

Clinical Governance Framework 2017-2020

EDITION 1 - 2017



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Commissioner's foreword

This year marks the 125th Anniversary of Ambulance Services in Queensland. Building on a strong legacy, the Queensland Ambulance Service (QAS) has seen many changes in the past few years, with more significant changes ahead.

Changes to the Machinery of Government (MoG) have seen the return of our Ambulance Service to the State Department of Health and over-arching change with the abolition of the Health Quality and Complaints Commission (HQCC) and the creation of the Office of the Queensland Health Ombudsman (OHO).

I am both proud and pleased to have seen the introduction of our QAS Digital Clinical Practice Manual (DCPM), the new Electronic Ambulance Report Form (eARF), an increase in the Scope of Practice of paramedics and significant continuing Officer education and professional development.

2018 will see the introduction of a National Paramedic Registration Scheme that will require a major cultural shift by paramedics nation-wide.

To keep pace with all of these changes and to best place QAS into the future – a new QAS Clinical Governance Framework 2017-2020 has been developed.

QAS needs a forward thinking integrated Clinical Governance Framework (CGF) that maintains and improves the reliability and quality of QAS patient care, as well as improving patient outcomes. This Framework, whilst needing to be robust, must be simple and be able to be applied practically by all QAS staff to achieve the defined goals.

I endorse the new Clinical Governance Framework 2017-2020 and I ask all QAS personnel to embrace its principles and to actively engage in the systems and processes it provides.

Russell Bowles ASM

Commissioner
Queensland Ambulance Service

Introduction

Clinical Governance can be defined as the framework through which the QAS is accountable for continuously improving the quality and safety of our services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. Effective Clinical Governance makes it clear that clinical quality and safety is everyone's business in the QAS.

The QAS has three inter-relating components to our Clinical Governance Framework 2017-2020:

1. Professional expertise and proficiency

- Minimum educational requirements
- Paramedic professional competency standards
- Initial certification
- Ongoing currency of practice/Continuing Professional Development (CPD)
- In-field coaching
- Officer portfolios
- Recency of practice and recertification

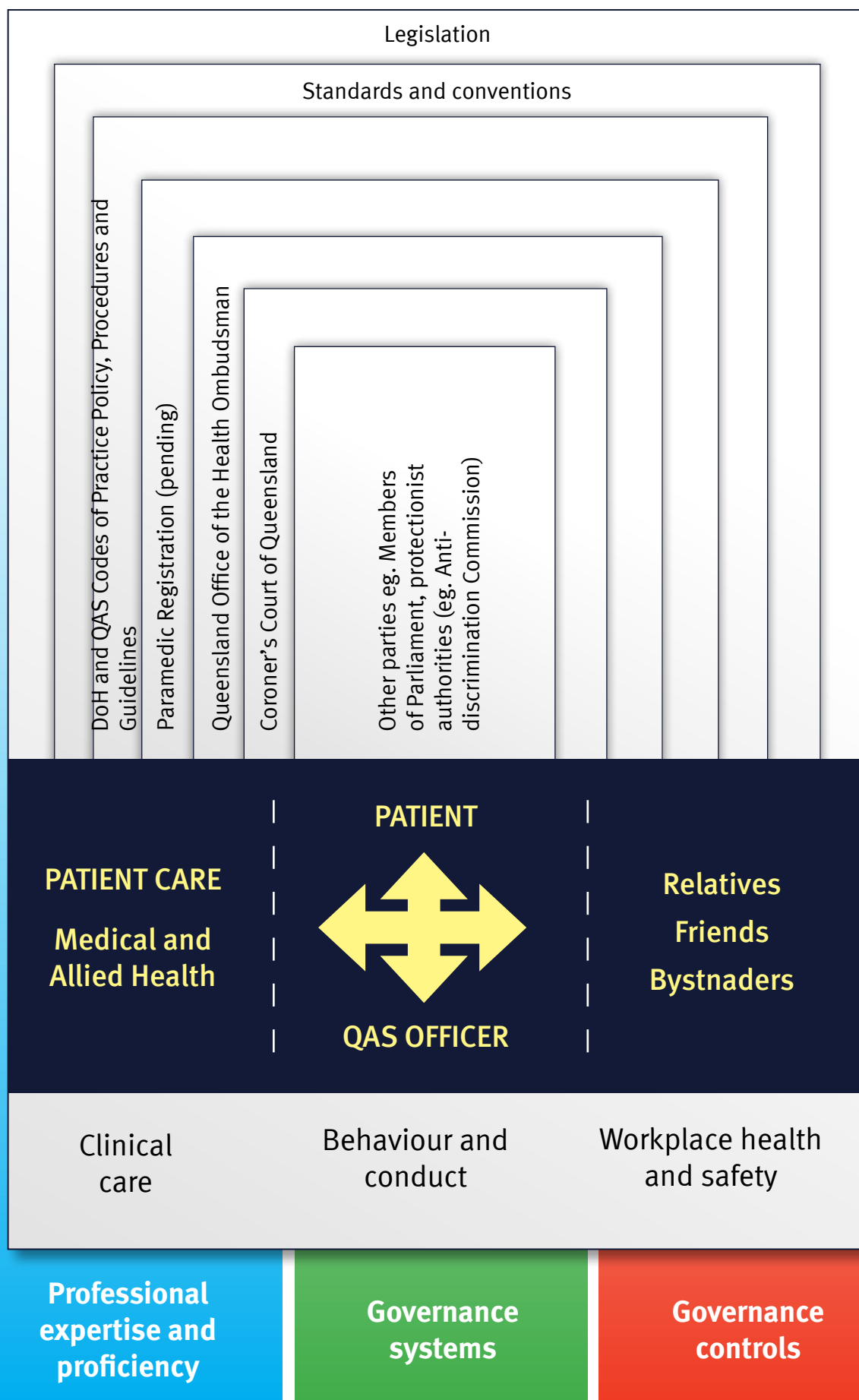
2. Governance systems

- Paramedic registration (pending)
- Codes of Practice, policies, plans and procedures
- Performance Management Framework (PMF)
- Credentialing
- Learning Management System (LMS)
- Supervision and support
- Safety and quality improvement
- Officer Dashboard
- Research

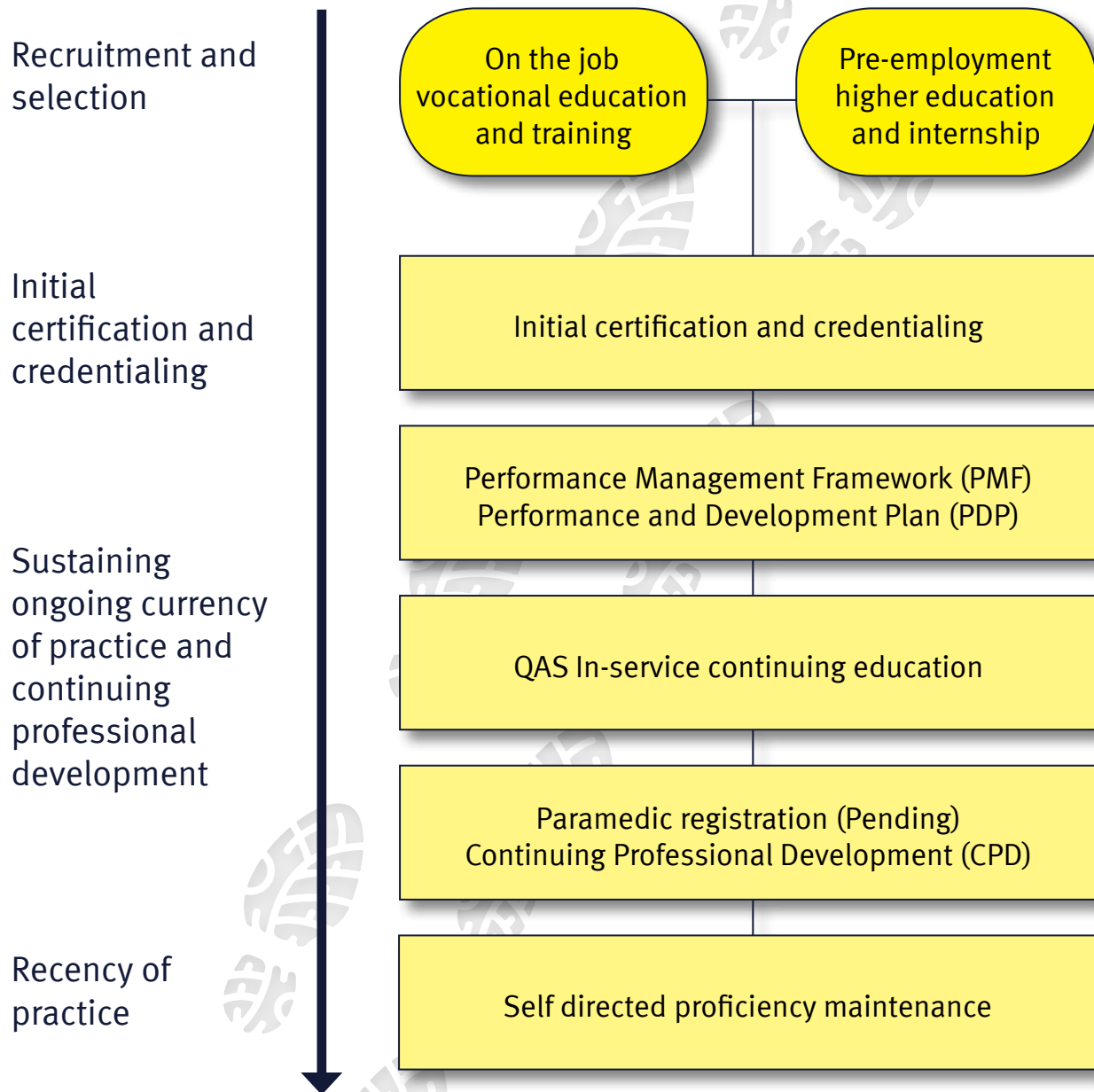
3. Governance Controls

- Clinical auditing
- Incident investigation
- Complaints management

QAS clinical governance framework



The professional journey



☐ Clinician

☐ Team member

☐ Self directed life long learner

Paramedic

☐ Health and social advocate

☐ Educator

☐ Supervisor/mentor

☐ Reflective practitioner

☐ Professional



Professional expertise and proficiency

Minimum educational requirements

- › The QAS has moved from the Vocational Education and Training (VET) to the higher education sector for the pre-employment education of paramedics.
- › The Council of Ambulance Authorities (CAA) has established a Paramedic Education Programs Accreditation Scheme (PEPAS) **for entry-level, or entry to practice level**, paramedic courses provided by the higher education sector. Typically - **Bachelor of Paramedic Science or double degrees in Paramedic Science and Nursing or equivalent**.
- › Formal accreditation of tertiary programs under PEPAS is aimed at ensuring that the required workforce skills, professional practice behaviours and competencies are reflected in the programs provided by the higher education sector in Australia and New Zealand.
- › This accreditation scheme is an essential part of a quality assurance process. It ensures that required standards are met and that there is consistency in the core components of the education programs provided. This provides confidence to graduating paramedics that the programs they have participated in have equipped them with the knowledge, skills and qualifications to be eligible to seek employment with public ambulance services – such as the QAS. The QAS also gives preference to employing graduates, on merit, who graduate from accredited para-medicine programs over graduates from non-accredited programs.

