**Supplementary file 4: Final Australian Included Practices**

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| **Final code** | **It is a waste of time doing 'X' because it doesn’t make care safer. Please tell us what 'X' is.** |  |
| Administrative task | updating contact details and data entry on computer systems  | 1 |
| Administrative task | There are many , many things which waste our time in clinical medicine - too many to specify here. These range from our having to fill in patient details on the electronic forms | 2 |
| Administrative task | de-identification of patient records stored on secure sites | 3 |
| Administrative task | it is a waste of time for previous addresses, phone numbers and contacts to be automatically transcribed from old admissions  | 4 |
| Administrative task | It is a waste of time in community pharmacy to call the precriber to 1) do an owing of three days only which is never practical nowadays. There are many contradictions and shortcomings in the pharmacy rules that may be outside the context of this survey.  | 5 |
| Administrative task | It is a waste of time in community pharmacy to call the precriber to 2) chase up owing scripts from GPs, | 6 |
| Administrative task | contacting drs regarding small amendments | 7 |
| Administrative task | It is a waste of time in community pharmacy to 5) ring the prescriber to interchange vaccines | 8 |
| Administrative task | It is a waste of time in community pharmacy to call the precriber to 6) chase up paper copies of scripts.  | 9 |
| Administrative task | sorting scripts,  | 10 |
| Administrative task | dating scripts, | 11 |
| Administrative task | Obtaining original, wet ink signature on documents (rather than electronic).  | 12 |
| Administrative task | Issuing temporary ID cards to staff when leave cards at home. | 13 |
| Administrative task | My Health Record Gap Analysis .Small day surgeries dont have the capacity to implement this  | 14 |
| Administrative task | keeping track of feeds and deliveries and warehouse stock - became time consuming for dieticians | 15 |
| Administrative task | this issue is about spending a lot of time trying to address situations where a patient is 'medically cleared' but has needs related to treatment for which there are no services and for which the person has no informal support or financial capacity to pay for. eg responsible adult to monitor overnight after surgery; aggressive homeless mental health patient who needs woud care post surgery ( and assessed as unable to attend out patient clinic or safe for community nurse.l  | 16 |
| Administrative task | Manually ordering - air mattress for prevention patient pressure injury and cancelling on discharge a nightmare - should be computerised with corpas.  | 17 |
| Administrative task | nurses ordering medication that have run out - this is done manually when the medication charts are electronic. | 18 |
| Administrative task | Ordering of nutritional product to wards | 19 |
| Administrative task (box ticking) | Signing patients off to go to the ward from ED | 20 |
| Administrative task (box ticking) | chasing a GP referral to access Midwifery care.  | 21 |
| Administrative task (box ticking) | looking up outdated practice guidelines on local intranet,  | 22 |
| Audit and feedback | Safety crosses | 23 |
| Audit and feedback | Safety crosses;  | 24 |
| Auditing | Follow up of notifiable conditions for surveillance purposes only, not for clinical Management or public health control of clusters/outbreaks | 25 |
| Auditing | using secret algorithms and benchmarking to judge work  | 26 |
| Auditing | Continual auditing of areas that don't need following | 27 |
| Audits done with no effect | tracking incidents without introducing best practice including systems and procedures to ensure improved and safe care | 28 |
| Audits done with no effect | Auditing areas of the department that are not accounted for.  | 29 |
| Audits done with no effect | Conducting audits as a tick box excercise to provide accreditation evidence only even it is not indicated and will lead to no outcomes. | 30 |
| Audits done with no effect | Extensive case reviews | 31 |
| Audits done with no effect | audits re compliance | 32 |
| Audits done with no effect | 1)Audits that are not specific to improving patient care.  | 33 |
| Blanket policy | Routine observation on clinically well patients because it is mandated with no allowance made for clinical judgment  | 34 |
| Blanket policy | rountine observations rather than based on patient need | 35 |
| Blanket policy | Nursing staff being made to do pressure checks and other blanket checks which do not have clinical relevance to paediatrics | 36 |
