in this standard.		**M**		1. Develop a Consumer Engagement Framework and consider how a consumer representative could be supported at AT to contribute to the preventing and controlling infections standard.

STANDARD 3: PREVENTING AND CONTROLLING INFECTIONS

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Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
	implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making **Not Met**					2. Consider the role of consumers in providing feedback to paramedics on their hand hygiene practices.

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Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
3.05	The health service organisation has a surveillance strategy for healthcare-associated infections and antimicrobial use that: a. Incorporates national and jurisdictional information in a timely manner b. Collects data on healthcare-associated and other infections relevant to the size and scope of the organisation c. Monitors, assesses and uses surveillance data to reduce the risks associated with infections d. Reports surveillance data on infections to the workforce, the governing body, consumers and other relevant groups e. Collects data on the volume and appropriateness of antimicrobial and support appropriate antimicrobial use relevant to the size and scope of the organisation f. Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing g. Monitors responsiveness to risks identified through surveillance h. Reports surveillance data on the volume and appropriateness of antimicrobial use to the workforce, the governing body, consumers and other relevant groups **Met with Recommendations**	There is no evidence of an antimicrobial surveillance system at AT. There is a newly created occupational exposure spreadsheet and contact tracing spreadsheet implemented by the Infection Control Nurse Consultant to support surveillance. There is regular liaison between the Infection Control Nurse Consultant and the Public Health Unit when contact tracing or public health follow up is required. It is unclear if there is a system whilst the role is vacant. There is some evidence of monitoring of infection prevention and control systems at various levels of the organisation however the information is reviewed at 7 committees making accountability and decision making difficult.		M		*Consider the approach to antimicrobial stewardship described in 3.01* 1. Review the structure to ensure that a single Executive is accountable for the infection prevention and control system and there is a committee responsible for monitoring the outcomes and improvement actions. 2. Ensure at least annually, the governing body receives an update on the status of Standard 3 actions, risks and improvement actions. 3. Develop a committee workplan that outlines the timing of reports on compliance to the key areas of the standard, audit results and progress against improvement action plans. 4. Monitor the antimicrobial stewardship program and the prevalence of use of antimicrobials in AT.

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			L	M	H	
3.06	The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare, jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws. **Met**	There is guidance in the App to support Paramedic decision making when applying standard and transmission-based precautions. Paramedics were observed to be wearing gloves when good hand hygiene practices would have been appropriate.	L			
3.07	The health service organisation has: a. Collaborative and consultative processes for the assessment and communication of infection risks to patients and the workforce b. Infection and prevention control systems, in conjunction with the hierarchy of controls, in place to reduce transmission of infections as far as reasonably practical c. Processes for the use, training, testing and fitting of personalised equipment by the workforce d. Processes to monitor and respond to changes in scientific and technical knowledge about infections, relevant national or jurisdictional guidance, policy and legislation e. Processes to audit compliance with standard and transmission-based precautions f. Processes to assess competence of the workforce in appropriate use of	There is screening for infectious risks of patients at the time of calling 000 via the Communication Centre call taker. Alerts are sent via the SCAD system. Standard practices for Paramedics such transporting a single patient, wearing PPE and handover to hospital staff of significant infectious risk occurs. Paramedics were able to describe situations where they would notify the receiving Emergency Department of an infectious patient. There were no audits available for this part of the standard. There was workforce fit testing during the COVID pandemic, staff reported that they were fit tested however a number reported AT does not stock the most suitable mask for them any longer.		M		1. Ensure that the clinical governance framework outlines the roles, responsibilities, accountabilities and reporting requirements for infection prevention and control. 2. Review the current infection prevention workforce training to ensure that the training package meets all the requirements for Standard 3. 3. Measure and report staff personal protective equipment fit testing compliance rates. 4. Ensure that audit reports on infection prevention and control systems are tabled at a committee responsible for taking actions to improve where the performance is below the acceptable standard. 5. Report patient complaints and feedback to a committee responsible for taking actions to improve where the performance is below the acceptable standard.

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Action		Comment	Priority L	Priority M	Priority H	Recommended Action or Improvement Strategy
	standard and transmission-based precautions g. Processes to improve compliance with standard and transmission-based precautions **Met with Recommendation**	There is workforce training in infection control practices however the package was not able to be viewed. It is listed in the DoH Core Competencies procedure for all staff. There was no evidence provided to demonstrate assessment of the competence of the workforce in standard and transmission-based precautions. There has been a gap analysis by the Infection Prevention Nurse Consultant against this standard. It is difficult to determine if improvements have been made as yet.				6. Seek feedback from the workforce on the performance of the infection prevention and control system periodically and evaluate if improvements are required.
3.08	Members of the workforce apply standard and transmission-based precautions whenever required, based on the risk of transmission of infectious agents, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs and patient placement to prevent and manage infection risks d. The risks to the wellbeing of patients in isolation	There is screening for infectious risks of patients at the time of calling 000 via the Communication Centre call taker. Alerts are sent via the SCAD system. Paramedics were able to describe the risk assessment for patient infections which would require PPE or wounds which might be colonised and need covering to prevent spread. There is evidence of cleaning products which are not standardised, cleaning of the ambulances is infrequent, paramedics report cleaning the ambulance after an infectious patient using wipes on all hard surfaces.			**H**	1. Ensure that SRLS incidents are reported where there are patients not identified at the point of call for infectious risks. 2. Undertake audit of clinical documentation to ensure that patient infectious risks are identified and documented. 3. Ensure that cleaning standards are described in the appropriate AT Infection Prevention Procedure. Ensure that it describes cleaning required for the different AT vehicles, clinical and non-clinical equipment and Ambulance Stations. 4. Undertake cleaning audits to ensure that vehicle and equipment cleaning is undertaken as required between patients.

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			L	M	H	
	e. Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems, workflow design, facility design, surface finishes f. Precautions required when the patient is moved within the facility or between external services g. The need for additional environmental cleaning or disinfection processes and resources h. The type of procedure being performed i. Equipment required for routine care **Met with Recommendation**	Paramedics were observed to wipe the patient stretcher after each patient using clinell wipes. The Form 10A used by non-emergency transport staff outlines the infectious risk for patients and provides guidance on when single patient transport is required. There was no procedure available to review on the care and cleaning of equipment, the environment or stations.				5. Review the contract related to station cleaning to ensure that the cleaners are undertaking cleaning to prevent the transmission of infections and to the level reflected in this standard. Ensure that sterile stock rooms and medication rooms are regularly cleaned and audits are conducted of the cleaning. 6. Apply to the Commission for Quality & Safety for *not applicable for Actions 3.08c & 3.08d* on the basis that AT do not provide overnight accommodation to patients and AT does not isolate patients for any duration of time.
3.09	The health service organisation has processes to: a. Review data on and respond to infections in the community that may impact patients and the workforce b. Communicate details of a patient's infectious status during an episode of care, and at transitions of care c. Provide relevant information to a patient, their family and carers about their infectious status, infection risks and the nature and duration of precautions to minimise the spread of infection **Met with Recommendation**	There is screening for infectious risks of patients at the time of calling 000 via the Communication Centre call taker. Alerts are sent via the SCAD system. There was no patient level information available on the AT section of the DoH website or the website more broadly on infection control. The website lists infection prevention and control however it is about this standard, references an out-of-date plan (2020-2022) and is not in easy-to-understand language.		M		1. Consider easy to understand patient information on the management of simple infections such as gastro or flu which can be accessed via the DoH website or electronic communication from secondary triage, call takers or paramedics. 2. Promote the role of Care@Home in the management of simple infections using easy to understand patient information. 3. Consider how the AT system could be updated proactively by patients or their families when the patient has a known ongoing infectious risk so that Paramedics are alerted every time an ambulance is called.