(VET) Certificate and Diploma level courses in paramedic studies are no longer recognised by QAS as a CAA member jurisdiction for the purposes of employment as an entry-level paramedic.

Paramedic professional competency standards

- › Competency can be described as skills, attitudes and other characteristics (including values and beliefs) attained by an individual through knowledge (gained through vocational study) and experience (gained ‘on road’), which together are considered adequate to enable the individual to work as a paramedic. Competence is the consistent application of knowledge and skill to the standard as required by the industry in the workplace; it embodies the ability to adapt to new situations and environments.
- › Professional competency can be described as skills, attitudes and other attributes (including values and beliefs) attained by an individual based on knowledge (gained through study at bachelor’s degree level at least at university) and experience (gained through concurrent or subsequent practice) which together are considered sufficient to enable the individual to practise as a paramedic. Professional competence reflects the standard required by industry of graduates in the workplace.
- › It should also be noted that the delivery of professional services requires personal competence as well as quality procedures if the service is to be delivered to a standard that is acceptable to both consumers and professional peers, has credibility in a professional sense and meets all regulatory requirements. Professional standards relating to the systems, procedures and information used by individuals to achieve a level of conformity and uniformity for paramedic practice are described in QAS standards and guidelines and should be used in conjunction with the Professional Competency Standards.

Professional expectations of a paramedic

1. Acts in accordance with accepted standards of conduct and performance.
2. Make informed and reasonable decisions.
3. Demonstrates professional autonomy and accountability.
4. Develops and maintains professional relationships.

Knowledge, understanding and skills required for practice

1. Demonstrates the knowledge and understanding required for practice as a paramedic.
2. Operates within a safe practice environment.
3. Identifies and assesses health and social care needs in the context of the environment.
4. Formulates and delivers clinical practice to meet health and social care needs within the context of the environment.
5. Critically evaluates the impact of, or response to, the paramedics actions.

Initial certification

- › A graduate paramedic will obtain an independent authority to practice and clinical credentialing as an ACP2 within the QAS after they have successfully completed the *QAS Graduate Paramedic Initial Service Program* (refer to program for details).
- › To successfully complete the program, a graduate must have received endorsement to progress at each of the end of milestone progression meetings, and endorsement from the LASN Manager on the end of program report. Once the end of program report has been completed and endorsed by the LASN Manager, QASEC will be responsible for generating an authority to practice.

NOTE: Competency standards and competency-based performance are not intended to be a competency-based career framework, replace accredited training, be aligned with remuneration nor replace or retest entry level professional standards or qualifications.

Ongoing currency of practice and Continuing Professional Development (CPD)

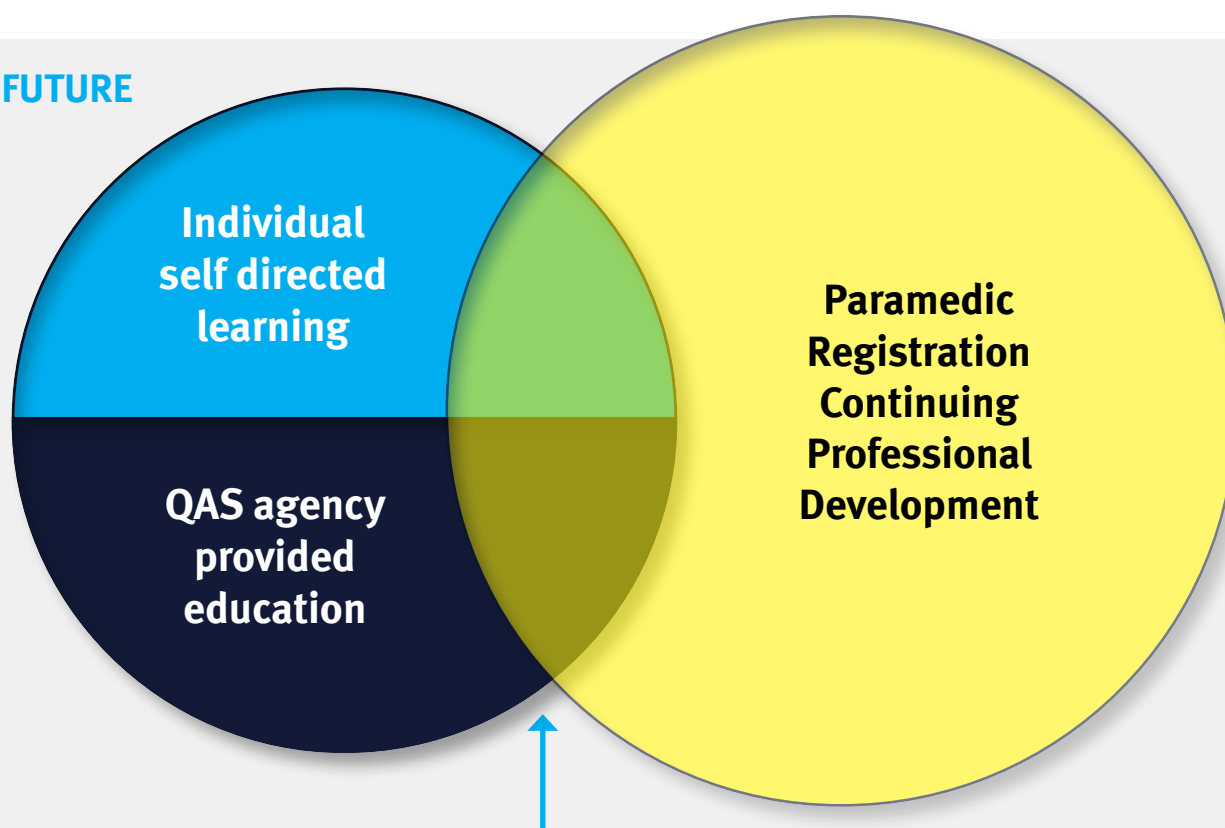
- › Once paramedic registration is established – paramedics will become registered health practitioners and must undertake CPD by law to maintain professional registration.
- › The CPD requirements of each health practitioners National Board are detailed in the Registration Standards for each profession and published on each Board website. These detail the number of credits/points/hours practitioners must spend each year on learning activities. **This will also occur with the paramedic board once established.**
- › QAS will provide additional guidelines regarding agency specific ongoing mandatory currency of practice/Continuing Professional Development (CPD) activities. QAS will look to seek accreditation of these activities that will count towards credits/points/hours accumulation towards registration.

Ongoing currency of practice and Continuing Professional Development Process

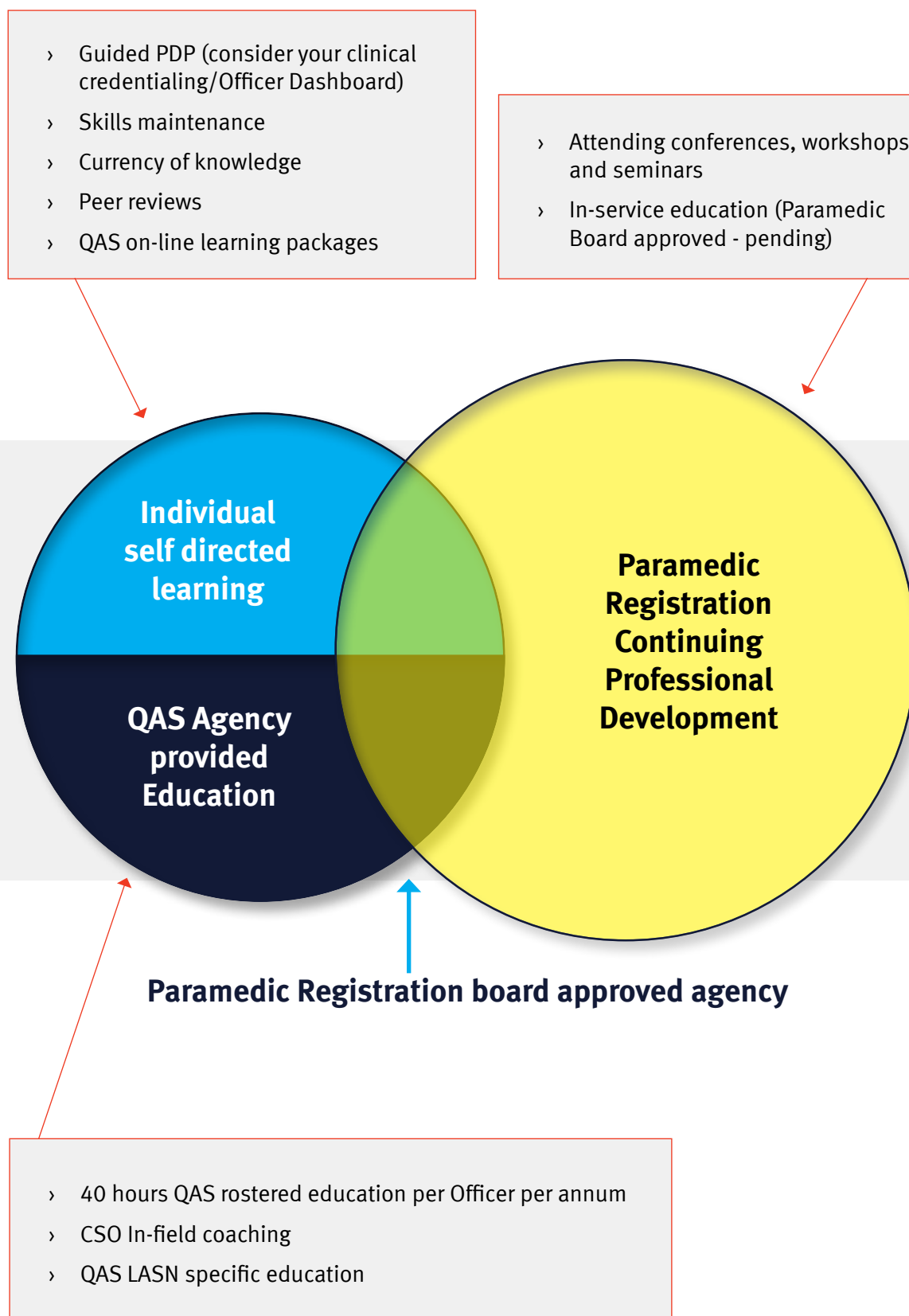
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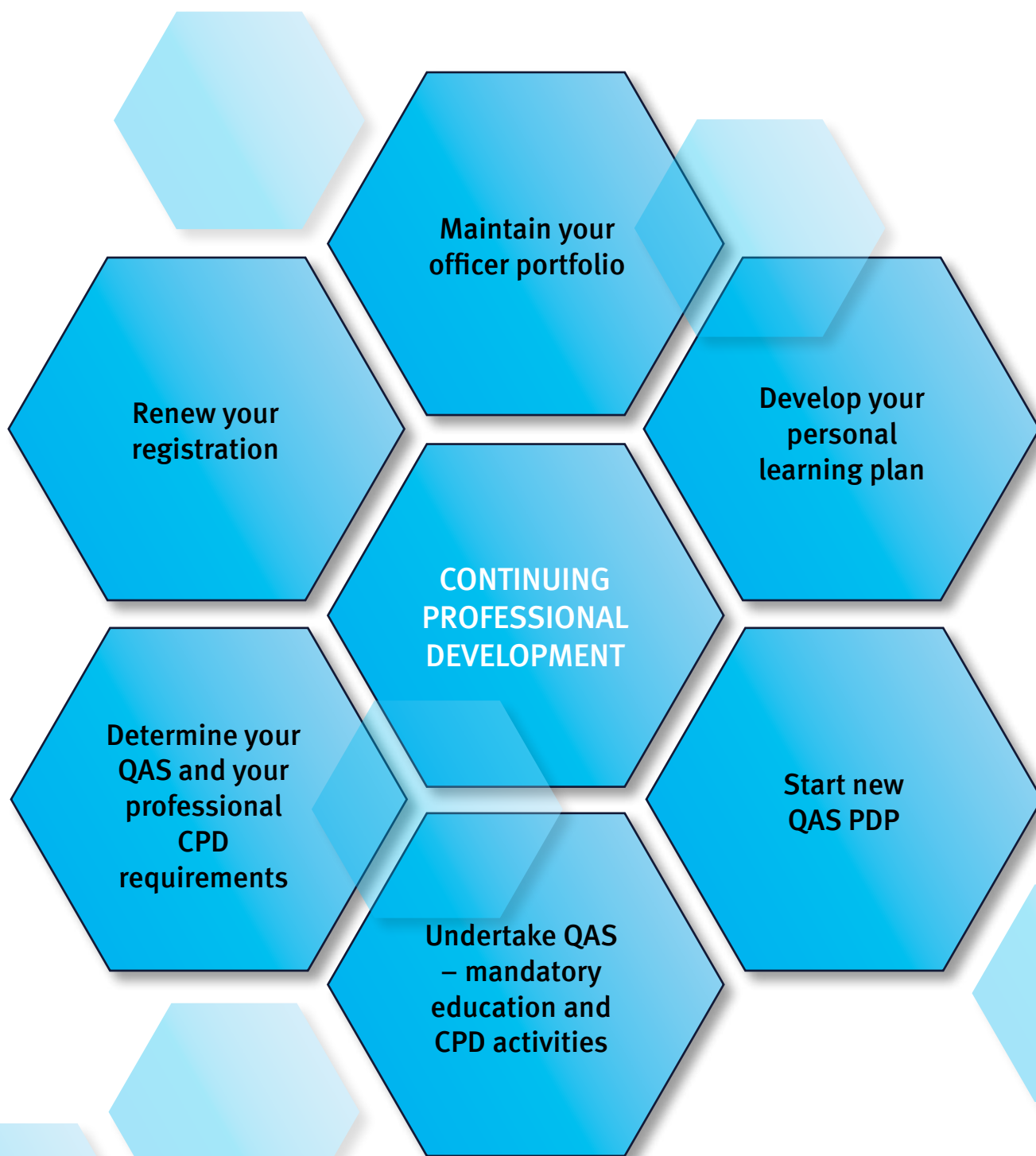
FUTURE