| Blanket policy | A full set of blood tests on almost all patients who present to emergency regardless of what their complaint is or their clinical state | 37 |
| Blanket policy | Mandatory assessments on all patients regardless of their age, acuity or reason for admission. | 38 |
| Blanket policy | Pressure risk assessments on outpatients are low yield, and if there is pressure risk the mental health team is not the most qualified to review or in a position to modify the risk. And if in a nursing home, another organisation should be responsible.  | 39 |
| Blanket policy | Hundreds of papers have been written on risk assessment. The upshot is: yes, standardised inventories may predict long term risk better. BUT the tools in use on mental health wards do not predict risk in the time period that they are being used for (they predict long term risk). And the escalation recommended in the original document is.referral.to a mental health nurse who will consider if I need to be involved.  | 40 |
| Blanket policy | 2. Doing falls risk assessment for obviously very low risk patients e.g fit and young, ambulatory patients | 41 |
| Blanket policy | Making iv infusions only at time we need them not in advance | 42 |
| Blanket policy | Daily showers in am. | 43 |
| Blanket policy | Labs demanding hand written labeling of blood tubes other than transfusion specimens as it increasing illegibility.  | 44 |
| Blanket policy | Electrical Safety Testing ( EST ) | 45 |
| Blanket policy | Daily checks on Emergency Trolleys in our Theatre unit which is locked At the end of our working day. | 46 |
| Blanket policy | Needing a second person to log another user off merchant (override).  | 47 |
| Blanket policy | Writing on forms the full wording of common chemical compounds e.g. 0.9% normal saline (when normal saline IS 0.9%) | 48 |
| Blanket policy | Reviewing whether to continue 1:1 special nurses on patients who have required them long term and/or have detailed instructions from the team,  | 49 |
| Blanket policy (box ticking) | Managing the multiple weekly safety notices/recalls for products we dont even stock. Poor manufacturing has led to a huge increase of notices( 10-20 per week) of software updates , packing issues, information sheet updates. No harm has come to any patients in the notices and we feel this is the companies just risk manging for their sake  | 50 |
| Blanket policy (box ticking) | Temperature checking is important for everyone but asking staff who know they cannot be at work when they are sick; if they have any cold or fly symptoms is a waste of their time. General public is very important to ask! | 51 |
| Blanket policy (box ticking) | requiring written consent before chemotherapy can commence | 52 |
| Blanket policy (box ticking) | ticking the bureaucratic boxes | 53 |
| Blanket policy (box ticking) | Mandatory check box consultations before a patient can access a procedure | 54 |
| Blanket policy (box ticking) | Doing tasks because the standards say so , rather than its of benefit to care .  | 55 |
| Blanket policy (box ticking) | whs | 56 |
| Blanket policy (box ticking) | Anticoagulation check boxes are stupid. They are appropriate in settings where short term anticoagulation needs to be considered constantly. In ambulant patients, at their baseline risk, with complex medical needs (i.e. all patients) the individuals who most commonly fill out medical charts are being forced to positively make a statement regarding anticoagulation risk that is not timely or necessary and they are probably unqualified to do  | 57 |
| Communication issues | educating patients about treatment on the phone | 58 |
| Communication issues | Follow up phone calls after discharge.  | 59 |
| Communication issues | 3) Conflict resolution with patients who do not wish to take responsibility for their own care and have beyond reasonable expectations of pharmacy staff/ processes/ resources. | 60 |
| Communication issues | Poor initial or rushed communication with patient before a procedure - poor teamwork | 61 |
| Communication issues | Character building | 62 |
| Communication issues | X' is the delivery of medication after the patient is discharged as it is not ready when the patient is being discharged.  | 63 |
| Communication issues | Providing suggestions in meetings but have executives or leaders basically slam every reasonable suggestion - cover up cultures "because things have always been done this way" - would have liked to have avoided having to attend any of these meetings set under the guise of "consultation" just to have our time wasted.  | 64 |
| Communication issues | arguing with ADON and bed managers about staffing when we have no ratios to back up our needs | 65 |
| Communication issues | Continiually developing Wound care flowcharts | 66 |
