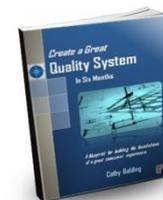


THE KEY CONTRIBUTION OF RIPERNS TO MEETING *THE NATIONAL SAFETY AND QUALITY HEALTH SERVICE STANDARDS (NSQHSS)*

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Linking national S&Q Standards with the work of RIPERNS

- The Standards are a (strong) means to an end
- RIPERNS are also a means to an end
- Linking the two
- Defining 'the end'

The National Safety and Quality Health Service Standards (NSQHS Standards) (on a scale of 1-10?...)

**Standard 1
Governance for Safety and
Quality in Health
Service Organisations**



**Standard 2
Partnering with
Consumers**



**Standard 3
Healthcare
Associated
Infections**

**Standard 10
Preventing Falls and
Harm from Falls**



**Standard 9
Recognising and
Responding to Clinical
Deterioration in Acute
Health Care**



**Standard 4
Medication
Safety**

**Standard 8
Preventing and
Managing Pressure
Injuries**



**Standard 5
Patient Identification
and Procedure
Matching**

**Standard 7
Blood and Blood
Products**



**Standard 6
Clinical
Handover**

What's different about the National Safety and Quality Health Service Standards?

- The National S&Q Standards are focused on the **process of care: *what happens and how things are done every day*** at point of care, whereas previous accreditation standards were more management system focused
- The Standards aim to promote consistency and use of evidence, and reduce variability in clinical practice across the organisation
- The Standards raise the bar:
 - Some requirements are more demanding than the practices most health services currently have in place
 - They will highlight patient risk more effectively
- Achieving the standards across the health service is not a desktop exercise: requires *focus, planning, effective change management and everyone working together* from 'Chair to Chairside'.
- Last but not least: they're our first set of *mandatory* patient safety and quality standards

So where do RIPERNs fit?

- Mapping between the work of RIPERNs and the NSQHSS shows many direct or similar links:

For example:

RIPERN	NSQHSS
Medications	Standard 4: Medication Safety
Monitoring and identifying deteriorating patients	Standard 9: Recognising and responding to clinical deterioration

Standards and RIPERNS

4.1.1	<p><i>Governance arrangements are in place to support the development, implementation and maintenance of organization wide medication safety systems.</i></p> <p>The RIPERN program has been endorsed by the Board of Management following a change in the Drugs, Poisons and Controlled Substances Act to include your health service. An application is then required to be made to the Department for an extension of the role of the health service to have RIPERN nurses able to practice within the health service.</p>
4.1.2	<p><i>Policies, procedures and protocols are in place that are consistent with legislative requirements, national, jurisdictional and professional guidelines.</i></p> <p>The policies and procedures have been altered in line with the application for changes to the health service Poison Control Permit to drive the RIPERN program.</p>
4.3.1	<p><i>A system is in place to verify that the clinical workforce have medication authorities appropriate to their scope of practice.</i></p> <p>Each RIPERN nurse is responsible to demonstrate annually that they hold AHPRA registration for Advanced Practice.</p>
4.13.2	<p><i>Information that is designed for distribution to patients is readily available to the clinical workforce.</i></p> <p>It is a requirement that RIPERN nurses provide documentation to the patient of any medications they dispense.</p>
6.3.3	<p><i>Actions are taken to increase the effectiveness of clinical handover.</i></p> <p>An important part of this program is to ensure that adequate feedback is given to the patient's GP, and there needs to be a system in place to gain evaluate that effectiveness of the handover processes.</p>

Standards and RIPERNs

1.2.1	<p>Regular reports on safety and quality indicators and other safety and quality performance data are monitored by the executive level of governance.</p> <p>Reports on evaluation of outcomes of care should be reported to the Board of management through a clinical review committee to demonstrate achievement to a suite of nominated KPIs. An action plan will support the improvement from identified data.</p>
1.2.2	<p>Action is taken to improve the safety and quality of patient care.</p> <p>Appointing a RIPERN is evidence of action taken to improve the quality of care. An evaluation system has been developed to ensure quality of the care delivered by the RIPERN nurses. This has been put up as a framework and can be included on the annual quality monitoring program for the health service.</p>
1.4.2	<p>Annual mandatory training programs to meet the requirements of the standards.</p> <p>The designated role of the RIPERN nurse should identify areas where mandatory training needs to be demonstrated.</p>
1.4.4	<p>Competency based training is provided to the clinical workforce to improve safety and quality.</p> <p>Part of the program has suggested each health service determine how each RIPERN nurse will demonstrate competency for identified clinical procedures. This is an important part of using RIPERN nurses within each health service.</p>
1.7.2	<p>The use of agreed clinical guidelines by the clinical workforce is monitored.</p> <p>Within the suggested program guidelines, it is suggested the health service undertake ongoing clinical reviews of the actions taken by each RIPERN nurse to ensure they actually follow the clinical guidelines when providing care.</p>
1.8.1	<p>Mechanisms are in place to identify patients at increased risk of harm</p> <p>RIPERNs identify and monitor patients' management of their medications and identify risks</p>
1.10.1	<p>A system is in place to define and regularly review the scope of practice for the clinical workforce.</p> <p>The RIPERN scope of practice is defined in the Drugs, Poisons and Controlled Substances Act, and needs to be reinforced in policy within each health service.</p>
1.10.2	<p>Mechanisms are in place to monitor the clinical workforce are working within their agreed scope of practice.</p> <p>The scope of practice of RIPERN nurses needs to be defined and monitored, as it is for all clinicians.</p>
1.18.1	<p>Patients and carers are partners in the planning for their treatment</p> <p>RIPERNs work with consumers and carers to ensure safe medication management</p>
1.20.1	<p>Data collected from patient feedback systems are used to measure and improve health services in the organization.</p> <p>It is assumed health services will have implemented the RIPERN program because of an identified need and with community support to address that need.</p>

Finding the matches is the first step

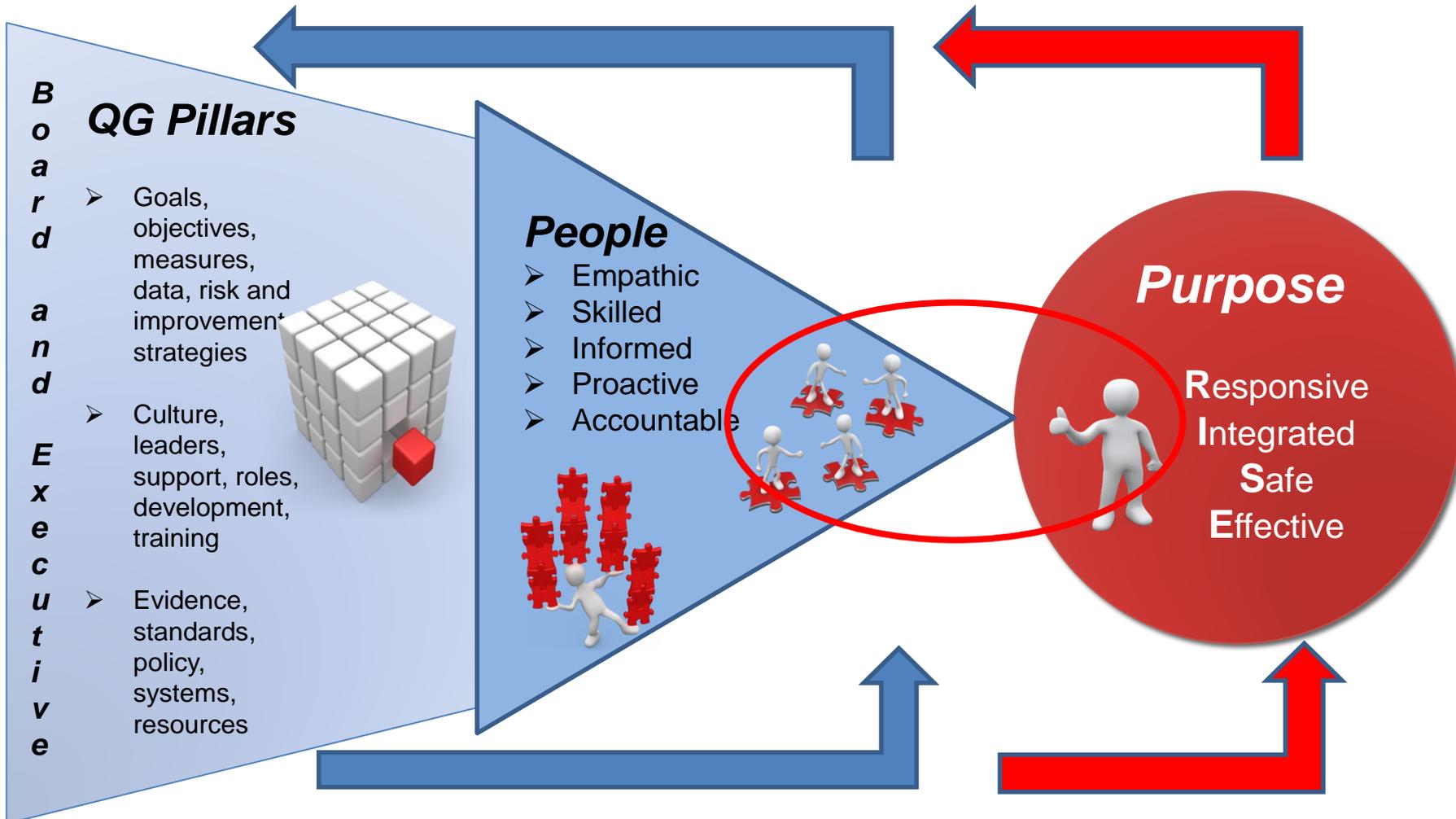
- Tap into the process for meeting the standards in your organisation:
 - Depending on where you are at in the accreditation cycle, your organisation will be engaged in:
 - Gap analysis
 - Implementation, reporting and evaluation
 - Identifying and creating evidence
- Talk to your manager and quality manager:
 - How can the RIPERN's role assist with this?
 - Tap into the workgroups and committees working on meeting the standards
 - Be invaluable!

And... position RIPERN role as part of the bigger picture of the quality of care your organisation provides...

- 1.6.1 An organisation-wide quality management system is used and regularly monitored
- 1.6.2 Actions are taken to maximise patient quality of care
- Your hospital will need to:
 - determine how to define good quality for your hospital, and put in place plans to achieve this
 - develop a schedule of audits of clinical and organisational systems to monitor performance
 - implement strategies to improve performance
 - determine what reports your organisation needs to understand its performance and the reports needed by your senior executive to understand your performance
 - involve the workforce in the development, monitoring and improvement of these systems.

(draft Small Hospital Guide, 2013)

The RIPERN must link *quality systems with quality care* (Balding, 2013)



So we achieve more of...



AND...

Snapshots

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"Mr. Franklin. What did I tell you about wheelies in the hallway?"

Thankyou!



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