Paramedic Registration board approved agency training



NOTE: Guided competency validations now form part of individual Officer self directed learning - skills and knowledge maintenance.



In-field coaching

- › **QAS In-field coaching** can be defined as the process by which one person, usually of superior rank and experience, guides the development of another individual. Additionally, the role is intended to be dynamic and interactive, thereby making the success of the relationship dependent on constructing meaningful dialogues and designing tangible actions.
- › **QAS In-field coaching** should occur between Educators, Clinical Support Officers, Critical Care Paramedics/more senior paramedics with more junior or less experienced paramedics.
- › The role of the **QAS In-field coach** is as an advocate, coach, teacher, guide, role model, valued friend, door-opener, benevolent authority, available resource, cheerful critic, and career enthusiast. Good In-field Coaches combine many of these roles, both generating leadership development for succeeding generations and innately leading change.
- › It is also a two-way street - other paramedics with their unique perspective can open new thinking, provide new insights, information and fresh ideas for stimulating **In-field Coaches** life-long learning journey and enhancing patient care quality and safety.
- › **QAS In-field coaches need**
 - high standards
 - realistic expectations
 - effective communication and interpersonal skills
 - understanding of the principles of adult learning
 - flexible teaching strategies
 - commitment to a regularity of interaction
 - ability to provide effective feedback
 - to be able to maintain confidentiality
 - to establish mutual respect
 - to exhibit mutual commitment
 - to earn mutual trust.

Officer portfolios

Developing and maintaining their own **Officer Portfolio (Professional Practice Portfolio)** provides paramedics with personal and portable evidence of competency and Continuing Professional Development (CPD).

Your **Officer Portfolio (Professional Practice Portfolio)** should contain as a minimum:

- › **Personal information (examples only)**
 - Curriculum Vitae.
 - Role description.
 - Current paramedic registration certificate (pending).
- › **Performance and Development Plan (PDP)**
 - Current PDP.
 - Completed PDPs.

› **Ongoing currency and CPD (examples only)**

- Cases attended – volume and acuity (Officer Dashboard).
- Mandatory agency education and training (LMS).
- Conferences/seminars attended.
- Tertiary study.
- Clinical audit and clinical quality activities.
- In-field coaching.
- Feedback from colleagues, patients and organisations.
- Extramural activities.
- Research or project work.
- Committee participation.

The information in your **Officer Portfolio (Professional Practice Portfolio)** will be required by the QAS and the Paramedic Professional Registration Authority (pending) to confirm completion of specific mandatory education and participation in CPD for registration. A number of commercial software applications are available to assist you with these requirements.

Recency of practice and recertification

Recency of Practice

- › To ensure that they are able to practise competently and safely - paramedics must have recent practice in the field they intend to work and maintain an adequate connection with the profession. The specific requirements for recency depend the level of experience of the paramedic and, if applicable, the length of absence from the field.
- › National law will require the Paramedic National Registration Board to develop registration standards about the requirements for Recency of Practice (RoP) for registered paramedics. Recent practice is an important way that practitioners maintain their professional skills and knowledge. The QAS will also require specific standards to be met for clinical authority to practice, credentialing and recertification.
- › Recency of practice means that a paramedic has maintained an adequate connection with and recent practice in the profession since qualifying for, or obtaining initial certification and professional registration (pending).
- › Clinical practice is when a paramedic is directly involved in providing direct clinical care or providing oversight of direct clinical care of patients, or is directly involved in on-road clinical education.
- › Practice means any role, whether remunerated or not, in which the individuals use their skills and knowledge as a paramedic. Practice in this context is not restricted to the provision of direct clinical care. It also includes using professional knowledge (working) in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on the safe, effective delivery of services in the paramedic profession.
- › QAS supports paramedics who wish to return to practice after a period of absence, or who wish to change their area of clinical practice. Investment in these processes will ensure the workforce is safe and competent and will support necessary growth in workforce numbers.

Clinical recertification following any period of restricted practice will be covered by the standard and the QAS credentialing process.



Governance systems

Paramedic registration (pending)

Background

The inclusion of paramedics into the National Registration and Accreditation Scheme for Health professions (NRAS), was approved by Health Ministers on 6 November 2015. Health Ministers discussed options for the registration of paramedics and, on a majority vote, the meeting agreed to move towards a national registration of paramedics to be included in the NRAS, with only those jurisdictions that wish to register paramedics adopting the necessary amendments.

The expected outcome of national registration for paramedics includes the following:

- › The ability of the legislation to protect the public by:
 - establishing minimum qualifications and other requirements for the registration of a person as a paramedic
 - providing powers to deal effectively with paramedics who have an impairment that affects their practice, are poorly performing or who engage in unprofessional conduct or professional misconduct
 - preventing persons who are not qualified, registered and fit to practise from using the title 'paramedic' or holding themselves out to be registered if they are not.
- › The facilitation of the provision of high quality education and training in paramedicine through the accreditation of training programs for registration purposes.
- › Improvements to the transparency and accountability in the delivery of public and private sector paramedicine services.
- › To provide a suitable regulatory framework for the public and private sector paramedic workforce.
- › As a result of changes to the National Law, Queenslanders will have access to a complaints handling system which provides timely management of health complaints within legislated timeframes (both through the National Paramedicine Board of Australia (Board) and also through the Office of the Health Ombudsman) for registered and non-registered health practitioners and other health service providers. The Queensland health complaints process comprises a co-regulatory model, where the Office of the Health Ombudsman provides priority intake of complaints for Queensland.

Benefits of registration

Public safety

The underpinning reason for national registration of paramedics is to enhance public safety. Paramedics do an immense amount of good through their advanced clinical interventions. Used inappropriately, those same procedures, drugs and techniques may also rapidly harm or kill a patient. Registration would provide additional public confidence that a registered paramedic has appropriate contemporary education, experience, qualifications and authority to practice. A registered paramedic would be subject to a system of review to ensure ongoing fitness to practice and a transparent and consistent complaints mechanism by an independent board.

Consumers/patients

Paramedics provide a unique service in the continuum of Health Care. Patients are often facing a health crisis and at their most vulnerable when a paramedic is needed. Generally, patients do not have the luxury of researching and selecting a paramedic of their choice. When the emergency health system is activated, often by '000', the patient must accept those practitioners on the scene. Further, due to injury or illness, the patient may not be able to provide informed consent to treatment. Paramedics often provide care on the basis of 'implied consent'. This places an additional obligation on paramedics and government to ensure that a well-managed and regulated standard of care is provided to members of our community at often the most vulnerable time in their lives. National registration would ensure a consistently high standard of regulation of paramedics so that minimum standards of competency applied across the nation.

Protection of title

Currently, anyone can call themselves a paramedic. In essence, a paramedic is anyone who applies even a bandaid and who is not a medical practitioner. National registration would enshrine in law that only those people who meet the criteria set down by the relevant Regulatory Board under the Australian Health Practitioners Regulation Agency can use the title of Paramedic. Again, this would enhance public confidence and safety. It would also protect the time and financial investment that genuine paramedics have made to gain their qualifications and achieve registration to practice. A person claiming to be a paramedic but who is not registered would be guilty of an offence.