| Communication issues | watching CEO video news - generally a very inefficient way of using a lot of time to communicate,  | 67 |
| Communication issues | Keeping information collected only within the institution collecting the information. Information needs to be available to the whole medical network of each individual patient, whether that be via a central hb and patient approved password | 68 |
| Communication issues | Multiple phone calls to have unwell patients transferred to a tertiary facility. In order to have a patient transferred you require an accepting stream or doctor. With complex patients it may be a vascular issue for example but complicated by a fracture or an endocrine problem. Teams then pass on the patient and suggest you call another team. meanwhile patinet is still no closer to tertirary care and is potentially deteriorating | 69 |
| Communication issues | similar with "global emails" many are irrelevant to many of the staff receiving them -  | 70 |
| Communication issues | Repetitive emails for all different faculties to repeat the same information relating to whole organisation issues | 71 |
| Communication issues | multiple emails with same info  | 72 |
| Communication issues | circular communications | 73 |
| Communication issues | call up to twice to have blood products delivered,  | 74 |
| Communication issues | a lot of time is spent ascertaining/ clarifying allocation - allocation is designed to provide a good outcome but require multiple considerations to determine - variables are which medical unit; what is the exact diagnosis ; what if the condition is not yet diagnosed; which ward is the person on or was the person on when a particular incident occurred; while most obvious to staff not always obvious to other staff who come to associate a particular SW with a particular ward or diagnosis or medical unit so extra time spent redirecting/ updating other SW on what happened/ referring on ;  | 75 |
| Communication issues  | When people have poor communication that leads to a double- up in work. | 76 |
| Covid-related | I am owner/operator of a business in private practice and it is hard to think of an x. I can only relate this to my experience in aged care, the x is isolating the residents. | 77 |
| Covid-related | Isolation  | 78 |
| Data collection | Collecting data for the purpose of reports which actually are not relevant to safety but are required for contract compliance  | 79 |
| Data collection | For general nurses there is too much electronic data to be collected. The EMR system is great don’t get me wrong but there is too much time going from one page to the next. | 80 |
| Duplication | Mandatory annual competencies separately for each of the 3 hospitals I work in  | 81 |
| Duplication | Whole ward handover and then doing bedside handover as well | 82 |
| Duplication | When a retrieval is requested - they hand over to nurses in retrieval coordinations centre. The flight nirse then rings the referring hospital to get the same handover. Delaying departure | 83 |
| Duplication | Providing a nursing handover from printed medical and nursing documents from ED when we transfer patients to any ward outside of ED. This has several implications in my opinion. Firstly, the transferring nurse relies too much on the script of the medical assessment rather then understanding why the patient has presented to ED, mechanism, signs and symptoms etc, trends in deterioration, treatment. This bad practice alll is printing medical records that are often not disposed of confidentially as they are not apart of the ward medical record as they’re available on eMR. This practice also stops the nurse handing over throughly at the beside (if appropriate).  | 84 |
| Duplication | Repetitive multiple meetings and submeetings for all different faculties to repeat the same information relating to whole organisation issues such as demonstrated with COVID19. This tends to create misinformation when interpreted down the line. Could do one meeting now for one organisation on the same topic as a ZOOM or teleconference with IT capacity put into place to each indiividual department to join in to ensure correct information and transparency and objectiveness and also allow for right down at the roots level to be engaged with the broader executive level, such as has been happening with the CEO providing updates on COVID19 | 85 |
| Duplication |  Lot of info doubled up in meetings waste of time (especially during COVId time). Not sustainable - viscous cycle.  | 86 |
| Duplication | Overservicing Post natally - universal baby health checks | 87 |
| Duplication | often assessment are sort of doubled up.  | 88 |
| Duplication | numerous repetitive information on eMR. | 89 |
