

Australian Safety and Quality Framework for Health Care



Australian Health Ministers endorsed the Australian Safety and Quality Framework for Health Care in 2010. The Framework describes a vision for safe and high-quality care for all Australians and sets out the actions needed to achieve this vision. The Framework specifies three core principles for safe and high-quality care. These are that care is **consumer centred**, **driven by information**, and **organised for safety**.

The Framework sets out twenty-one areas for action that all people in the health system can take to improve the safety and quality of care provided in all healthcare settings over the next decade.

The Framework should:

- be used as the basis of strategic and operational safety and quality plans
- provide a mechanism for refocusing current safety and quality improvement activities and designing goals for health service improvement
- be used as a guide for reviewing investments and research in safety and quality
- promote discussion with consumers, clinicians, managers, researchers and policy makers about how they might best form partnerships to improve safety and quality



Tools, resources, and examples to support local use of the Framework are available from the Australian Commission on Safety and Quality in Health Care at www.safetyandquality.gov.au

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Safe, high-quality health is always:

What it means for me as a consumer or patient:

Areas for action by people in the health system:

1 CONSUMER CENTRED

This means:

Providing care that is easy for patients to get when they need it.

Making sure that healthcare staff respect and respond to patient choices, needs and values.

Forming partnerships between patients, their family, carers and healthcare providers.

I can get high-quality care when I need it.

I have information I can understand. It helps me to make decisions about my health care.

I can help to make my care safe.

My health care is well organised. The doctors, nurses and managers all work together. I feel safe and well cared for.

I know my healthcare rights.

If something goes wrong, my healthcare team look after me. I receive an apology and a full explanation of what happened.

1.1 Develop methods and models to help patients get health services when they need them.

1.2 Increase health literacy.

1.3 Partner with consumers, patients, families and carers to share decision making about their care.

1.4 Provide care that respects and is sensitive to different cultures.

1.5 Involve consumers, patients and carers in planning for safety and quality.

1.6 Improve continuity of care.

1.7 Minimise risks at handover.

1.8 Promote healthcare rights.

1.9 If something goes wrong, openly inform and support the patient.

2 DRIVEN BY INFORMATION

This means:

Using up-to-date knowledge and evidence to guide decisions about care.

Safety and quality data are collected, analysed and fed back for improvement.

Taking action to improve patients' experiences.

My care is based on the best knowledge and evidence.

The outcome of my treatment and my experiences are used to help improve care.

2.1 Use agreed guidelines to reduce inappropriate variation in the delivery of care.

2.2 Collect and analyse safety and quality data to improve care.

2.3 Learn from patients' and carers' experiences.

2.4 Encourage and apply research that will improve safety and quality.

3 ORGANISED FOR SAFETY

This means making safety a central feature of how healthcare facilities are run, how staff work and how funding is organised.

I know that the healthcare team, managers and governments all take my safety seriously.

The health system is designed to provide safe, high-quality care for me, my family and my carers.

When something goes wrong, actions are taken to prevent it happening to someone else.

3.1 Health staff take action for safety.

3.2 Health professionals take action for safety.

3.3 Managers and clinical leaders take action for safety.

3.4 Governments take action for safety.

3.5 Ensure funding models are designed to support safety and quality.

3.6 Support, implement and evaluate e-health.

3.7 Design and operate facilities, equipment and work processes for safety.

3.8 Take action to prevent or minimise harm from healthcare errors.