Greater flexibility and portability of recognition

National registration would simplify the current situation where a myriad of different training and qualification arrangements make moving between employers complex, expensive and time consuming. A registered paramedic would find it much easier to move between employees whether private, public, potentially with the Defence Force or internationally. Ideally, employers should only have to advertise for a registered paramedic at some level. Employers would have the confidence that a nationally registered paramedic has been independently credentialled. It would simplify and streamline the recognition process and enhance workforce sustainability.



PARAMEDICS
A U S T R A L I A

Paramedics as individual practitioners will need to comply with five mandatory standards:

1. Continuing Professional Development (CPD)
2. Criminal history checks
3. English language skills
4. Recency of practice
5. Professional indemnity insurance.

During the first three years of the scheme - it is likely that provisions will allow paramedics who are already practising but do not hold a qualification approved by the new paramedic board (eg. Bachelor degree) for general registration to be granted general registration under special “grandparenting” provisions.

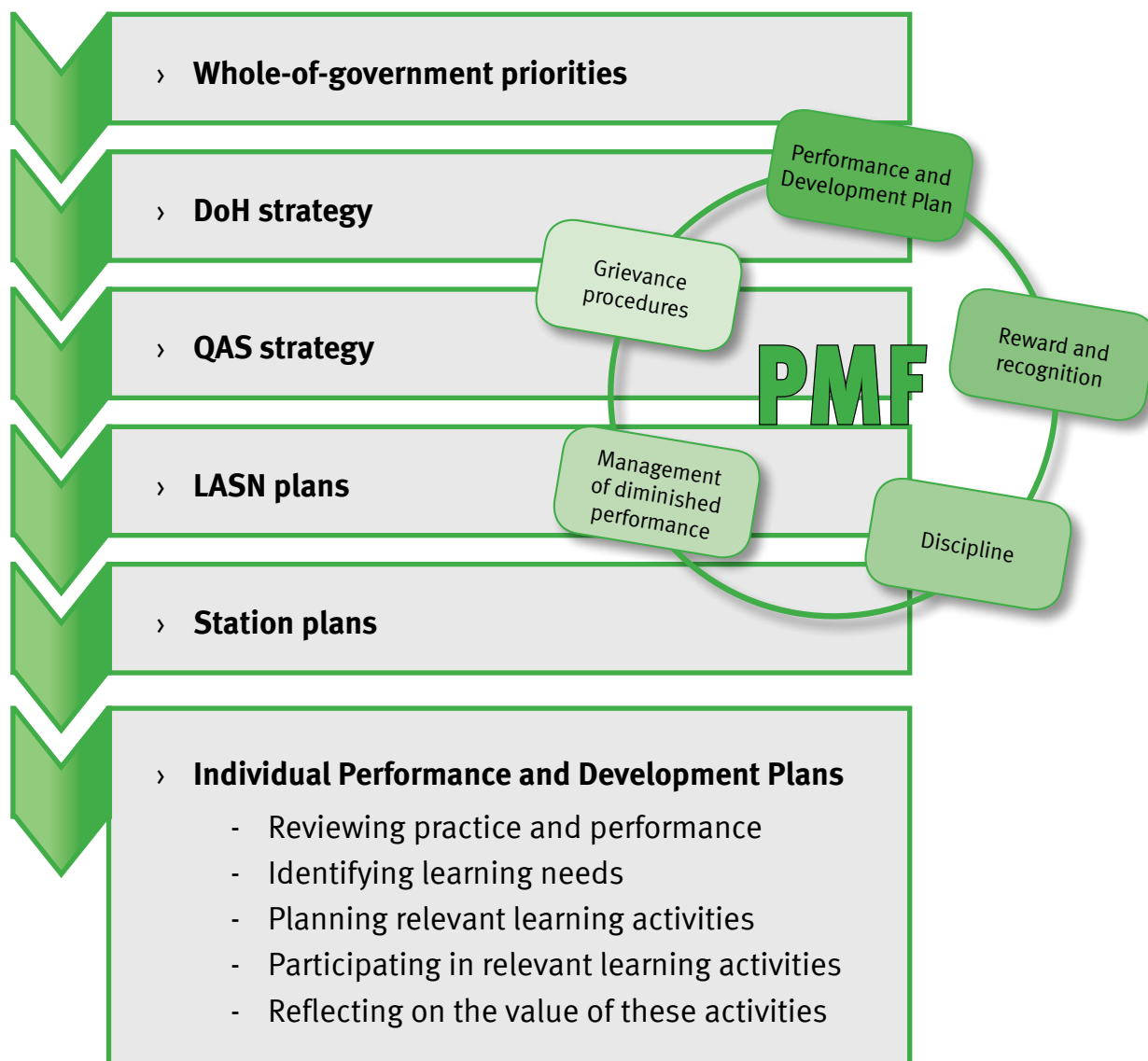
Codes of Practice, policies, plans and procedures

The QAS Clinical Governance Framework must be integrated with strategic and operational planning processes and policy development to maintain a modern, effective and dynamic organisation, which is committed to highest quality patient care.

QAS Codes of Practice, policies and procedures seek and encourage input from all levels of the organisation.



Performance Management Framework (PMF)



There are six major components of the **QAS Performance and Development Plan (PDP)** process. All employees and managers are required to:

1. **participate** in the PDP process twice a year (an initial plan set up and 6 monthly review) for existing employees and within three months of commencement for new employees
2. **develop** a PDP or formally document a discussion about performance feedback, learning strategies and actions required to obtain new skills or develop existing skills for the current position. The PDP or discussion must be consistent with the QAS Strategy and the QAS CGF
3. **participate** in a performance meeting to assess previous performance and clarify the employee's role. This will involve reflection on their own performance and provision of data to support their self-assessment across a range of relevant dimensions of performance
4. **participate** in ongoing management of workplace performance including work allocation, coaching and regular feedback discussions
5. if necessary, **manage** unsatisfactory performance
6. **record** on the appropriate form that the PDP process has been completed for each employee.

Credentialing

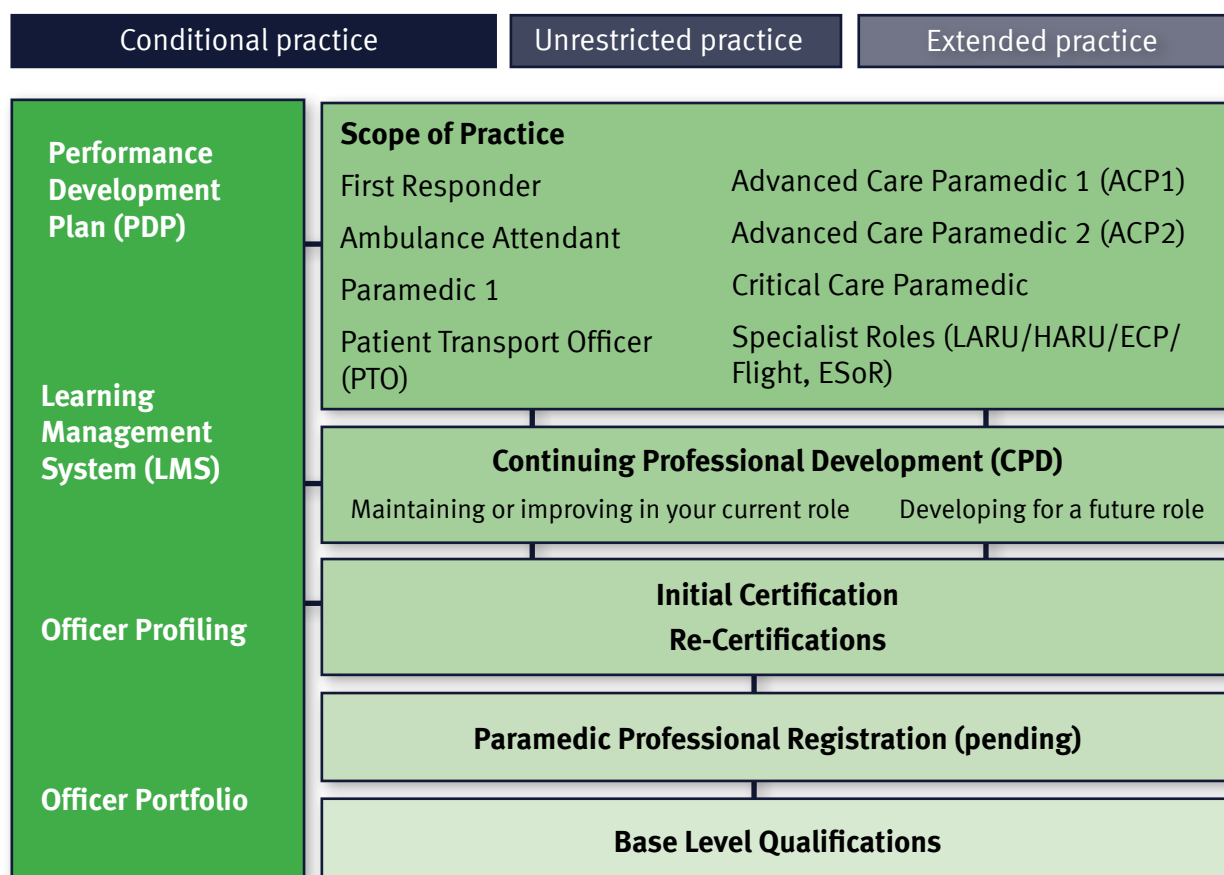
- › QAS Credentialing is the process of reviewing paramedics individual qualifications and experience to determine their competence, performance and professional suitability to provide high quality care within specific scope of practice in certain settings and geographical locations.
- › Credentialing/ defining the scope of clinical practice occurs at the point of employment through initial certification and is renewed biannually (or by change to clinical level or conditions).
- › All QAS paramedics must only practise within the bounds of their education, training competence and within their capacity and capability.

Credentialing

- ☒ Be able to demonstrate currency, recency and proficiency against your credentialed scope of practice.
- ☒ Have a current Performance and Development Plan (PDP).
- ☒ Hold current paramedic registration (pending).

If these criteria are met - individual Officer Clinical Credentialing will occur as part of the Identification (ID) Card issuing process.

QAS credentialing framework



Conditional practice

Examples

- › Graduate Paramedics during the Initial Service Program
- › Non-frontline managers

Credentialing maybe specifically related to the duration of a program of study.

Credentialing maybe individually specific and determined by a number of variables including role, location, clinical exposure, actual and proposed workload and currency and recency of practice.

Specific conditions / restrictions may also be applied as part of a management of diminished performance process.

Unrestricted practice

Examples

- › ACP II
- › CCP
- › PTO's

Authorised Officers with Scope of Practice as defined in the QAS Clinical Practice Manual (CPM) without any extensions or conditions of practice.