| Duplication | every activitiy should be done with the view that it makes a patient /staff safer. X could be double entry of patient data into medical records. | 90 |
| Duplication | more than one audit on the same topic. e.g. currently there is a monthly pressure injury audit and a once a year point prevelance pressure injury audit. the once yearly is not needed if we check these same things every single month. there is a twice yearly audit on advanced care directive cardboard dividers in the patient bedside folders, the dividers are not what makes a patient safe the actual care directive is, this audit is not helping patient safety.  | 91 |
| Duplication | repetive compliance audits that are measuring the same attributes, but require reporting on different templates to different parties | 92 |
| Duplication | Repeated audits of activities with high compliance | 93 |
| Duplication | Developing own audits | 94 |
| Duplication | Developing own training materials, | 95 |
| Duplication | Developing own responses to advisories | 96 |
| Duplication | Double checking All IV drugs in the unit are being double checked and double signed. Not all need to be double checked, yes if it was paediatric doses or not protocol, but not all.  | 97 |
| Duplication | “Independent double check of medications” as it is almost never independent. | 98 |
| Duplication | double checking ALL intravenous medication administration | 99 |
| Duplication | having to transcribe key points from progress entries - admissions/ relevant heath information such as diagnoses and investigations | 100 |
| Duplication | double documenting safety checks in the ICU; we document on the patient chart (hard copy) and again in the online pt notes;  | 101 |
| Duplication | Doubling up on patient info in a lot of different platforms -electrnoic, paper etc. BUT also expected to do an audit to ensure we're "compliance" (pressure is on - you never win) therefore patient care is compromised when already so time poor. See this everywhere and not getting better. Compliance audits are important but NOT on every patient care form. So much repetition.  | 102 |
| Duplication | Ineffective documentation / information systems that require you double up on your documentation. | 103 |
| Duplication | Having hybrid documentation systems so that some records are kept on paper and some are kept on the computer. This creates duplication of documentation.  | 104 |
| Duplication | If several patients need to be booked in the first and subsequent patients arent added to the computer until all the hard copies are done. We cannot do blood tests, imaging, other tests until the patient is added to the computer so we have to wait. We often chase up with admin staff to prioritise but its slow and clunky. Example: Patient 1 arrives to ED. The admin staff ask their questions and complete the paper copy ready to double this onto the computer. As they try to do this 5 new patients arrive. The admin then do the additional 5 paper copies and in total this takes 20 minutes. They then put patient 1 onto the computer system 25 minutes later so we as clinicians are left waiting that long to be able to request blood tests or xrays. Its ridiculous  | 105 |
| Duplication | The current practice in the Emergency Dept is all patients get booked in by admin staff. The process is VERY antiquated, clunky and disrupts prompt patient requirements and slows clinical decision making. Every patient is asked multiple questions using a piece of paper. This information then gets transcribed to the computer so there is unnecessary doubling up and this process is time consuming.  | 106 |
| Duplication | Duplicating documentation in written and digital form. | 107 |
| Duplication | Moving to document some information in multiple places (both paper-based and electronic) - too many systems that don't talk to one another).  | 108 |
| Duplication | Checking schedule 8 drugs 3 time ms a day | 109 |
| Duplication | 1/ Medication checks - S4D & S8 and IV meds (3 checks)  | 110 |
| Duplication | Over documenting in patient notes/ reports daily in numerous required fields. Followed by verbal hand over to the coordinator or next shift. | 111 |
| Duplication | 1. COVID-19 screening patients over the phone prior to their appointments as they were being screened prior to entry to the hospital  | 112 |
| Duplication | 2) Having to answer calls to multiple nurses re: supply of the same medicine for the same patient (had four calls re: the same iron infusion in the span of about 30 minutes once). Info on whether pharmacist has reviewed an order is available on electronic medchart. | 113 |
| Duplication | Rounding patients with AND without consultants | 114 |