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			L	M	H	
3.10	The health service organisation has a hand hygiene program that is incorporated in its overarching infection and prevention and control program as part of standard precautions and: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits to the workforce, the governing body, consumers and other relevant groups d. Uses the results of audits to improve hand hygiene compliance **Not Met**	Hand Hygiene is not listed on the Core Mandatory Training draft procedure provided. Some Paramedics reported having done Hand Hygiene Australia's learning package. There are no hand hygiene compliance audits. There was little observed use of ABHR products, some paramedics were observed carrying small packs, the placement in stations is ad hoc, it is improved in the newer stations although placement was not consistent with current practices.			H	1. Mandate Hand Hygiene training for the workforce. 2. Audit vehicles and stations for ABHR and place them in high use areas, in medication rooms and clean stock rooms. 3. Audit Hand Hygiene practices using accredited Hand Hygiene Auditors 4. Monitor and report to the Committee responsible for oversight of this standard compliance and improvement works. 5. Report to Hand Hygiene rates as part of annual reporting to the governing body on standard 3.
3.11	The health service organisation has processes for aseptic technique that: a. Identify the procedures where aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique	There is no risk assessment provided to determine if a risk-based approach has been undertaken for AT on ANTT. There is a CWI which has a list of procedures that describes when ANTT applies at AT. This was not available to be viewed at assessment when requested. There has been some training in ANTT undertaken with some educators and CSO's prior to the		M		1. Undertake a review of CPGs to determine if there is an option to reduce the insertion of PIVC in AT through alternate practice such as oral medication. 2. Monitor and report rates of invasive device insertions. 3. Undertake a risk assessment of all invasive procedures undertaken at AT to consider if ANTT can be achieved, that is key parts, and key sites are not touched, and the

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Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
	Not Met	departure of the Infection Prevention Nurse Consultant.				environment can be controlled to eliminate risk of cross contamination. a. If this can be achieved, such as in the insertion or replacement of a urinary catheter by the Community Paramedic then ANTT should be routinely used. b. If this cannot be achieved, such as equipment to create a sterile field is not available or in road trauma resulting in PIVC access, PIVC should be removed at hospital as per the DoH guidance on pre-hospital PIVC. 4. Consider which workforce should be trained in ANTT based on the risk assessment conducted above. 5. Monitor compliance to ANTT practices.
3.12	The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare. **Met with Recommendation**	There were no clearly defined processes in place for the management of invasive devices which were readily available to Paramedics.		M		1. Clearly define and describe the processes for the management of invasive devices in services where they are inserted, based on the risk assessment above. 2. Consider applying to the Commission for Quality & Safety for not applicable in parts of AT where invasive devices are not inserted based on the risk assessment
3.13	The health service organisation has processes to maintain a clean and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare, and jurisdictional requirements – to:	There is evidence of cleaning products which are not standardised, cleaning of the ambulances is infrequent, Paramedics report cleaning the ambulance after an infectious patient using wipes on all hard surfaces.			H	1. Ensure that cleaning standards are described in the appropriate AT Infection Prevention Procedure. Ensure that is describes cleaning required for the different AT vehicles, clinical and non-clinical equipment and stations.

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Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
	a. Respond to environmental risks, including novel infections b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy e. Use the results of audits to improve environmental cleaning processes and compliance with policy **Met with Recommendation**	Paramedics were observed to wipe the patient stretcher after each patient using clinell wipes. There was no procedure available to review on the care and cleaning of equipment, the environment or stations. There were MDSS for the cleaning products in stations located near the cleaning products. Cleaning products, mops and buckets were stored in garage areas subject to dust and dirt, storage areas were dirty and cleaning product labels were not always readable.				2. Provide training for the workforce on appropriate use of cleaning products and ensure that products are used according to the manufacturer's specifications. 3. Undertake cleaning audits to ensure that vehicle and equipment cleaning is undertaken between patients, at the commencement or end of the shift and at the end of the shift block. 4. Review the contract related to station cleaning to ensure that the cleaners are undertaking cleaning to prevent the transmission of infections and to the level reflected in this standard. 5. Ensure that sterile stock rooms and medication rooms are regularly cleaned, and audits are conducted of the cleaning.
3.14	The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Clinical and non-clinical areas, and workplace amenity areas c. Maintenance, repair and upgrade of buildings, equipment, furnishings and fittings. d. Handling, transporting and storing linen e. Novel infections, and risks identified as part of a public health response or pandemic planning	There were no processes described with documents reviewed to evaluate infectious risks. There was no procedure available to review on the care and cleaning of equipment, the environment or stations. Maintenance of stations was variable; the repair and upgrade of stations is not always determined by a risk-based approach.			**H**	1. Ensure that building maintenance, equipment repairs, suitable furnishings and fittings are described in the appropriate AT Infection Prevention Procedure. Ensure that it describes cleaning required for the different AT areas such as garages, external facades, windows, roller doors, clinical and non-clinical equipment and rest areas and admin areas at stations. 2. Provide training for the workforce on appropriate use of cleaning products and

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			L	M	H	
	Met with Recommendation	There was consistency in contracts for pest control and fire equipment checks. Linen storage was often in a dirty area comingled with domestic washing machines, dryers, medications and cleaning sluice sinks. Linen trolleys had covers although not one was observed to be covered. Linen was found to be delivered and placed on the floor rather than the trolley by the linen service. There were multiple examples of patient equipment such as slide sheets being washed in the domestic washing machines and dryers at the station using domestic washing detergent. There were stations where the carpet floor was heavily soiled, there is no routine cleaning of carpet floors in high traffic areas.				ensure that products are used according to the manufacturer's specifications. 3. Undertake cleaning audits to ensure that building and equipment cleaning is undertaken routinely and at least annually. 4. Review the contract related to station cleaning to ensure that the cleaners are undertaking cleaning to prevent the transmission of infections and to the level reflected in this standard. 5. Ensure that patient linen is managed and supplied through a commercial contract. 6. Remove washing machines and dryers where they are not required to improve the workforce amenity such as in remote stations. 7. Where washing machines and dryers remain, using a risk-based approach, where no alternate commercial linen service can be sourced, ensure the washing machine and dryer are commercial grade, have detergent dosing systems installed and there are clear work instructions for the laundering of patient equipment such as restraints or straps. 8. A cleaning schedule should be developed for the commercial washing machine and dryer. 9. Audits should be undertaken for compliance to the cleaning standard and reported to the Committee responsible for oversight of this standard.

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Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
3.15	The health service organisation has risk-based workforce vaccine-preventable disease screening and immunisation policy program that: a. Is consistent with the current edition of the Australian Immunisation Handbook b. Is consistent with jurisdictional requirements for vaccine-preventable diseases c. Addresses specific risks to the workforce and patients **Not Met**	The AT Immunisation procedure was rescinded. The DoH policy is not released. There is no monitoring of Immunisation status for the workforce as documents requested at onboarding are not received centrally. There is no follow up of lapsed or missing immunisations for vaccine preventable illnesses. There is an annual flu vax campaign.			**H**	1. Define the workforce vaccine preventable disease screening and immunisation policy using a risk-based approach. 2. Implement a robust system for recording worker immunisation status. 3. Monitor workforce compliance and report as part of routine reporting to the Committee responsible for this standard. 4. Ensure immunisation compliance is reported to the governing body as part of annual reporting.
3.16	The health service organisation has risk-based processes for preventing and managing infections in the workforce that: a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare b. Align with state and territory public health requirements for workforce screening and exclusion periods c. Manage risks to the workforce, patients and consumers, including for novel infections d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual e. Monitor and manage the movement of staff between clinical area, care settings,	There is a policy which outlines occupational exposure management as well as workforce policy on attendance at work when unwell. Personal Protective Equipment is readily available to the workforce (Consider reviewing stock levels in some places to reduce risk of expiring stock). Paramedics reported an awareness of not attending work when unwell and the need for exclusion periods for some illnesses. Paramedics reported supportive mechanisms during COVID period when isolation was required following exposure or illness.				

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Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
	amenity areas and health service organisations f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection g. Provide for outbreak monitoring, investigation and management h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is an increased risk of transmission of infection **Met**	The Infection Prevention Nurse Consultant had a process with the Public Health Unit for outbreak monitoring; it is unclear how this would occur in their absence. There is a Business Continuity Plan for workforce management.				
3.17	Where reusable equipment, instruments and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufactures' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • The patient • The procedure • The reusable instrument, instruments and devices that were used for the procedure c. Processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections	No reusable medical devices are used at AT			L	Apply for Not Applicable for this action. *Ambulance Tasmania has undertaken a risk assessment and determined that no reusable medical devices are available to the workforce and therefore a not applicable is requested.*

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Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
3.18	The health service organisation has an antimicrobial stewardship program that a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that is informed by current evidence-based Australian Therapeutic Guidelines and resources, and includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard e. Acts on the results of antimicrobial use and appropriateness audits to promote continuous quality improvement **Not Met**	There is no obvious antimicrobial stewardship program in place. Only one antimicrobial medication is used, in limited clinical situations, one requires a doctor consult the other does not leading to opportunity for missed administration or confusion.		M		1. Document the approach to antimicrobial stewardship in an AT procedure. 2. Undertake a risk assessment which considers the approach to antimicrobial stewardship and the limited scope of use. Consider making both situations 'doctor consult' and then section the AMS to the Critical Care and Retrieval service in the same way Blood Management occurs. 3. If the approach at point 2 is adopted, apply to the Commission for Quality & Safety for not applicable in all other parts of AT. 4. Audit compliance to the antimicrobial stewardship program and make improvements where required.
3.19	The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding	There is no obvious antimicrobial stewardship program in place. Only one antimicrobial medication is used, in limited clinical situations, one requires a doctor consult the other does not leading to opportunity for missed administration or confusion. There is limited monitoring of use		M		1. Undertake a risk assessment which considers the approach to antimicrobial stewardship and the limited scope of use. Consider making both situations 'doctor consult' and then section the AMS to the Critical Care and Retrieval service in the same way Blood Management occurs. 2. If the approach at point 1 is adopted, apply to the Commission for Quality & Safety for not applicable in all other parts of AT.