Extended practice

Examples

- › HARU
- › Flight paramedics
- › LARU
- › ESoR (Rural Practice)
- › Other specific extensions

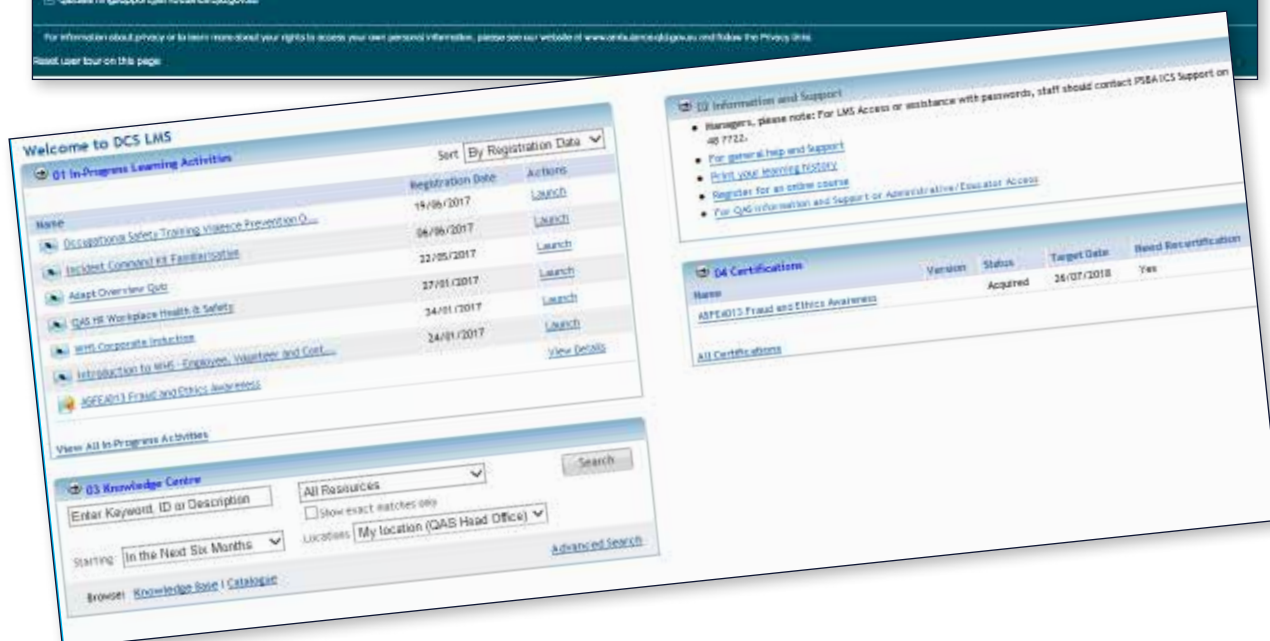
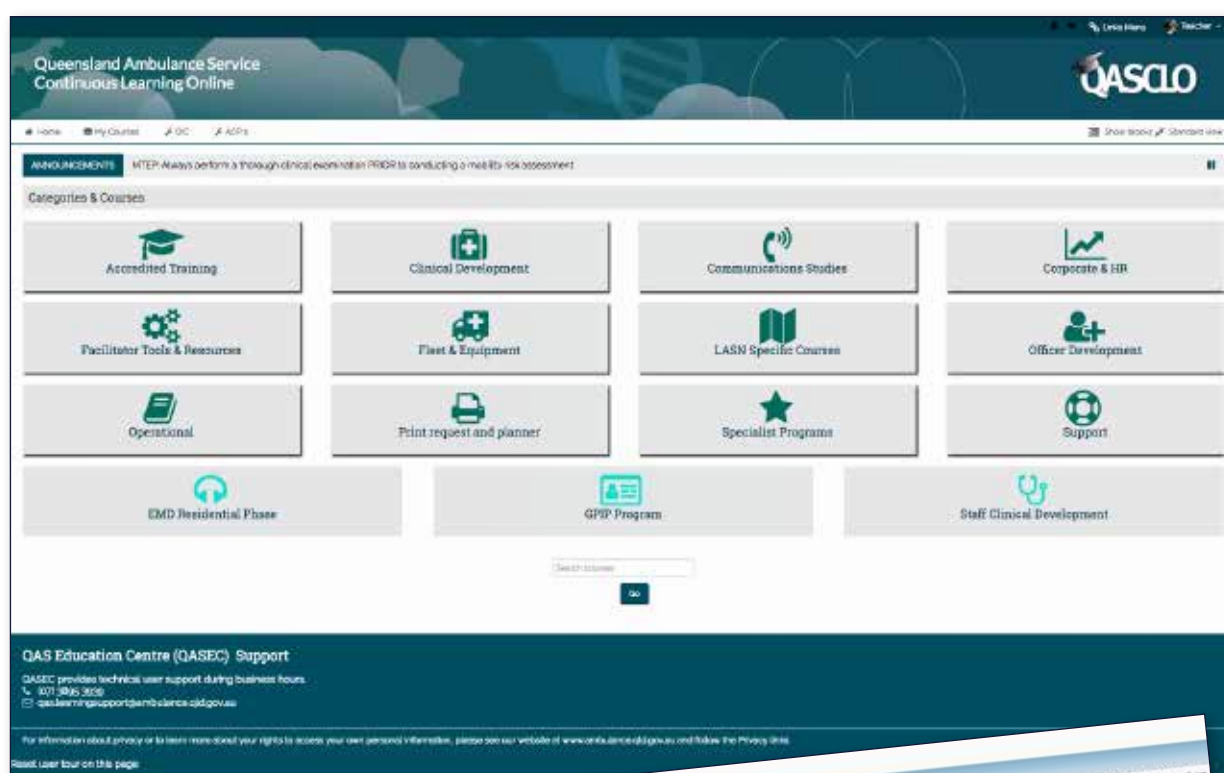
Credentialing is individually specific and determined by a number of variables including the QAS Officer Dashboard, geographical location, clinical exposure, actual and proposed workload and currency and recency of practice.

QAS Officer Clinical Credentialing is initiated and managed through the QAS Identity Card issuing process

Learning Management System (LMS) and QAS Collaborative Learning Online (CLO)

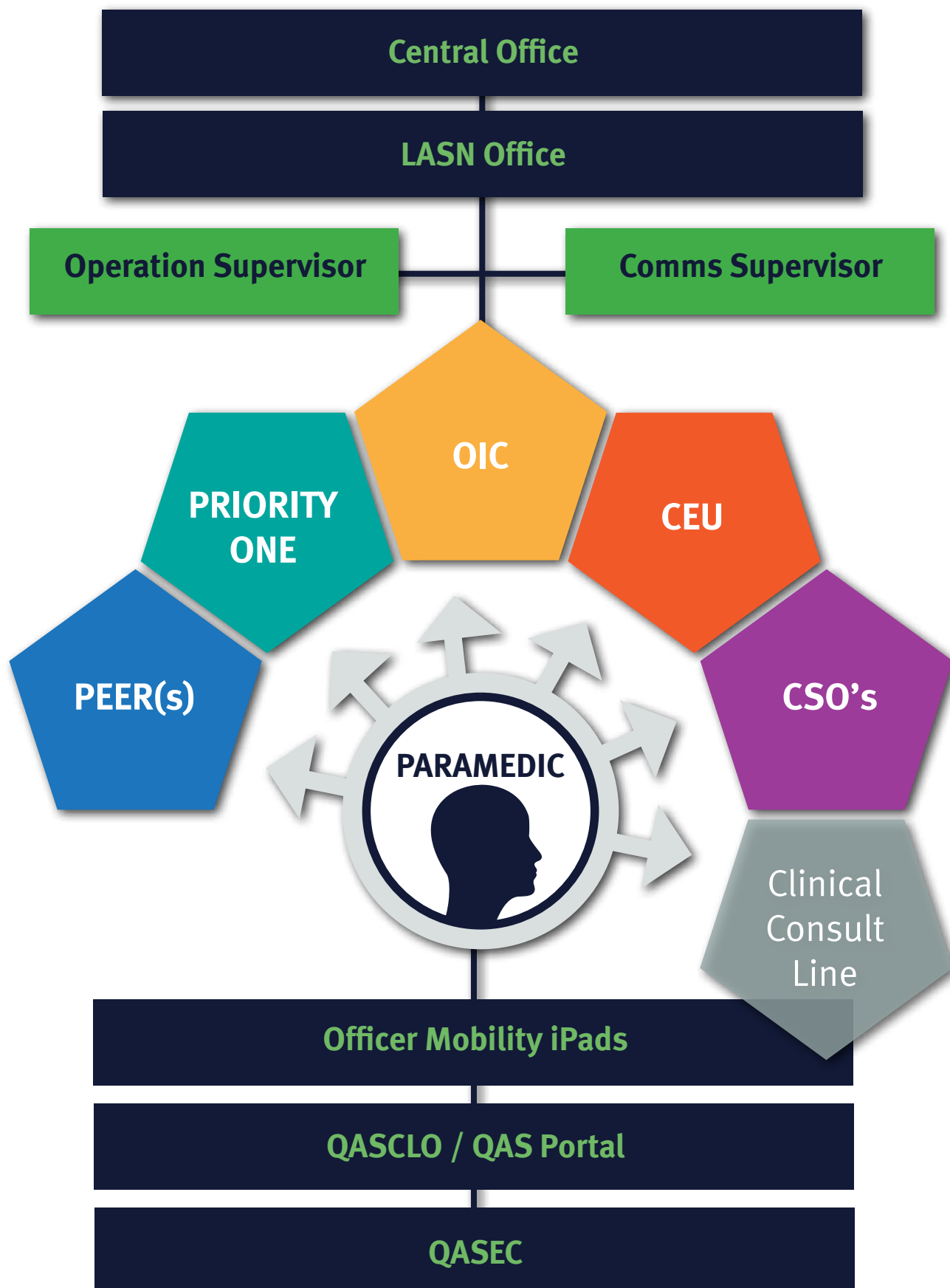
The Saba LMS software is marketed as a 'global learning management' tool, which allows the user to provide a training or educational experience that focuses on the learner. It provides QAS with a learning content delivery platform, learning record management and a host of learning administrative functions essential for QAS as a Vocational Education and Training (VET) – Registered Training Organisation (RTO).

QAS Collaborative Learning Online (QASCLO) is an externally hosted platform used for the delivery of online training and educational resources. QASCLO also contains further information regarding many offline courses offered by QAS Education Centre (QASEC).



Supervision and support

QAS Supervision and support is available to paramedics from a wide variety of sources from within broader QAS Operational / Educational and support functions.



Safety and quality improvement

A range of participants are involved in ensuring the safety and quality delivery of pre-hospital ambulance services in Queensland. These include:

- › **Paramedics**

Improvements to systems can be achieved when paramedics actively participate in organisational processes, safety systems, and improvement initiatives. Paramedics make our governance systems safer and more effective if they have a broad understanding of their responsibility for safety and quality, follow safety and quality procedures, supervise and educate other members of the workforce and participate in the review of performance procedures individually, or as part of a team.