| Equipment | Looking for progress notes to R/V and documentation | 115 |
| Equipment | 4. Looking for lacking items in the unit | 116 |
| Equipment | having to spend a lot of time sourcing basic necessities for discharge- clothing / shoes/ . they are available but at a cost of time walking; cannot use ward assistants for the task; may have to wait on availability of person who holds the keys; may have to travel even further if no stock; sometimes lots of time negotiating for items; sometimes no availablikty at all - a lot of patients have no family or friends. Few have the capacity to order on line. the ususal realsons are the belongings are cut off due to trauma, soiled ( vomit/ diarrhoea / blood / ) . Same situation with transport - long walk to get card for bus or train/ advocacy for hospital system to take some people home or to airport which is not something they are required to do - it is patient's responsibility but many patients have no one to take them home money or card - eg: lost or stolen in the event / waiting for next pension payment - then they may not know how to get home - feel lost - so need to get home if in an unfamiliar area - came up by air ambulance from country/ assaulted in city but don't live here/ from overseas/ going to refuge or crisis accommodation in unfamiliar area/ directions to get to welfare centre for food etc - so may need help from someone with bookings/ directions / printing print planner  | 117 |
| Equipment | finding a tendon hammer in the wards | 118 |
| Equipment | Wearing a body worn camera  | 119 |
| Equipment | The KED - Pro device | 120 |
| Equipment | falls mats because they are trip hazards themselves | 121 |
| Equipment | Non Slip Socks | 122 |
| Equipment | Red identification armbands for patients with allergies | 123 |
| Equipment  | Searching for equipment | 124 |
| Governance | repeated accreditations | 125 |
| Governance | Calling PBS authority line (and waiting some minutes) to get approval for increased quantities of non-narcotic medication  | 126 |
| Governance | also not sure clinical governance committees are that helpful.  | 127 |
| Governance | lengthy corporate procedures  | 128 |
| Governance | The level and layers of dept and federal compliance. Compliance has increased to the point where time and resources are deflected from patient care to meet increased healthcare compliance.  | 129 |
| Governance | anything that the Ministry of Health or Infectious diseases specialists/epidimiologists recommend | 130 |
| Governance | Documents particularly those required to access government benefits can be long (and get longer every year) repetitive and often difficult to relate to particular patients and their problems | 131 |
| Governance | Issuing policy after policy post an adverse event as people can't keep up with or remember policy on the fly | 132 |
| Governance | Have to start a screening procedure and it then changes 1 week later (realised by "powers unnecessary" Inconsistent processes = a waste of time. Immediate managers can streamline e.g. having to sign everyone into hospital (not just visitors and patients) - Only lasted 2 days.  | 133 |
| Handovers | Bedside handover | 134 |
| Handovers | Clinical handover away from the patient  | 135 |
| Hospital environment |  “How We’re Doing” posters - and such like - in ward & common corridors;  | 136 |
| Hospital environment | quality and safety noticeboards | 137 |
| Hospital environment | Cleaning of beds | 138 |
| Hospital environment | bedmaking,  | 139 |
| Incident reporting | mandatory incident reviews for negligable or no harm on the same topic continuously; | 140 |
| Incident reporting | repeated "deep dives" into HACS | 141 |
| Incident reporting | Reporting incidents | 142 |
| Incident reporting | Incident forms | 143 |
| Incident reporting | riskmans | 144 |
| Incident reporting | Incident reporting | 145 |
| Incident reporting | Some obligatory Riskmans;  | 146 |
| Incident reporting | incident reports | 147 |
| Incident reporting | monitoring incidents without trends and actions. | 148 |
| Incident reporting | IIMS were used as a learning tool, they now seem to be made a bigger issue that required...........in sone instances....sometimes that is necessary........but in lots of cases not and increase the amount of paperwork for both managers and due to the need to be seeing to do something increase the workload at the bedside taking away from patient care | 149 |
| Infection control | It is a waste of time putting a white "patient" gown over my scrubs when I have to exit the Operating Suite to go to the ward briefly. The gown does not touch anything, as only my hands would be touching things.  | 150 |
| Infection control | Wearing disposable gowns over scrubs.  | 151 |
| Infection control | