Guidance on Completing Quality Assurance Application Form

1. ***Project Title*** *- Please keep it short and informative*
2. **Project details, including summary and overall aims –** ***Include*** *a background information on why you are conducting the project e.g., assessing clinical practice. If you are looking critically at clinical care you need to identify and reference evidence of good clinical practice standards/guidelines on which to base your assessment. Summarise the overall aims and expected outcomes of the project.*
3. ***Type of QA*** *– select the type from the options provided*
4. **Aim of the Quality Assurance -** *Describe the aims of this project, clearly outlining the name of the current standard or guideline being used for comparison. You must include this document as supporting evidence with your application. For example:*

   a. To review current local standards of care against the recognised national/international standard or guideline <insert full name of the standard/guideline here> with the aim of improving patient outcomes and enhancing service delivery. The referenced standard/guideline will be included as supporting documentation with this application.

   AND/OR

   b. To generate data that will inform the development or refinement of clinical standards and guidelines, particularly in areas where higher-level evidence is limited. This review will also be used to guide future assessments of clinical practice. The current comparison standard/guideline <insert full name of the standard/guideline here> will be provided as supporting documentation.]

5. ***Standard, Guideline or Benchmark Used for Comparison –*** *list the name of the standard/guideline*
6. ***Benefits of the Quality Assurance -*** *If the QA is assessing compliance with a known clinical standard/guideline then the following likely benefits can be used; however, if these benefits are not relevant to your audit, please provide relevant information about your specific audit benefits.*

   [For example:

   The benefits of this audit are to:

   1. Review current practice and determine the level of compliance with a <insert clinical standard>.

   2. Increase awareness and understanding among the clinicians of the <insert clinical standard> and its importance.

   3. Improve standards of patient care and compliance with the <clinical standard>.

   All of which will improve the quality of care provided to <insert the patient cohort information> at Ramsay Health Care.]

7. ***Is this QA related to a previous QA? –*** *Answer Yes or No*
8. ***Data Collection and Identification***

- *Describe the data collection method, specifying exactly how data will be obtained. If the QA activity involves reviewing medical records, indicate whether this review will occur prospectively (e.g., on the ward during patient admission) or retrospectively via a request to Health Information Services.*
- *Identify who will collect the data, including the role or position (not just a name) of the person responsible. Confirm whether this person normally has access to the required information.*
- *Describe who else will have access to the collected data. Typically, access is limited to members of the audit team.*
- *Indicate the planned timeframe or specific dates during which data collection will occur.*
- *Explain how the data will be collected, including the data collection tool or system to be used. Most commonly, data are recorded using an Audit Form (paper and/or electronic), such as forms used for medical record reviews at ward level or through established audit systems. Alternatively, data may be entered directly into a <u>password protected and encrypted</u> Excel file, or other secure electronic system. <u>These files must be stored on an RHC hospital computer</u>. The data collection tool must be provided with your application.*

[For Example:

*The information will be collected from <existing or current/new> medical records <on the ward during patient admission> or <via a request to Health Information Services>. Data will be collected in **re-identifiable format**. All data will be entered onto the <audit case report form/electronic audit database> and assigned a unique audit identification number. A master identifier list containing the patient UR number and the corresponding audit identification number will be stored **separately** in a password-protected electronic file accessible only to authorised research personnel involved in the audit. Data collection will be performed by <insert name and position>, and it is expected to be completed within <insert timeframe>, commencing <insert start date> and concluding <insert end date>.*

<Paper case report forms will be stored securely in a locked cabinet located in the <insert name of department, and Principal Investigator> department office, and access will be restricted to authorised research personnel>. All electronic datasets will be stored in password-protected and encrypted files on the secure shared drive of computers within Ramsay Health Care <insert hospital name>. These files are accessible only to authorised research personnel.

If the QA activity involves non-identifiable data (e.g., anonymous survey or data extracted without allocation of a code and the use of a master re-identifier list): the dataset will be assigned an QA reference number without a master re-identifier list. No identifiable information will be collected, and re-identification will not be possible.]

9. ***Data Storage***

- *Describe who owns the data. Data ownership generally rests with the Applicant, in their capacity as a Ramsay Health Care employee.*
- *Describe how the data will be stored and secured, clearly outlining the storage arrangements for both paper and electronic data, including details on secure locations, password protection, encryption, locked cabinets, and restricted access.*
- *State the required retention period. At Ramsay Health Care, QA data must be stored securely for a <u>minimum of 12 months</u>. If the data will be (or may be) published, it must be retained for:*

I. 5 years from the decision to publish, or
II. 5 years from the decision not to publish,
III. in accordance with the Health Records Act Schedule 1 – Health Privacy Principles, Section 4, 4.2(b)(ii).

[The standard statement below can be used if it is relevant to your QA activity.

All data will be kept for a minimum of twelve months from completion of the QA activity.

<All datasets will be kept for a period of five years from publication or for five years from subsequent decision not to publish.> The data will then be destroyed in a secure confidential manner according to the Ramsay Health Care and National Guidelines at the time of destruction.

10. *Proposed Dissemination of Results*

Outline how you will be communicating the results of your QA and to whom. If you are intending on presenting the results as a poster or paper for a Conference, please include this in your dissemination process. Please also outline any intent to publish this data in scientific journals.