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			L	M	H	
	• compliance with the antimicrobial stewardship policy and guidance • areas of action for antimicrobial resistance • areas of action to improve appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines • the health service organisation's performance over time for use and appropriateness of use of antimicrobials **Not Met**	There is no reporting to clinicians and the governing body on antimicrobial use.				1. Audit compliance to the antimicrobial stewardship program and make improvements where required. 2. Report to the clinicians and the governing body on antimicrobial use at least annually. 3. Apply to the Commission for Quality & Safety for a Not Applicable related to a, b, c based on a risk assessment which identified that the use of a single antimicrobial broad-spectrum agent in the pre-hospital setting for two conditions is appropriate and lifesaving treatment.

STANDARD 4: MEDICATION SAFETY

Leaders of a health service organisation describe, implement, and monitor systems to reduce the occurrence of medication incidents, and improve the safety and quality of medication use. The workforce uses these systems.

Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
4.01	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management. b. Managing risks associated with medication management. c. Identifying training requirements for medication management **Not Met**	There is a DoH medication and a high-risk medication management procedure. The CPG's contain medication management advice for AT paramedics. The CPG's available for use vary depending on level of paramedic. There is AT no high-risk medication management procedure.		M		1. Implement auditing program which ensures that medication management is compliant with AT medication management procedure and CPG's (see Action 1.08) 2. Use the audit results to better understand the risks related to medication management. 3. Report to governing body and back to the workforce, the audit results and action plans arising from the audits undertaken. 4. Define the mandatory training requirements for all Paramedics in medication management and monitor training compliance rates.
4.02	The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management. b. Implementing strategies to improve medication management outcomes and associated processes. c. Reporting on outcomes for medication management **Met with Recommendation**	SRLS reporting of medication incidents is low with only reports of only 3 per month (actual data not available to be viewed), so incident data alone cannot be relied upon to inform medication management effectiveness. The implementation of the ATOM system and medication management improvements for schedule 8 medications is excellent. There has been significant improvement in medication management through monitoring of compliance and follow up of poor results. The implementation of the infusion pump medication library is an evidence-based example of a strategy to improve medication management processes and patient safety.		M		1. Implement auditing program which ensures that medication management is compliant with AT medication management procedure and CPG's (see Action 1.08) 2. Report to governance committees and back to the workforce, the audit results and action plans arising from the audits undertaken. 3. Use the data from medication outcomes monitoring to review the medication formulary to ensure medications available to paramedics are safe and effective for use in the pre-hospital setting.

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Leaders of a health service organisation describe, implement, and monitor systems to reduce the occurrence of medication incidents, and improve the safety and quality of medication use. The workforce uses these systems.

Action		Comment	Priority L M H	Recommended Action or Improvement Strategy
		Paramedics reported inserting PIVC to administer antiemetic medication which may have an alternative available such as a wafer. VACIS case notes not audited against CPGs for compliance in medication administration unless a serious adverse event occurs.		
4.03	Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care. b. Meet the patient's information needs. c. Share decision-making. **Met with Recommendation**	Paramedics were observed involving patients and families in decisions about their care and the use of medications to treat the condition. Paramedics were observed describing the medication being offered, its use and how it would help the patient in simple language. Paramedics described patient care where the patients had refused medication, or medication had not been given at the patients request.	M	1. Describe the processes to partner with patients and their families to ensure that patients are shared decision makers, are making decisions based on informed consent and Paramedics are using effective communication techniques to discuss medication treatment options with patients. 2. Implement auditing program which ensures that clinical records are reviewed for compliance partnering with consumers in medication management actions described above (see Action 1.08). 3. Report to governance committees and back to the workforce, the audit results and action plans arising from the audits undertaken.
4.04	The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing, and administering medicines for relevant clinicians.	Legislation in place, Commissioner of Ambulance Delegated authority to AT Chief Executive CPG's outline medications by Paramedic level Doctor Liaison Service can authorise medication use outside of scope of paramedic	M	1. Consider how the variation to CPG's is captured and documented regarding medication administration. 2. Implement auditing program which ensures that medication variation is monitored (see Action 1.08)

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Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
	Met with Recommendations					
4.05	Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care **Met with Recommendation**	Community Paramedics have been trained by the Pharmacist to take a best possible medication history. Paramedics were observed to review medication lists provided by patients and their families to determine if it was safe to administer treatment. Documentation of medications in the VACIS case notes was limited to those felt 'relevant' to treatment provided or the patient presentation.		M		1. Determine the role of best medication history for all levels of paramedic, describe this in a clinical procedure or CPG. 2. Implement auditing program which ensures that best medication history is compliant with AT clinical procedure and CPG's (see Action 1.08) 3. Report to governance committees and back to the workforce, the audit results and action plans arising from the audits undertaken. 4. Determine the paramedic education required to undertake the best medication history based on above (see Action 4.01c).
4.06	Clinicians review a patient's current medication orders against their best possible medication history (BPMH) and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care **Met with Recommendation**	Training undertaken for Community Paramedics by the Pharmacist.		M		1. Undertake a risk assessment which considers the approach to best medication history taking and the limited scope of use in emergency situations. Consider making best medication history only applicable to certain streams of care such as Community Paramedics and Extended Care Paramedics. 2. If the approach at point 1 is adopted, apply to the Commission for Quality & Safety for not applicable in all other parts of AT.
4.07	The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation.	Allergies are recorded in ESCAD with job notification if alert is recorded.		M		1. Add to the Risk Register the limitations of the VACIS system as a medical record and add an action which ensures that Allergies are

STANDARD 4: MEDICATION SAFETY

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	Met with Recommendation	In VACIS, paramedics can document an allergy, but it is not visible next time patient uses AT service.				handled in a contemporary manner in the new Health Record tender.
4.08	The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system **Met with Recommendation**	In VACIS, paramedics can document an adverse drug reaction and their treatment. A SRLS is completed for any ADR. Pharmacist provided data that there has been 1 in past 12 months.		M		1. Implement auditing program which ensures that clinical records are reviewed for possible ADR as part of routine case audits (see Action 1.08). 2. Report to governance committees and back to the workforce, the audit results and action plans arising from the audits undertaken. 3. Monitor the SRLS for ADR reporting and trigger case review of the clinical record.
4.09	The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration (TGA), in accordance with its requirements **Met**	AT do not usually use new to market medications which are more prone to ADR reportable to TGA. The Pharmacist would make the report for any ADR.				

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			L	M	H	
4.10	The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice. b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems. c. That specify the requirements for documentation of medication reviews, including actions taken as a result **Not Applicable**					Apply for Not Applicable for this action. *Ambulance Tasmania does not provide medication reviews and therefore a not applicable is requested.*
4.11	The health service organisation has processes to support clinicians to provide patients with information about their individual medicines' needs and risks **Met with Recommendation**	Paramedics were observed to discuss medication options with patients. Patient consent to treat is included in CPGs. Most medications within AT are single dose medications to treat the active complaint. Resolution of the complaint is regarded as effective medication management. *This action should be read in conjunction with Partnering with Consumers standard 2.03-2.10 and Medication Safety Standard 4.03 which outlines involving patients in their own care, shared decision making, providing informed consent and effectiveness of communication.*		M		1. Implement AT wide procedure that describes processes for a. discussing the risks and benefits of medications and seeking informed consent b. accessing consumer medicine information by the workforce c. documenting in the clinical record the patient choices and education provided to patients and families when administering medication d. providing patients and families with information on how to identify an allergy and report an ADR 2. Implement auditing program which ensures that clinical records are reviewed for compliance to the patient consent, medication

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						use against CPG and patient information medication processes (see Action 1.08). 3. Report to governance committees and back to the workforce, the audit results and action plans arising from the audits undertaken.
4.12	The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes. b. Distribute the current medicines list to receiving clinicians at transitions of care. c. Provide patients on discharge with a current medicines list and the reasons for any changes **Met**	Paramedics were observed to document in the clinical record some 'relevant' current medications. Paramedics were observed to consider the patients current medications when deciding on medication treatment options. The clinical record was observed to contain medications administered during the episode of care by the Paramedics and medication administration description (medication name, dose, route, time) was provided during handover to health service staff. Form 10.4A is used by NEPT crews, facilities initiate the form to communicate patient condition, medications and reason for transport.				Apply for Not Applicable for Actions 4.12a and 4.12c. *Ambulance Tasmania does not make changes to patients' medications and patients do not get discharged from AT and therefore a not applicable is requested for 4.12a and 4.12c.*
4.13	The health service organisation ensures that information and decision support tools for medicines are available to clinicians **Met with Recommendation**	CPG's contain information on medications and the indications for use. The CPG app requires users to identify the level of paramedic and aligns CPGs to the paramedic level. The App updates frequently.		M		1. Consider AT approach to medication safety and the use of medication calculators are part of routine practice, alternatively consider mandating use in high-risk medication administration, vulnerable patient cohorts or both.

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		The Pharmacist receives emails from users about discrepancies in medication information in the CPG's and then there is follow-up and changes to the CPGs if required following review. The medication calculators in the App are easy to use and provide clear instruction on dose and route and who is authorised to administer (ICP, AP). Some Paramedics reported that they did not routinely use the medication calculators. Clinical Service Updates regarding medication and CPG changes are communicated to the workforce.				2. Describe the approach in a medication related procedure and notify the workforce of the change in practice. 3. Implement auditing program which ensures that clinical records are reviewed for compliance to the use of decision support tools such as medication calculators in medication administration (see Action 1.08). 4. Ensure that decision support tools are built into the tender requirements for the future Health Record where the calculator inputs are transcribed to the patient record automatically.
4.14	The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines **Met with Recommendation**	A procedure outlining the disposal of medications is being updated during assessment. There were a number of medication rooms which were hot or unsuitable being used for medication storage. Some newer medication rooms have air conditioning in place to maintain appropriate storage conditions. Keyless Schedule 8 safes were observed to be in use at AT stations. ATOM is in place to manage the safe and secure management and oversight of S8 medications. Follow up of the S8 medication administration through ATOM software has led to improvements in compliance with clinical documentation. Pharmacist can view clinical cases		M		1. Consider the role of Operations Supervisors and above in viewing S8 medication administration data available in ATOM and the role each level has in compliance monitoring. 2. Implement auditing program which ensures that clinical records are reviewed for compliance to the medication use against CPG processes (see Action 1.08). 3. Implement a reporting system that allows governance committees routine reporting of medication room audit results, medication related risks and corrective actions.

Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
		and cross reference with S8 medications and patient administration. All medication fridges have central monitoring with alerts in place for when out of range, this includes medication fridges within paramedic vehicles. There is a procedure in place for the disposal of unused and expired medications, there are pharmaceuticals for destruction bins are located in all medication rooms. These bins were observed to be full at times. Operational Supervisors described management of medications that had expired as part of their role. Auditing of medication cupboards occurs on 20th of the month by Paramedics and medication expiry dates are checked, stock replacement orders are placed. Paper based forms are used to order and order authorisation is required by the Operations Manager. This process is covered by an Operational Work Instruction (OWI) Transfers of all specified medications is back to the THS for appropriate disposal. Strive for 5 guidelines is part of the process involved in the safe handling and storing of vaccines. Vaccines are limited to ADT in Community Paramedic vehicle fridges.				

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		There is a *Site Medication Compliance Audit* which is part of the Site Inspection Compliance – Medication Management Procedure is undertaken by an AT Manager or above who does not work at the inspection site. The site inspection includes assessment of the building security, AT vehicles and medication rooms. Any non-compliance is to be re-audited in 3 months. Audits are unannounced and random. The audit was completed by the Pharmacist last year, the findings included mostly security elements and auto close doors which were actioned. The audit was handed over to Directors of Operations to continue to conduct ongoing audit, checklist tool not being used.		
4.15 **Not Met**	The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely	There is a DoH High Risk Medication procedure. There are AT drug protocols which are in place for all medications. There is no list of high-risk medications used in the organisation. There is no evidence when reviewing medication rooms or medication kits that high risk medications are stored or labelled differently to other medications.	**H**	1. Develop a list of high-risk medications for AT and make that list available to paramedics. 2. Implement education and training on high-risk medication storage, indications for use and administration. 3. Feedback from Quality Improvement systems should inform strategies to mitigate medication safety risks (Action 4.02) including those involving high-risk medications.

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		There is Tall Man Lettering in place for like named medications. THS provides all medication dispensing to medication rooms. There is a procedure describing the use of syringe labelling however this was not observed during Paramedic shifts. Paramedics were able to describe the process for when to label lines and syringes.				4. Implement auditing program which ensures that compliance to syringe and line labelling processes (see Action 1.08).

STANDARD 5: COMPREHENSIVE CARE

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Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
5.01	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care. b. Managing risks associated with comprehensive care. c. Identifying training requirements to deliver comprehensive care **Not Met**	There is no overarching policy outlining the risk assessment and processes for comprehensive care. There is no risk assessment related to comprehensive care. There is no defined mandatory training for core elements of comprehensive care.		M		1. Review the comprehensive care procedures to ensure that they cover all aspects of the standard such as risk screening and risk assessment, falls, pressure injuries, end of life care, shared decision making, advance care directives, cognitive impairment, suicide and self-harm and use of restraints. 2. Develop a risk register which outlines the risks associated with implementing the requirements of comprehensive care at AT and the action to address the gaps identified. 3. Identify the workforce training requirements to meet the needs of comprehensive care standard. 4. Review the structure to ensure that a single Executive is accountable for comprehensive care and there is a committee responsible for monitoring the outcomes and improvement actions. 5. Ensure at least annually, the governing body receives an update on the status of standard 5 actions, risks and improvement actions. 6. Develop a committee workplan that outlines the timing of reports on compliance to the key areas of the standard, audit results and progress against improvement action plans.

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5.02	The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care. b. Implementing strategies to improve the outcomes from comprehensive care and associated processes. c. Reporting on delivery of comprehensive care **Not Met**	SRLS reporting of incidents related to clinical care is low (actual data not available to be viewed), so incident data alone cannot be relied upon to determine the effectiveness of clinical care. There is no monitoring of clinical care outcomes. Clinical Case review occurs in SAC 1 events. There is an excellent clinical case review process in the critical care and retrieval service.		M		1. Implement auditing program which ensures that clinical care is compliant with AT comprehensive care procedure and CPG's (see Action 1.08) 2. Report to governance committees and back to the workforce, the audit results and action plans arising from the audits undertaken. 3. Use the data from clinical care outcomes monitoring to review the CPG's available to paramedics and ensure that they are reflective of current clinical practice which is safe and effective for use in the pre-hospital setting.
5.03	Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care. b. Meet the patient's information needs. c. Share decision-making **Not Met**	Paramedics were witnessed to discuss care options with patients and families. Paramedics were observed to actively involve patients in decisions about their care. There is no reporting, monitoring or involvement of consumers in comprehensive care as per the principles in Partnering with Consumers standard.	L			1. Develop a Consumer Engagement Framework and consider how a consumer representative could be supported at AT to contribute to the comprehensive care standard. 2. Evaluate the documentation of patient choice, shared decision making and patients involvement in their care in the clinical record. 3. Monitor complaints and compliments related to clinical care delivery.
5.04	The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment.	Secondary triage develop care plans for frequent callers.		M		1. Implement auditing program which ensures that clinical care planning is compliant with AT comprehensive care procedure and CPG's (see Action 1.08)

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	b. Provide care to patients in the setting that best meets their clinical needs. c. Ensure timely referral of patients with specialist healthcare needs to relevant services. d. Identify, at all times, the clinician with overall accountability for a patient's care **Met with Recommendation**	Community Paramedics and Care@Home teams allow patients to be managed at home rather than be transported hospital for minor complaints. There are established referral pathways for Mental Health emergencies where Mental Health clinicians are consulted to assess patients. VACIS lists all paramedics involved in care.				2. Evaluate referral pathways for alternate care pathways to ensure safe and effective care is maintained. 3. Establish a clinical documentation standard, audit care to ensure that documentation is accurate and complete.
5.05	The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team **Met with Recommendation**	The Critical Care and Retrieval team demonstrates multidisciplinary team collaboration which enhance clinical care and safety. The culture within the team has been influenced by the aviation crew with the use of checklists for infrequently performed tasks. AT has clearly defined scope of practice for Non-Emergency Transport staff, Paramedics, Intensive Care Paramedics, Flight Intensive Care Paramedics. The nursing and medical roles are less well described.		L		1. Review all positions at AT to ensure that there are clear roles and responsibilities for each team member, especially in the newer roles such as community paramedics, nurses and registrars rotating through Critical Care and Retrieval. All position descriptions should have clear roles and responsibilities for delivering the elements of comprehensive clinical care within a defined scope of practice supported by credentialing.
5.06	Clinicians work collaboratively to plan and deliver comprehensive care **Met**	The Communication Centre, Secondary Triage, Community Paramedics, Paramedics, Intensive Care Paramedics and Critical Care and Retrieval all plan care in collaboration with the patient and family.		L		
5.07	The health service organisation has processes relevant to the patients using the service and the services provided:	Risk assessment is the core business of a Paramedic, it frames all thinking, the CPG's support and guide		L		1. Ensure the Comprehensive Care procedure outlines the risk screening approach and lists

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	a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion **Met**	practice. CPG's also define the risks associated with the condition. Form 10A used by Non-Emergency Transport teams list risks.				the minimising harm criterion (linked to Action 5.01)
5.08	The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems **Not Met**	Not done, nowhere to record findings in VACIS. Paramedics could discuss the increased social and health risks and shorter life expectancy.		M		1. Routinely identify Aboriginal and Torres Strait islander people and record findings in the administrative or clinical system. 1. Incorporate into the Comprehensive Care procedure a statement about the increased social and health risks faced by indigenous communities. 2. Consider referral pathways for Aboriginal Lead Health Organisations for low acuity care.
5.09	Patients are supported to document clear advance care plans **Not Applicable**		L			Apply for Not Applicable for this action. *Ambulance Tasmania does not create Advanced Care Directives however when patients provide them, AT workforce are able to follow the directives and therefore a not applicable is requested.*

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5.10	Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care. b. To identify cognitive, behavioural, mental, and physical conditions, issues, and risks of harm. c. To identify social and other circumstances that may compound these risks **Met with Recommendation**	CPG's outline care and clinical decision making. Risk thinking integrates patient assessment and care decisions. Paramedics were observed to consider the clinical presentation, social factors and shared decision making to determine the care plan. The Leave at Home CPG has red flags list which excludes patients being left at home.		M		1. Incorporate into the Comprehensive Care procedure the risk screening processes, when they should occur and include how social circumstances can influence and change the care plan. 2. Incorporate evidence based & validated risk screening tools into the CPG's to identify cognitive, behavioural, mental and physical health conditions such as 4AT for Cognition or the Columbia tool for suicidality. 3. Implement auditing program which ensures that clinical care is compliant with AT comprehensive care procedure and CPG's (see Action 1.08) 4. Report to governance committees and back to the workforce, the audit results and action plans arising from the audits undertaken. 5. Ensure documentation standards are met, and risk screening occurs as described in CPG's.
5.11	Clinicians comprehensively assess the conditions and risks identified through the screening process **Met with Recommendations**	CPG's outline current risk assessments required.		M		1. Define the conditions where a risk screening should occur and then insert the risk screening tools into the CPG's. 2. Ensure that decision support tools are built into the tender requirements for the future Health Record where the risk screening tools are built into the patient record automatically.

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5.12	Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record **Not Met**	Alerts are communicated via the ESCAD system as part of the job description. Alerts are linked to an address rather than a patient. If the patient calls from an alternate address the alert will not be known unless the Paramedics recognise the name of the patient. Alerts are not visible in VACIS. Alerts are not routinely documented in the clinical documentation by Paramedics		M		1. Add to the Risk Register the limitations of the VACIS system as a medical record and add an action which ensures that Alerts are handled in a contemporary manner in the new Health Record tender. 2. Incorporate into the Comprehensive Care procedure the documenting Alert processes, when they should occur and how to have an alert applied to the ESCAD system. 3. Implement auditing program which ensures that Alerts are documented in the clinical record (see Action 1.08).
5.13	Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm. b. Identifies agreed goals and actions for the patient's treatment and care. c. Identifies the support people a patient wants involved in communications and decision-making about their care. d. Commences discharge planning at the beginning of the episode of care. e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence **Met with Recommendation**	Not in a procedure available to be viewed during the assessment. Paramedics were observed to using shared decision making in cases attended by the team. Discussion with the patient, family, Police to plan care was evident. The Communication Centre, Secondary Triage, Community Paramedics, Extended Care Paramedics and Care@Home teams use referral pathways to support on-going care needs.		M		1. Incorporate into the Comprehensive Care procedure the documenting shared decision-making processes, treatment and transport decisions. 2. Implement auditing program which ensures that shared decision making is documented in the clinical record (see Action 1.08).

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5.14	The workforce, patients, carers, and families work in partnership to: a. Use the comprehensive care plan to deliver care. b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care. c. Review and update the comprehensive care plan if it is not effective. d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur **Not Met**	No evidence during assessment that this is undertaken		M		1. Incorporate into the Comprehensive Care procedure a definition of what the comprehensive care plan is for each stream of care (such as emergency care, extended care, critical care) 2. Define the short-term nature of the work undertaken at AT limits the care planning timeframes. 3. Implement auditing program which ensures that care planning is documented in the clinical record as it is defined (see Action 1.08).
5.15	The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care **Not Met**	No evidence during assessment that this is undertaken		M		1. Incorporate into the Comprehensive Care procedure a definition of how end of life care is supported for each stream of care where it is applicable (such as extended care, Care@Home) 2. Undertake a risk assessment which considers which streams of care end of life care supports may be provided and the limited scope of use in AT. 3. If the approach at point 2 is adopted, then apply to the Commission for Quality & Safety for not applicable in all other parts of AT. 4. Implement an auditing program which ensures that end of life care planning is documented in the clinical record as it is defined (see Action 1.08).

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5.16	The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice. **Not Met**	There is a Palliative Care project in progress		M		1. Describe in an AT procedure how AT workforce can access specialist Palliative Care advice to support end of life care with or without transporting the patient to hospital (such as out of hours) through partnerships with health services.
5.17	The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients. b. Are documented in the patient's healthcare record **Not Applicable for 5.17a**	No evidence during assessment that this is undertaken		M		1. Define how AT supports end of life care (such as out of hours) but does not develop end of life care plans. 2. If no role in developing plans is confirmed, apply to the Commission for Quality & Safety for a not applicable for this criterion. *Ambulance Tasmania does not create end of life care plans however when patients provide them, AT workforce are able to follow the plan and therefore a not applicable is requested for Action 5.17a.*
5.18	The health service organisation provides access to supervision and support for the workforce providing end-of-life care **Not Met**	There is no specialist supervision for staff who support end of life care at AT at the time of assessment.		M		1. For the workforce who support end of life care such as extended care, Care@Home, engage specialist supervision and supports to maintain staff wellbeing.
5.19	The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care	No evidence during assessment that this is undertaken		M		1. Implement auditing program which ensures that end of life care is provided as documented in the end-of-life care plan (see Action 1.08). Consider the conduct of the audit

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	Not Met					in partnership with the health service provider. Develop mechanisms to receive feedback where variations to care are identified. 2. Consider where documentation occurs for end-of-life care provided by AT workforce.
5.20	Clinicians support patients, carers, and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care. **Not applicable**			L		1. Define the role of AT in shared decision making for end-of-life care, 2. If AT has no role in the decision making, apply to the Commission for Quality & Safety for a not applicable for this criterion. *Ambulance Tasmania does not create end of life care plans, and the shared decision making would occur prior to AT involvement however the AT workforce are able to follow the plan and therefore a not applicable is requested for Action 5.20.*
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. **Met with Recommendation**	All AT ambulances have pressure relieving mattresses in place. CPG describes that transport on the spine board should not occur as it increases pressure injury risk.		M		1. Incorporate into the Comprehensive Care procedure a definition of how pressure injury prevention occurs for each stream of care (such as emergency care, extended care, critical care) 2. Define the short-term nature of the work undertaken at AT limits the pressure injury prevention measures to equipment and positioning in the Comprehensive Care procedure.

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						3. Describe the pressure injury prevention equipment specifics in the Comprehensive Care procedure. 4. Implement auditing program which ensures that pressure injury prevention is documented in the clinical record where additional measures are implemented such as in prolonged transfers (see Action 1.08). 5. Report to the workforce and the governing body on pressure injury prevention, equipment audit outcomes and any pressure injury incidents reported at least annually.
5.22	Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency **Met with Recommendation**	Paramedics reported skin assessment is undertaken as part of the secondary survey when applicable.			L	1. Incorporate into the Comprehensive Care procedure a definition of when skin assessment occurs for each stream of care (such as emergency care, extended care, critical care) and the patient conditions where skin assessment should be undertaken such as in patients who have a prolonged time on the floor following a fall or frail people with existing pressure injuries. 2. Define the short-term nature of the work undertaken at AT limits the skin assessment in all patients in the Comprehensive Care procedure (describe AT taking a risk-based approach).

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			L	M	H	
5.23	The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries. b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries. **Not Met**	There was no evidence of any patient, carer or family information brochures or flyers available during assessment.	L			1. Develop with patient, family and carer input a pressure injury information flyer which is available to various workforce groups to use as needed. 2. Describe the pressure injury prevention equipment specifics for each workstream in the Comprehensive Care procedure.
5.24	The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management **Met with Recommendation**	Responding to people who have fallen and are injured or can't get up is the core business of AT. Paramedics were observed to consider the frailty and risk of fall when transferring patients to the ambulance. There is limited opportunity to provide information to patients, carers and families on post fall management.		M		1. Describe AT role in falls prevention, consider clinical data review to determine frequency of falls, any seasonality to request for help following a fall such as Spring when more high falls might occur due to people doing home maintenance or increased falls in the elderly during winter when the home is more cluttered. Consider collaboration with DoH to raise awareness and promote public health messages. 2. Incorporate into the Comprehensive Care procedure a definition of how falls prevention occurs for each stream of care (such as emergency care, extended care, critical care) 3. Define the short-term nature of the work undertaken at AT limits the falls prevention measures to patient transfer decisions in the Comprehensive Care procedure.

STANDARD 5: COMPREHENSIVE CARE

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						4. Describe the transfer equipment available to Paramedics in the Comprehensive Care procedure. 5. Implement auditing program which ensures that patient transfer considers patient safety and prevents falls is documented in the clinical record where measures are implemented such as the use of a facility hoist to safely transfer a patient to the stretcher or AT equipment is used to lift the patient off the floor (see Action 1.08). 6. Report to the workforce and the governing body on falls prevention, equipment audit outcomes and any falls with harm incidents reported at least annually.
5.25	The health service organisation providing services to patients at risk of falls ensures that equipment, devices, and tools are available to promote safe mobility and manage the risks of falls. **Not Applicable**			M		1. Apply for Not Applicable for this action. *Ambulance Tasmania has undertaken a risk assessment and determined that there is no role for AT in the provision of equipment or devices for patients at risk of falls and therefore a not applicable is requested.*
5.26	Clinicians providing care to patients at risk of falls provide patients, carers, and families with information about reducing falls risks and falls prevention strategies.	Patients at risk of falls are excluded from being left at home on the Leave at Home CPG. There is an opportunity for the workforce when in people's homes to provide information on the need		M		1. Describe AT role in patients at risk of falls. 2. Incorporate into the Comprehensive Care procedure a definition of how falls prevention occurs for each stream of care (such as emergency care, extended care, critical care)

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	Met with Recommendation	for improved accessibility (ramps) or decluttering (rugs, clear walkways) to reduce falls risks.				3. Define the short-term nature of the work undertaken at AT limits the falls reduction measures to an information sheet or brochure which advises families to seek further assessment in the Comprehensive Care procedure. 4. Consider the development of an information sheet or brochure which paramedics can refer families to when there are opportunities identified to minimise the risk of falling during a case.
5.27	The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice. **Not Applicable**			L		1. Apply for Not Applicable for this action. *Ambulance Tasmania has determined that there is no role for AT in the provision of food and nutrition for patients and therefore a not applicable is requested.*
5.28	The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk. c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone.			L		1. Apply for Not Applicable for this action. *Ambulance Tasmania has determined that there is no role for AT in the provision of food and nutrition for patients and therefore a not applicable is requested.*

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	d. Support patients who require assistance with eating and drinking **Not Applicable**					
5.29	The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment, and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation. **Not Met for 5.29a** **Not Applicable for 5.29b**	The 4AT was in development and ready to be implemented when the team were at AT in July 2024. The 4AT has not been implemented yet. Further, there appears to be no connection between the use of 4AT for cognitive screening and the Capacity & Consent CPG being developed and the workforce educated about at the time of this assessment visit.		M		1. Describe AT role in Cognitive Assessment and Delirium Prevention and incorporate into the Comprehensive Care procedure for each stream of care (such as emergency care, extended care, critical care) 2. Define the short-term nature of the work undertaken at AT limits the role AT have in Delirium prevention in the Comprehensive Care procedure. 3. Define the screening tools available to the workforce to screen for cognitive impairment and link to the capacity and consent processes as an objective measure of capacity. 4. Implement auditing program which considers cognitive screening tool use and how capacity to consent is documented in the clinical record (see Action 1.08). 5. Report to the workforce and the governing body on cognition screening frequency audit outcomes and any capacity or consent incidents reported at least annually. 6. Apply for Not Applicable for Action 5.29b.

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						Ambulance Tasmania has determined that there is no role for AT in the prescription or administration of antipsychotic and psychoactive medications for cognitively impaired patients and therefore a not applicable is requested.
5.30	Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat, and manage cognitive impairment. b. Collaborate with patients, carers, and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care **Not Met**	The use of the 4AT screening tool will assist the workforce to recognise cognitive impairment. Paramedics were observed to provide individualised care to reduce the anxiety of the patient whilst the assessment occurred and decisions about treatment were considered.		M		1. Describe AT role in recognition of cognitive impairment and describe that there is no role for AT in the prevention, treatment and management of cognitive impairment in the Comprehensive Care procedure for each stream of care (such as emergency care, extended care, critical care). 2. Define the short-term nature of the work undertaken at AT limits the role AT have in collaborating with patients, families and carers in the Comprehensive Care procedure. 3. Implement auditing program which considers patient outcomes for patients with cognitive impairment and distress during transport to a health service and care is documented in the clinical record (see Action 1.08).
5.31	The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm. b. Identify when a patient is at risk of suicide.	Assessment of self-harm occurs during the call taking at the Communication Centre. Details are provided in the dispatch information on the ESCAD. There are Mental Health staff who can provide specialist input and assessment in the community.		M		1. Describe AT role in the provision of care for patients, carers and families when someone is feeling at risk of self-harm, has self-harmed or is at risk of suicide and incorporate into the Comprehensive Care procedure for each

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	c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed **Met with Recommendation**	There are three different Mental Health models of care in place in the three regions of Tasmania within AT. Patients who are expressing suicidal ideation are usually transported to hospital for further assessment. The Mental Health Act can be used if necessary to support safe transport and Police are used if aggression is a concern. Paramedics described an approach where the least restrictive practice is used to facilitate transport to further assessment and care.				stream of care (such as emergency care, MHER, PACER) 2. Define the screening tools available to the workforce to screen for self-harm or suicidality such as the brief Mental State Examination or Columbia tool. 3. Implement auditing program which considers risk assessment and screening tool use and how self-harm, and suicide risk is documented in the clinical record (see Action 1.08). 4. Report to the workforce and the governing body on audit outcomes where suicide is completed or significant self-harm is completed following a decision to not transport at least annually.
5.32	The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts **Not Applicable**	There is an Emergency Services meeting which AT Managers or above attend which allows feedback on cases where the management of Mental Health patients are discussed.	L			1. Define in an AT procedure that there is no role for AT in the follow up planning for patients who have been transported to hospital. 2. Apply for Not Applicable for Action 5.32 *Ambulance Tasmania has determined that there is no role for AT in the follow up of arrangements of patients who have harmed themselves or reported suicidal thoughts after the initial assessment and transport to a health service and therefore a not applicable is requested.*

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5.33	The health service organisation has processes to identify and mitigate situations that may precipitate aggression **Met with Recommendation**	There are alerts attached to a patient address when aggression is identified by the call taker or previous aggressive incidents have occurred. There is no way to have an alert attached to a patient, so if the call comes from an alternate address there is no pre-warning. There are processes in place to attend with Police if required, some jobs are dispatched with staging for Police which means wait at a certain location until Police can accompany the Paramedics to the scene. All AT vehicles have duress alarms fitted, all AT radios have the capability to request assistance via a duress button.		M		1. Describe AT role in identifying and mitigating situations which might precipitate aggression and incorporate into an AT procedure. 2. Describe scenarios where Police attendance is mandatory, ensure Police have endorsed the approach. 3. Train the workforce in communication de-escalation techniques in addition to risk assessment and retreat procedures annually. 4. Report to the workforce and the governing body on the frequency of aggressive incidents, any lost time injuries, number of jobs where Police attendance is required and develop safety management plans for patients with a known history of aggression. 5. Ensure SRLS incident reports are completed for patient or by-stander aggression and clinical documentation occurs in the patient record.
5.34	The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent. b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce **Met with Recommendation**	There is a message on the DoH website about zero violence towards paramedics. There is a lack of training in de-escalation annually, Paramedics reported that aggression management may have been covered in an ESM session a few years ago. During induction, Paramedics are taught to manage aggression by pulling back to a safe distance from			H	1. Provide training to the workforce in contemporary evidence-based skills for the management of clinical aggression in addition to risk assessment and retreat procedures annually. 2. Report to the workforce and the governing body on the number of addresses with an alert for aggression in place.

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		the patient, removing themselves from the immediate location such as leaving the house, retreating to the ambulance or retreating to a staging location whilst awaiting Police to attend to support patient assessment.				
5.35	Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint. b. Govern the use of restraint in accordance with legislation. c. Report use of restraint to the governing body **Not Met**	Paramedics are designated Mental Health Officers under the Mental Health Act and need to satisfy themselves that the four circumstances apply to restrain a patient under the Mental Health Act. Paramedics reported using techniques to avoid restraint where possible. It could not be confirmed that all cases of restraint are audited and reported to the governing body in accordance with the legislation during the assessment. All restraint is reported to the Office of the Chief Psychiatrist.			**H**	1. Describe AT role in the use of restraint and the Mental Health Act and other situations and incorporate into an AT procedure. 2. Train the workforce in communication de-escalation techniques and practice through simulation of the use of restraints where restraints are used infrequently. 3. Implement an auditing program which reviews when restraints are used and provides assurance that the restraint is in accordance with the legislation (see Action 1.08). 4. Report to the workforce and the governing body on the frequency of restraint use. 5. Ensure SRLS incident reports are completed for restraint use and clinical documentation occurs in the patient record.
5.36	Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion.					1. Apply for Not Applicable for Action 5.36 *Ambulance Tasmania has determined that there is no role for AT in the use of seclusion and therefore a not applicable is requested.*

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	b. Govern the use of seclusion in accordance with legislation. c. Report use of seclusion to the governing body **Not Applicable**					

STANDARD 6: COMMUNICATING FOR SAFETY

Leaders of a health service organisation set up and maintain systems and processes to support effective communication with patients, carers and families; between multidisciplinary teams and clinicians; and across health service organisations. The workforce uses these systems to effectively communicate to ensure safety.

Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
6.01	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication **Met with Recommendation**	AT has several policies and procedures that outline best practice communication. The Call Centre has a very structured approach and training programs for staff and the team observed these translate to practice. VACIS documentation however is impeded by the structure and process of the software system. The DMR is currently not visible to clinicians on the road. Ongoing communication training is reliant on ESM inclusion		M		Re-evaluate the current risks with the communication processes, systems, training and monitoring, and review mitigations, training and inclusion on the risk register.
6.02	The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes **Not Met**	The team observed very poor compliance with IMISTAMBO that is part of AT communication policy. At the time of consultation there is no form of regular audit done on compliance with communication policies and procedures. Consequently, without auditing, it is challenging to develop and implement strategies to improve the effectiveness of communication.			H	Introduce a regular form of documentation and /or observational audit across AT (inclusive of non-urgent communication transfer processes).
6.03	Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care	An AT consumer feedback form which was described as having a 50% return rate is used to collect consumer feedback. As communicating for safety is AT core business, this survey should specifically address or give opportunity for		M		1. Finalise the Draft Consumer Framework. 2. Monitor and analyse consumer feedback received and report any thematic data relating to communication.

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	b. Meet the patient's information needs c. Share decision-making **Met with Recommendation**	consumers to feedback on communication processes. There is opportunity to merge this feedback with other forms of consumer feedback (complaint and compliments) and assess for any themes. The draft consumer framework should outline how governance is interrelated with consumer engagement. There is a process for carers and families to ring 000 to communicate concerns for those who family members that maybe in AT care. There is currently no process for Advance Care Directives to be available for viewing on record and further education is required to address staff's knowledge gaps in how to implement consumer wishes.				3. Review consumer survey data to ensure communicating for safety is purposeful and eliciting the information required for improvement.
6.04	The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations, and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes. **Met with Recommendation**	Consultants observed high compliance with the use of three identifiers. Information transfer compliance and use of IMSTAMBO is poor as stated in 6.02. Despite the VACIS system creating risk around the transfer of critical information to the record, staff have developed work arounds to improve safety.		M		See 6.01, 6.02 recommendations.

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6.05	The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated **Met**	Identification processes are well developed within AT all levels of service. Standard identifiers are used as per the policy.				
6.06	The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care **Met**	Processes are in place to correctly match patients with their intended care to ensure safe treatment and transfer. It is suggested that the EMS training on capacity to consent be implemented to all face-to-face service providers.				
6.07	The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover	The minimum information is well defined (IMSTAMBO) for paramedics however compliance is poor. Handing over to hospital services is fragmented and challenging due to the use of different communication formats (ISBAR/ISOBAR). Non-emergency services rely solely on the 10A form, and no verbal handover is given. The 10A form is not kept or filed by NPS therefore what is recorded in VACIS is inconsistent. There were verbal reports that recording in VACIS for this group was		M		1. Ensure compliance with handover practices and undertake observational audits to identify opportunities to improve. 2. Standardise and monitor NPT handover practices in line with best practice. 3. Consult with receiving stakeholders and come to agreement on best practice approaches.

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	Met with Recommendation	not complied with, particularly in the South, leaving no record of the transfer for AT. During the consultancy a paramedic handover was observed handing over to five different hospital clinicians for the one patient, at other times it was streamlined to two (triage and one clinician) as per best practice.				
6.08	Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient. f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care **Met with Recommendation**	Although processes are in place, there was little to no compliance with the IMSTAMBO approach observed. Non-emergency transport uses a different approach with the 10A form and there were witnessed variations in this approach as well. Consumer and carer/ family involvement in handover and communication showed large variation with staff appearing to be not clear on the approach to involve a consumer /carer. Feedback from triage nurses in Emergency Departments reinforced the above findings of inconsistency.		M		1. Review, standardise and monitor handover processes. 2. Consider meeting with stakeholders to understand barriers to highly reliable communication practices. 3. Implement and monitor a quality improvement plan after key barriers have been identified.
6.09	Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to:	There are policies in place to ensure critical information is communicated and information such as allergies, observations and OV risk are communicated. Communication of high-risk		M		Implement further training to ensure all critical information, alerts and risks are communicated to receiving clinicians.

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	a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient **Met with Recommendation**	medications, falls, Advance Care Directives, and cognitive impairment however are currently poorly understood by the AT workforce and further education, and training is required.				
6.10	The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians **Not Met**	Communication processes with consumers and carers/ families remains ad hoc and poorly defined. Escalation policies on how patients and carers can raise concerns and how to manage them need further development. Examples of this are Advance Care Directives, End of Life Care processes, and management of the cognitively impaired client with delirium and dementia focus and how issues related to these processes can be communicated.		M		1. Review current processes for patients and carers to communicate critical information. 2. Provide resources/tools for patient and families to use to communicate concerns. 3. Audit documentation for evidence of these communication episodes. 4. Develop an action plan for improvement on the results of above.
6.11	The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan **Met with Recommendation**	As the current clinical information systems do not support clinical documentation at the point of care, all the clinical notes are entered post the care event and not contemporaneously. There are situations where critical clinical information is handed over to other AT staff or to other healthcare providers verbally. There is no capacity to capture what is communicated and this is a clinical risk where critical information is involved.		M		Ensure the scoping of the VACIS replacement is assessed for capability to integrate with other hardware such as monitoring equipment in addition to other systems that could provide interfaces to critical clinical care information.

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		Further, variation was found during this review in what staff in the field include as information in a handover situation as well as how that information is documented in the clinical record. Much work is required by AT to identify critical points where handovers occur and to standardise the information which is communicated and documented. Articulating these requirements will then allow the systematic evaluation of compliance and performance against those requirements.				

STANDARD 7: BLOOD MANAGEMENT

Leaders of a health service organisation describe, implement and monitor systems to ensure the safe, appropriate, efficient and effective care of patients' own blood, as well as other blood and blood products. The workforce uses the blood product safety systems.

Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
7.01	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management **Met**	AT have reviewed the blood management policies, procedures and guidelines so that they align with the requirements outlined in the National Standards. The only service which gives blood is the Critical Care and Retrieval Service (CCS) which has medical staff on hand to review cases and to determine the need for the use of blood in accordance with the AT systems. Three units of O Neg are kept in monitored refrigeration at both the Launceston and Hobart bases. These units are monitored and when approaching their use by date are rotated back to the relevant hospital blood bank for use. No wastage occurs for the units allocated to AT.	L			1. Use the development and monitoring of the blood management systems in place at CCR as an exemplar of how the National Standards can be used and implemented. 2. Use the organisational structure developed for the National Standards to apply for a Not Applicable for the whole of AT except for CCR for Standard 7
7.02	The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management **Met**	Every episode of blood usage is case reviewed and presented to the CCR staff to sure that there was compliance with the AT requirements and alternatives to blood usage were considered.				
7.03	Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to:	As the use of blood is most often undertaken in an emergent situation where the consumer is not conscious or lacks capacity to be involved, the use				

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Action		Comment	Priority			Recommended Action or Improvement Strategy
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	a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making **Met**	of blood is only done where clinically necessary and in accordance with AT systems. As outlined above every case of blood usage is reviewed against the blood management systems. In the rare case of a consumer being conscious and able to give consent, their consent is obtained verbally and documented in the clinical notes by the prescribing medical officer.				
7.04	Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores. b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks **Met**	7.04 a is not applicable in the AT situation, and as stated previously, all blood usage is reviewed in accordance with the AT procedures and each case where blood is used is audited for compliance.				
7.05	Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record **Met**	All the details related to the transfusions undertaken by AT are documented in the clinical record in a way which allows the tracking of the units transfused to an individual consumer.				
7.06	The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria	The AT blood management systems are in line with evidence-based guidelines for the use of blood in emergency situations.				

STANDARD 7: BLOOD MANAGEMENT

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Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
	Met					
7.07	The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria **Met**	Even though it may be difficult to differentiate an adverse blood transfusion reaction in the emergent clinical situation, AT have the capacity to report adverse events into the SLRS systems.				
7.08	The health service organisation participates in haemovigilance activities, in accordance with the national framework **Met**	Blood is only used in AT in emergent situations, and every use of blood by AT is case reviewed for appropriate prescribing and number units used.				
7.09	The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer **Met**	Blood is appropriately stored in monitored refrigeration and tracing is in accordance with the blood banks of the Hobart and Launceston Hospitals.				

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Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
7.10	The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage. **Met**	As stated, three units of O Neg are kept at the Hobart and Launceston airports ready for use. This has been reviewed to determine whether more or less than three units is appropriate and has been assessed as an appropriate balance between availability and usage patterns. Even though more than three units may be required in a particular emergency case, AT have instituted movement and pick up systems to deliver more units if required. Plans have also been developed in liaison with the blood banks to provide O Pos units in times of shortages of O Neg units with appropriate risk management of the clinical situation. There is no wastage by AT as units are rotated out of AT by the blood banks prior to the use by dates, and all movement of the units is done using appropriate blood coolers with data loggers monitoring the storage temperatures. This maintains the cold chain throughout the transport and use through the whole time the units are in the possession of AT.				

STANDARD 8: RECOGNISING ACUTE DETERIORATION

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Action		Comment	Priority			Recommended Action or Improvement Strategy
			L	M	H	
8.01	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration. b. Managing risks associated with recognising and responding to acute deterioration. c. Identifying training requirements for recognising and responding to acute deterioration **Met with Recommendation**	Management of the deteriorating patient is in many aspects the core business of AT, there are multiple policies, procedures and CPG's in place to guide clinicians in their clinical decision making and practise. The call centre has a robust triage system in place and services are allocated according to priority. KPI's are monitored and available to staff for clinical practice review call centre practice. The NEWS2 and CEWT have been rolled out and been included in ESM training however as it has been recently implemented, translation into practice is still being embedded. Guidelines for escalation of deterioration are also on the 10A form for NPS, but they do not currently align with NEWS.			**H**	1. Continue rollout of NEWS training and audit and evaluate its effectiveness. 2. Re-evaluate the NPS process of escalation and its alignment with NEWS for consistency of best practice.
8.02	The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems. c. Reporting on effectiveness and outcomes of recognition and response systems. **Not Met**	There are no regular audits undertaken currently to assess compliance with NEWS or the 10A escalation procedure. There is some oversight if a serious incident occurs, and case review is completed. Feedback to those in the field regarding these cases is ad hoc the workforce reported little, if any, feedback is disseminated down when these serious events occur and the delay in feedback was noted. Due to the lack of auditing there is no robust improvement plans in place. The air retrieval service has a mortality and morbidity review process, however there is no regular death review process for road services other			**H**	1. Develop a regular audit schedule to address the current gaps. 2. Implement a robust improvement plan that is reported and monitored to ensure ongoing improvement and compliance. 3. Implement a death review process (outside of incident case review) for road services.

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Action		Comment	Priority L M H	Recommended Action or Improvement Strategy
		than the reported incident review process for serious adverse events. There is opportunity to also make better use of the cardiac arrest registry for case review.		
8.03	Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care. b. Meet the patient's information needs. c. Share decision-making **Met with Recommendation**	There are signs that AT are moving towards more integrated partnership with consumers with the CPG for the Capacity to consent about to go live (this has been delayed 4 months) and training be integrated into ESM. There appeared to be little resources available to ensure patients and carers information needs are met other than escalation processes to Dial 000 in an emergency. Further training is required to ensure the workforce understand and apply information outlined in Advance Care Directives. Shared decision making was not evidenced in a snap audit of VACIS records, and it was difficult to find evidence of any verbal agreements.	M	1. Apply recommendations from 6.03 in the context of 8.03. 2. Monitor and evaluate the implementation of Capacity to consent training and clinical application. 3. Review how documentation of shared decision making maybe captured in the clinical record.
8.04	The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to:	The implementation of NEWS is a positive step towards a structured system to support paramedics to recognise variation and deterioration. Front line staff reported they are using the system however	H	1. Endorse and implement the draft Non-Emergency Patient Transport protocols. 2. Address training requirements from Rec 1.

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			L	M	H	
	a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan. c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient. **Met with Recommendation**	there are still variations to use due to the recent implementation. NPT continue to use the 10A form for guidance on variation suitability to transport and a snap audit of 12 records showed that despite variation outside the suggested parameters and process for calling for advice, this procedure is not always followed. When questioned on this NPT staff this occurs when they know the patient normally sits outside of the agreed parameters. Currently NPT staff do not do any further vital sign recording or monitoring despite the current protocol from 2016 decreeing they should. A trial of NPT monitoring vital signs in the North has now been ceased however there appeared to be no robust evaluation. Monitoring equipment is not provided in NPT ambulances in the current state. This all creates inconsistency with protocol and practice. There is a new draft of the Non-Emergency Patient Transport Protocols, and the monitoring of vitals is inclusive of practice however it is yet to be rolled out.				3. Review documentation and tracking recommendations suggested in the Guide for the National Safety and Quality Standards for Ambulance Services in Standard 8.04 and identify any gaps. 4. Audit compliance with NEWS when rollout is complete.

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			L	M	H	
8.05	The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium. b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan. c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function, or emotional state are observed or reported. d. Determine the required level of observation. e. Document and communicate observed or reported changes in mental state **Not Met**	The 4AT is the preferred tool used by hospital services for the detection and early recognition of Delerium, however a tool and resource are yet to be rolled out across AT. In the case of delirium, history from carers and family is pivotal to understanding the patient's normal baseline and engagement is necessary to develop a history baseline. The team were informed that the 4AT was part of the geriatric care CPG that is in draft for COMPAR that is yet to rollout. This CPG, that is applicable only to the COMPAR team, will not address the wider gaps present for paramedic and NPT staff. This is a significant gap for the receiving health service and early assessment by ambulance staff would have a significant impact on ongoing care that is transferred, including placement for safety in Emergency Departments and the option to stay at home.			**H**	Develop procedures and guidelines relating to recognising, documenting and observing acute deterioration in a person's mental state. Ensure these CPGs are service wide and apply to delirium in the older person.

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			L	M	H	
8.06	The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration. b. Agreed indicators of deterioration in mental state. c. Agreed parameters and other indicators for calling emergency assistance. d. Patient pain or distress that is not able to be managed using available treatment. e. Worry or concern in members of the workforce, patients, carers, and families about acute deterioration **Met with Recommendation**	In reference to criterion in 8.06 the following applies: a. As per 8.04, recommendations apply b. As per 8.05 recommendations apply c. MET d. MET e. Procedures state that families/carers can call 000 or call service, however further work and monitoring is required on developing escalation processes in the deterioration procedure to embed it in practice. Workforces are clear on escalation process.		M		1. Apply 8.04 recommendations 2. Apply 8.05 recommendations 3. Review guidelines for family/carer escalation processes and ensure workforce are educated on the process.
8.07	The health service organisation has processes for patients, carers, or families to directly escalate care. **Met with Recommendation**	Processes are in place for families and carers to directly escalate care through dialling 000 and accessing the call centre. To date the frequency or results of this have not been analysed.	L			Analyse the use and themes that may present from family/carer escalation through the call centre and make improvements if required.
8.08	The health service organisation provides the workforce with	Robust processes and procedures are in place across the various workforce groups.				

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Action		Comment	Priority L M H	Recommended Action or Improvement Strategy
	mechanisms to escalate care and call for emergency assistance. **Met**			
8.09	The workforce uses the recognition and response systems to escalate care. **Met with Recommendation**	See 8.04	M	Apply 8.04 recommendations.
8.10	The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration. **Met**	The call centre acts as a triage process to ensure the right crew is sent to the right job. Training and induction processes are in place and are developing further.		
8.11	The health service organisation has processes to always ensure rapid access to at least one clinician, either on site or in proximity, who can deliver advanced life support. **Met with Recommendation**	AT have systems in place to ensure the provision for rapid access to advanced life support when required. These systems are monitored and reported on. The draft Work Core Learning procedure will provide further clarity on the level of life support competency that needs to be maintained by each of the subsets in the workforce. Education and	M	1. Deliver regular training to the workforce as defined in the Work Core Learning Procedure to ensure the workforce remains competent in their expected scope of resuscitation. This is inclusive of BLS through to ALS. 2. Ensure all medical consultants on call are aware of the scope and equipment available to the different levels of crews on scene.

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8.12	The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated. **Met with Recommendation**	The PACER program is well embedded into AT and is an excellent support for the community and workforce. The workforce is aware of escalation processes to ensure referral to mental health care and support is available to patients who are deteriorating. It would be valuable to assess whether appropriate transport and behaviour risk assessments are documented in care.	L			Review transport and behaviour risk assessments in the records to establish whether further training or quality improvements are required.
8.13	The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration. **Met**	There are appropriate communication channels to ensure hospitals and health services are notified of acute deterioration in mental state when required.				

Action		Comment	Priority	Recommended Action or Improvement Strategy
A1	The Multi-Purpose Service provides people accessing its aged care services with: a. Opportunities to establish and maintain relationships of their choice, including intimate relationships b. Support for daily living that promotes physical, emotional, cultural, spiritual and psychological wellbeing. c. Mechanisms to optimise independence and promote quality of life d. Support to make informed choices about their care, including taking risks to live the best life they can	**Not assessed or applicable.**		
A2	The Multi-Purpose Service supports people accessing its aged care services to: a. Participate in meaningful activities within and outside the organisation b. Establish and maintain social and personal relationships c. Enjoy and participate in activities of interest to them			
A3	The Multi-Purpose Service providing food and fluids to people accessing its aged care services ensures the food and fluids meet their preference, are varied, nutritious, appetising, and of adequate quantity.			
A4	The Multi-Purpose Service providing residential aged care services ensures there is a homelike environment that: a. Optimises a sense of belonging and interactions b. Supports access indoors and outdoors			
A5	The Multi-Purpose Service: a. Uses the recruitment system to ensure the workforce numbers and mix meet the care needs of people accessing services			

Action		Comment	Priority	Recommended Action or Improvement Strategy
	b. Uses the training system to ensure the workforce has the skills to deliver quality care and services.			
A6	The Multi-Purpose Service has processes to: a. Identify and respond to abuse and neglect of people accessing its services b. Effectively manage risks to support consumers live the best life they can.			