- › **QAS managers**

The role of managers in QAS is to implement and maintain systems, resources, education and training to ensure that clinicians deliver safe, effective and reliable care. Managing performance and facilitating compliance across the organisation is a key role. This includes oversight of individual areas with responsibility for the governance of safety and quality systems – including monitoring and reporting functions. Managers should be leaders who can model behaviours that optimise safe and high quality care. Safer systems can be achieved when managers consider safety and quality implications in their decision making processes.

- › **Support staff**

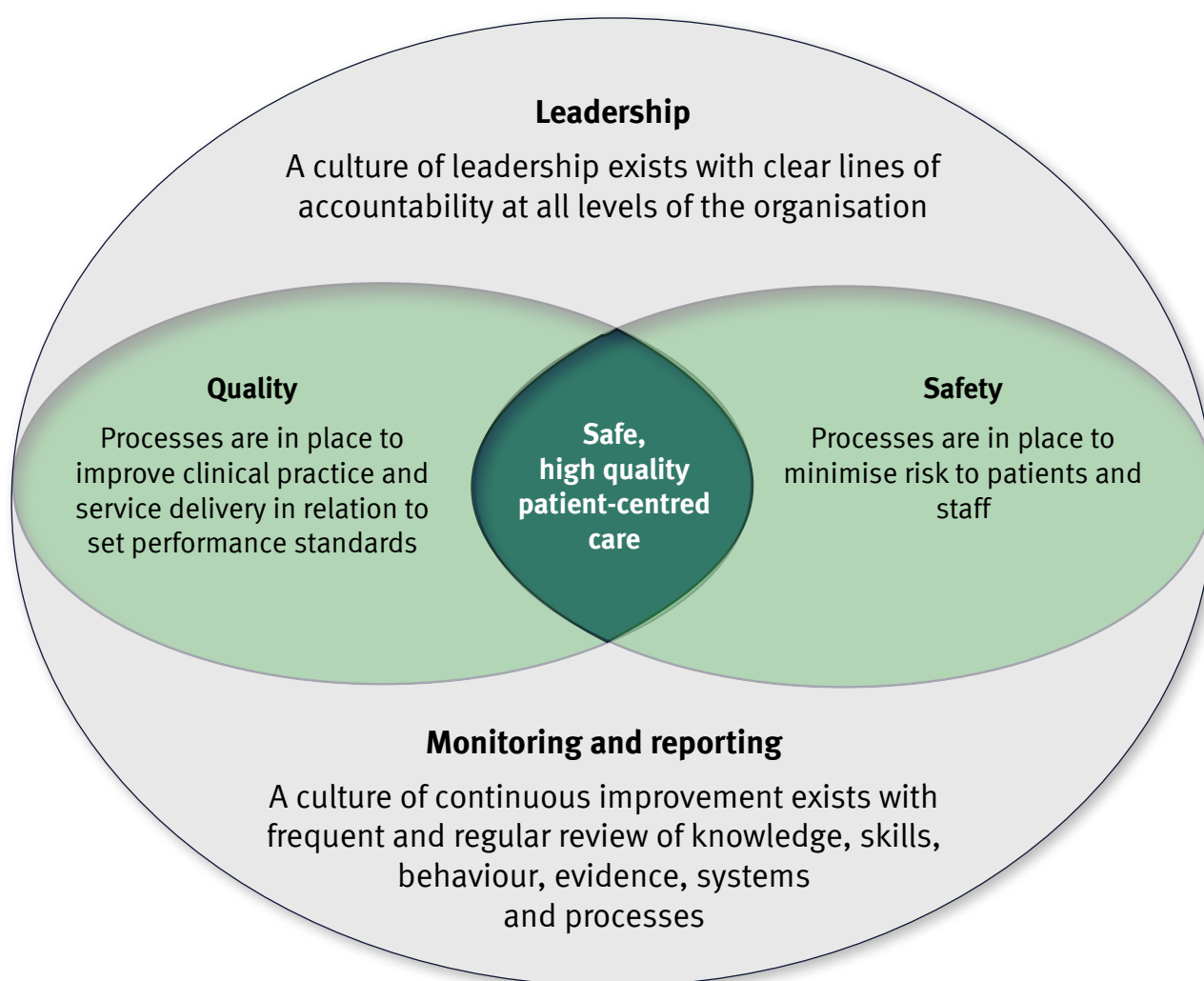
The role of the non-clinical QAS workforce is essential to the delivery of quality pre-hospital care. This group includes administrative, clerical and other critical clinical support staff or volunteers. By actively participating in organisational processes – including the development and implementation of safety systems, improvement initiatives and related training – this group can help to identify and address the limitations of our quality and safety systems.

- › **QAS Executive**

The role of QAS Senior Executives is to plan and review integrated governance systems that promote patient safety and quality, monitor performance and to clearly articulate organisational and individual safety and quality roles and responsibilities throughout the organisation. Explicit support for the principles of patient centred care is key to ensuring the establishment of effective service. As organisational leaders, QAS Executives should model the behaviours that are necessary to implement safe and high quality healthcare systems.

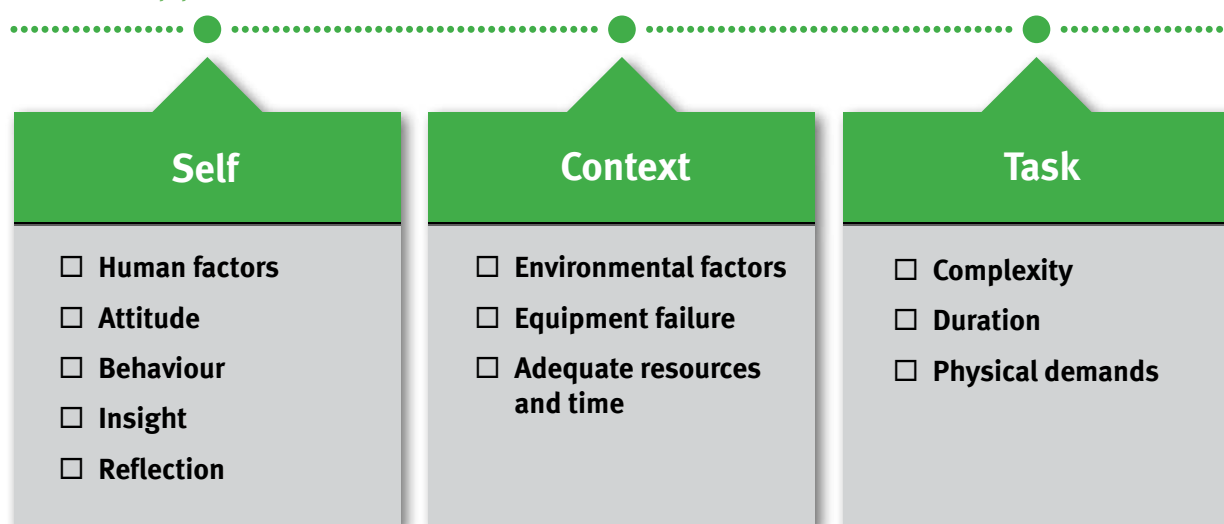
Good clinical governance in the QAS requires strong strategic and cultural leadership of clinical services, focusing on:

- › cultural leadership which requires and prioritises safety and quality and supports continuous improvement - allocating resources appropriately, to support the delivery of quality care
- › clarity of responsibility for managing the safety and quality of clinical care and delegation of the necessary management authority through the QAS Senior Executive Group
- › effective planning to enable development and improvement opportunities to be captured
- › reliable processes for ensuring systems for the delivery of clinical care
- › effective use of data and information to monitor and report on performance
- › well-designed systems for identifying and managing risk.



The QAS is committed to ensuring the highest quality in clinical standards and service delivery. All elements of clinical practice, service delivery and the associated governance arrangements should be constantly reviewed to ensure that the QAS remains in a position to provide the highest quality patient care. A supportive culture of continuous quality improvement is one in which individuals and teams grow, learn and contribute to service objectives, processes and systems are frequently reviewed and improved to maximise outcomes and efficiencies.

Person approach




System approach

Concentrates on conditions under which individual work. Tries to build defences against overt errors and mitigate their effect.

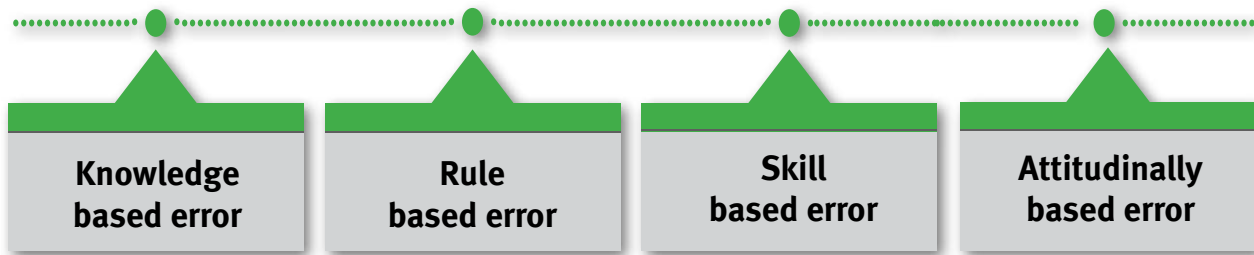
Automate, force functions, standardise, checklists, reduce steps and handoffs, add redundancies (double checks), process/task redesign, simplification.

QAS - Field Reference Guide (FRG), Pocket Guide, updated and simplified Protocols/policies and procedures, DoH 'Best Practice Guide to Clinical Incident Management'.

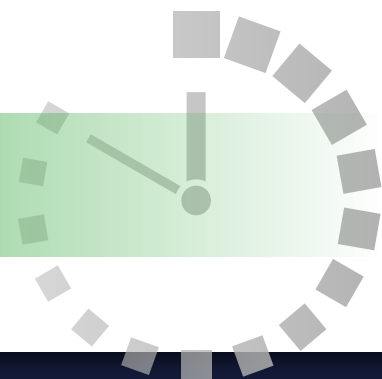


Error is common but just how common?
% of errors not reported (>25%)
Severe consequences for serious or sentinel events

Errors



...get it right every time!



Officer Dashboard

- › QAS has developed an Officer Dashboard - web-based application that gives Officers access to information drawn from a wide range of data systems. The application provides data at an individual Officer level to allow:
 - Officers to view their own data and performance for self reflection, PDP Planning and evidence for CDP for paramedic registration (pending)
 - Managers and Supervisors to access information about the Officers for whom they are responsible
 - Supervisors and Educators to identify key areas where an Officer may benefit from development opportunities.
- › eTimeSheets are the most important data source for this website. It derives Officer demographic information, OIC details, leave/overtime details etc. from the timesheet database.
- › eARF is used extensively as well. Other significant data sources include LMS, QACIR, ECLIPSE and VACISMGR.
- › The timesheet datasets such as Leave/Overtime and Officer-OIC relationships are refreshed fortnightly on a Wednesday after all officers have submitted their timesheets.
- › The eARF specific data (case nature/ final assessment etc.) are refreshed on a daily basis.
- › QACIR (Avg. Intervals)/LMS (Saba)/ECLIPSE data are refreshed on a daily basis.



Research

The QAS is committed to an evidence-based approach to delivering world class ambulance care to the Queensland community. Central to this approach is the support and promotion of research and analytics to inform clinical practice and safety, operational decision making, and to ensure that the QAS remains at the cutting edge of paramedic practice and education.

The QAS Information Support, Research and Evaluation Unit provides expert consultative research services; research and data governance; analytical reporting; and, practical research guidance, mentoring and academic supervision for paramedics undertaking formal studies and research projects.



Governance controls

Clinical auditing

There are so many competing demands on paramedics that often cases are discussed, but rarely are they systematically reviewed. QAS clinical auditing can provide a mechanism for something positive to come from every case reviewed.

The QAS clinical auditing process is about improvement in the quality of care through monitoring and evaluation, learning for both exemplary and sub-standard cases and implementation of change and re-evaluation.

In the past, QAS clinical audit has centred on individuals and protocol deviations. Punitive actions and reprisals have resulted in paramedics being overly fearful of error and not admitting to mistakes. This drives errors underground and focuses on system compliance rather than patient centred/ patient outcome focused care.

Cultivating a safe and just culture in the QAS

Patient safety and quality care requires the QAS build and maintain a safe and just culture.

Organisations with a positive patient safety culture are characterised by communications founded on mutual trust, by shared perceptions of the importance of safety and by confidence in the efficacy of preventative measures. A patient safety culture is comprised of many things, including openness, honesty, fairness and accountability. It requires and encourages the reporting of incidents and safety hazards and the audit and review of all elements of practice. It promotes understanding, learning and improvement. It requires flexibility and resilience so that people, unexpected situations and priorities can be managed in a timely and effective manner. Importantly, it includes the principles of patient centred care.

The QAS clinical auditing process will only ever be effective when it is conducted within a safe and just culture because paramedics know they will be treated fairly and will be held accountable for their actions and behaviours. This type of culture is largely based on an organisation 'possessing a collective understanding of where the line should be drawn between blameless and blameworthy actions. Differences are drawn between actions of intent, recklessness and those of unforeseen circumstances or complications of care.

This sort of culture cannot be implemented solely based on policy or procedure; rather, it needs to be consistently fostered over time and by example, at all levels in the organisation. Leadership is especially important in the initial stages of building a safe and just culture. Ultimately, everyone in the organisation has a role in helping to build and maintain this culture.

To promote a safe and just culture in which we learn from our mistakes, QAS must re-evaluate just how our disciplinary system fits into the equation. Disciplining employees in response to honest mistakes does little to improve the overall system efficacy or safety.

The QAS clinical auditing process will be reviewed, refer to page 32.

The QAS clinical auditing process now has two (2) components:-

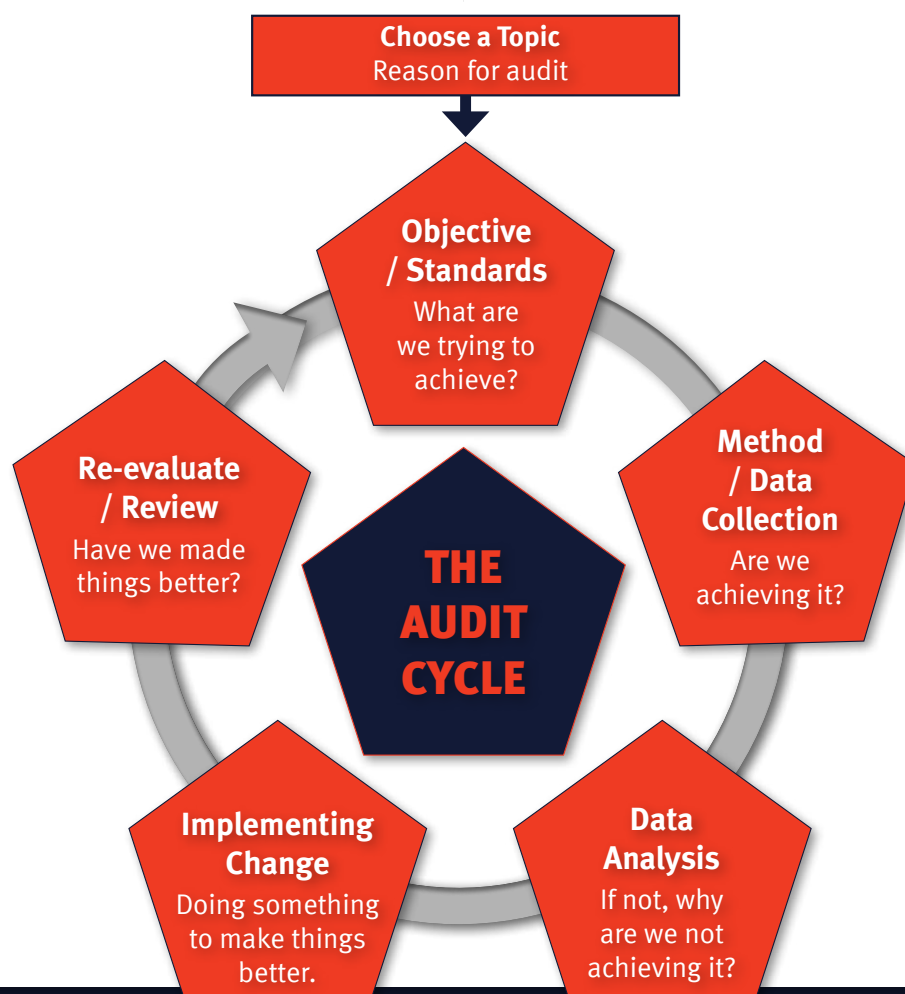
› **Paramedic self audit and review**

This is a primary case audit done at the time of the case or as a reflective practice exercise post case.

› **System audit**

This is a formal audit and review conducted to meet legislative, patient safety and quality or public interest needs [these are managed by the QAS Quality and Patient Safety Unit].

PARAMEDIC SELF AUDIT and REVIEW	SYSTEM AUDIT
Error prevention focus	System and trend analysis focus
› Paramedic [self reflection and review] <ul style="list-style-type: none"> - Note to self - Self corrective action [eg knowledge improvement or skills maintenance] - Peer review - CSO in-field coaching - CEU Educator assistance - Self reporting - Peer reporting - Patient safety reporting 	› Office of the QAS Medical Director <ul style="list-style-type: none"> - Self reported incidents - Peer reported incidents - Complaints [QAS/OHO/ AHPRA] - Patient safety reporting - Third Party Disclosures - LASN Clinical Governance Committee input - Targeted clinical trend analysis
Paramedic ECLIPSE System and Officer Dashboard	eARF Utilities



Case Reflection Guide/Personal Case Review

- › Case type?
- › How did the patient present? On arrival/examination, in transit, at destination (trends?)
- › Observations taken were appropriate? Yes/No. Comments
- › History/notes were appropriate? Yes/No. Comments
- › Treatment given - drugs given were appropriate? Yes/No. Comments
- › Treatment given - procedures performed were appropriate? Yes/No. Comments
- › Were there any drugs or procedures not given or performed that could have been considered? Yes/No. Comments
- › Times involved in case were appropriate? Yes/No. Received/dispatched/on-case/on-scene/at patient/department scene/at hospital/destination. Comments.
- › Appropriate use of the Emergency Medical System - back up called? Yes/No, hospital/destination appropriate? Yes/No, hospital/receiving facility notified? Yes/No. Comments.
- › eAmbulance Report Form Clinical completion appropriate? Yes/No. Comments
- › Does the provisional diagnosis match the nature of case and the treatment given? Yes/No. Comments.
- › Was the treatment given to the patient value adding / outcome focussed? Yes/No. Comments.
- › Officer feedback. Exemplary, satisfactory, follow-up required.

QAS incident investigation

The DoH Best Practice Guide to Clinical Incident Management and the QAS Clinical Incident Management Plan have been developed as resources to support those responsible for, or involved in, managing, analysing and learning from patient safety incidents in any healthcare setting. This guide aims to increase the effectiveness of analysis in enhancing the safety and quality of patient care, by providing methods and tools to assist in answering the following questions about each patient safety incident:-

- › **What happened?**
- › **How and why it happened?**
- › **What can be done to reduce the likelihood of recurrence and make care safer?**
- › **What was learned?**
- › **How can the learning be shared?**

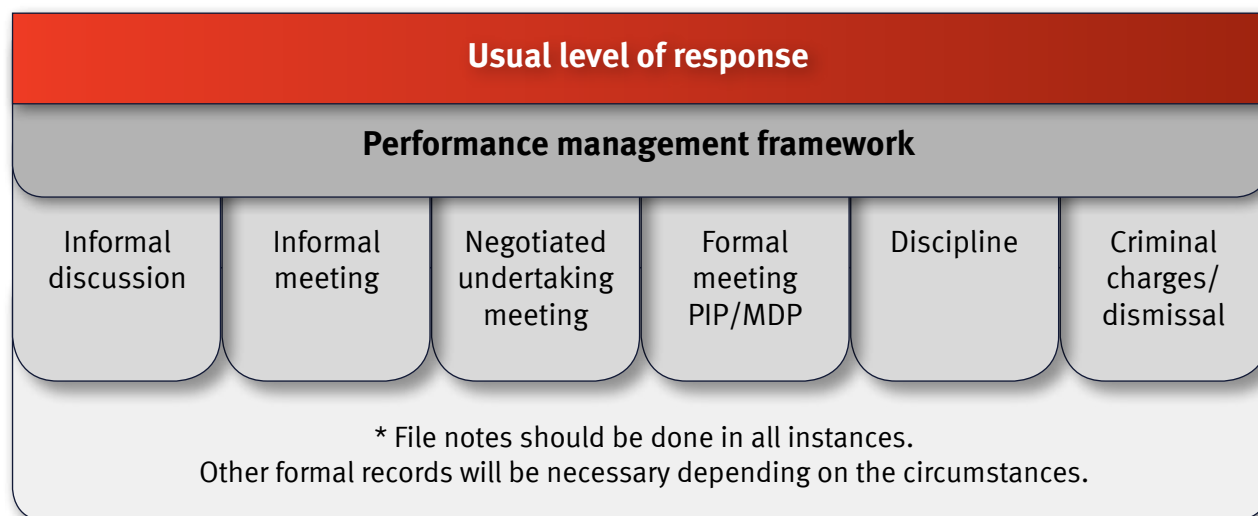
Key enhancements to the guide from previous policy and standards include:

- › the patient/family perspective
- › multiple methods of analysing incidents
- › a description of how analysis is intertwined with the incident management continuum
- › an innovative diagramming method to better identify contributing factors and their interconnections
- › a new section on developing, prioritising, validating and managing recommended actions.



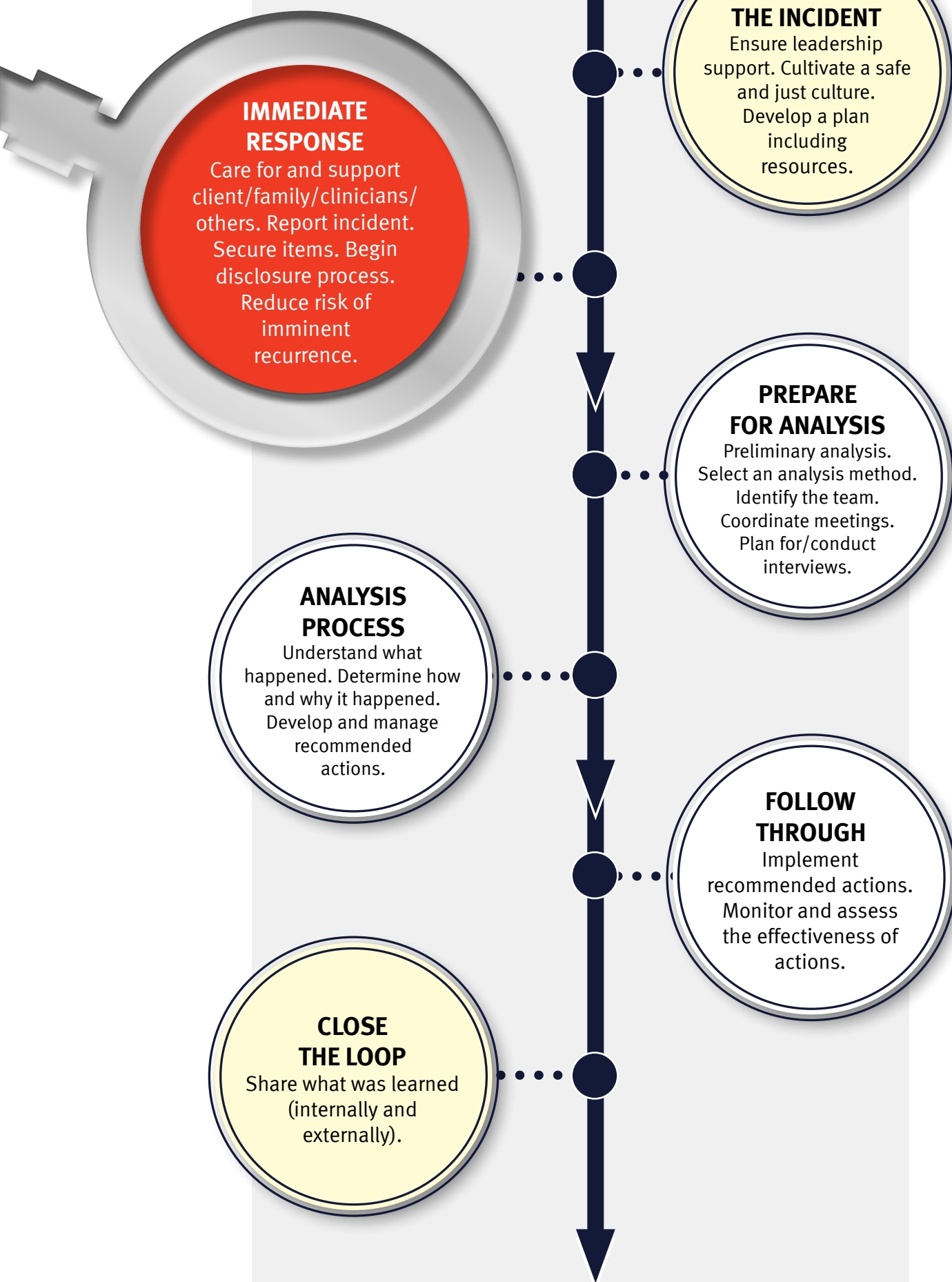
Unintentional → **Intentional**

Act of doing (time, place, event) Intent? - reasonability? - Recklessness? - Awareness? - Deception?



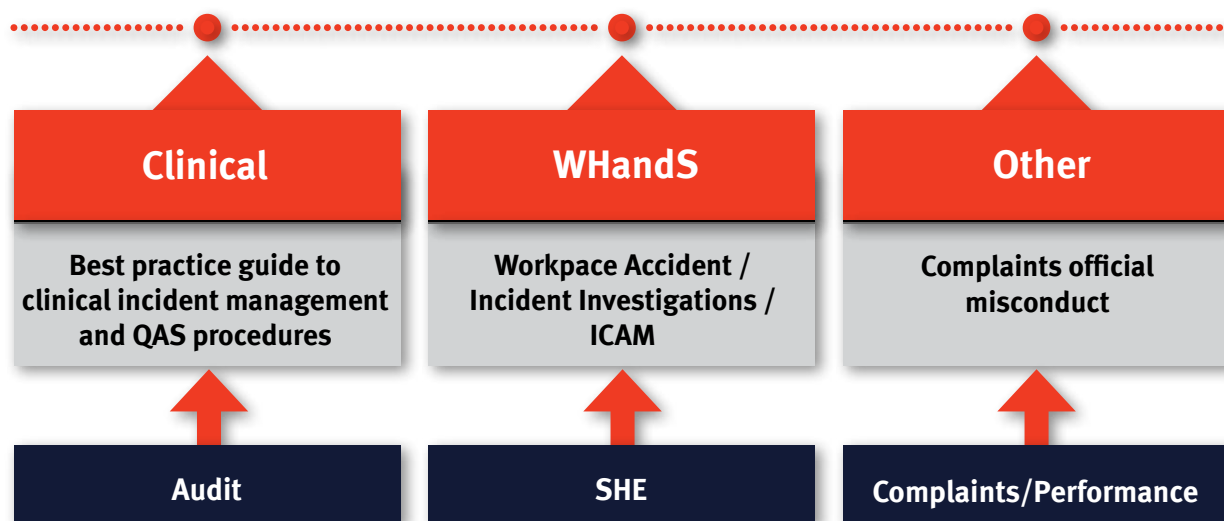
* Applying the principles of natural justice and procedural fairness

Best Practice Guide to Incident Investigation



QAS complaint management

•Terms of reference •Formal note taking •Taking statements •Risk in context •Public Interest Disclosure (PIP)



Core principles shared

Principles	This means we will...
People focus	<ul style="list-style-type: none"> › recognise and respect everybody right to provide feedback › demonstrate a commitment to addressing feedback in a timely manner and without charge › involve the complainant in the process as far as is practicable and appropriate
Remedies	<ul style="list-style-type: none"> › attempt early, informal resolution and compromise wherever possible, at the lowest level possible (i.e. at manager level) › offer remedies that are fair to all parties, minimising the possibility of ongoing dispute
Visibility and access	<ul style="list-style-type: none"> › ensure clear information is available on the QAS website about how and where to make a complaint and how complaints are managed › provide reasonable assistance to complainants with special needs in making complains › recognise and address complaints provided anonymously, or through an authorised third party in the same manner as any other complaint.
Responsiveness	<ul style="list-style-type: none"> › record, track, acknowledge and process complaints in a timely manner, in accordance with the relevant complaint procedure › ensure that the complainant is aware of the process, time-frames, their likely involvement in the possible outcomes of the complaint and any other necessary information
Objectivity and fairness	<ul style="list-style-type: none"> › manage complaints objectively and deal with them fairly, respectfully, consistently, in accordance with the principles of natural justice and without actual or perceived conflicting interest › take all reasonable steps to ensure that a complainant is not adversely affected › protect the rights of officers where they are the subject of a complaint › deal with complaints confidentially to the extent possible and with personal information in accordance with the Information Privacy Act 2009 › refuse to investigate a complaint if it is considered to be abusive, trivial or vexatious
Feedback	<ul style="list-style-type: none"> › provide adequate and timely feedback on complaints to all parties › notify complainants of their internal and external review options
Monitoring and reporting	<ul style="list-style-type: none"> › record and report complaints in accordance with legislative and other requirements › commit to using complaints as an essential tool for continuous improvement
Resources and training	<ul style="list-style-type: none"> › ensure adequate resources (including training where required) are available › empower staff to implement the QAS complaint management system as appropriate.

Suggested reading/references

Queensland Health Clinical Excellence Division, Patient Safety and Quality Improvement Service, National Safety in Quality Health Services (NSQHS) Standards

Australian Commission on Safety and Quality in Health Care <https://www.safetyandquality.gov.au/>

Council of Ambulance Authorities (CAA) Paramedic Professional Competency Standards http://caa.net.au/~caanet/images/documents/accreditation_resources/Paramedic_Professional_Competency_Standards_V2.2_February_2013_PEPAS.pdf

The National Code of Conduct for Health Care Workers (Queensland) <https://www.health.qld.gov.au/system-governance/policies-standards/national-code-of-conduct>

Council of Australian Governments (COAG) Standards for Health Workers https://www.health.qld.gov.au/__data/assets/pdf_file/0014/444101/national-code-conduct-health-workers.pdf

DoH “Best Practice Guide to Clinical Incident Investigations”

The NSW Ombudsman have a “Practice Manual for Managing Unreasonable Complaint Conduct”

The Commonwealth Ombudsman have a “Better Practice Guide to Complaint Handling”

Paramedics Australasia – “Paramedic Registration <http://www.paramedics.org/registration>

Australian Health Practitioners Regulation Agency (AHPRA) <http://www.ahpra.gov.au>

Acronyms

ACP1	Advanced Care Paramedic 1
ACP2	Advanced Care Paramedic 2
AHPRA	Australian Health Practitioners Regulation Agency
CAA	Council of Ambulance Authorities
CCP	Critical Care Paramedic
CEU	Community Education Unit
CGF	Clinical Governance Framework
CLO	Collaborative Learning Online
COAG	Council of Australian Governments
CPD	Continuing Professional Development
CSO	Clinical Support Officer
DCPM	Digital Clinical Practice Manual
DoH	Department of Health
eARF	Electronic Ambulance Report Form
ECP	Extended Care Paramedic
ESoP	Extended Scope of Practice
FRG	Field Reference Guide
HARU	High Acuity Response Unit
HQCC	Health Quality and Complaints Commission
ICAM	Incident Case Analysis Method
LARU	Low Acuity Response Unit
LMS	Learning Management System
MDP	Management of Diminished Performance
MoG	Machinery of Government
NSQHS	National Safety in Quality Health Services
NRAS	National Registration and Accreditation Scheme for Health professions
OIC	Officer-in-Charge
PMF	Performance Management Framework
PDP	Performance and Development Plan
PIP	Public Interest Disclosure
PEPAS	Paramedic Education Programs Accreditation Scheme
PTO	Patient Transport Officer
QAS	Queensland Ambulance Service
QASEC	Queensland Ambulance Service Education Centre
QHO	Queensland Health Ombudsman .
QASCLO	Queensland Ambulance Service Collaborative Learning Online
RTO	Registered Training Organisation
SARAS	Study and Research Assistance Scheme
VET	Vocational Education and Training

[illegible]



Clinical Governance Framework
2017-2020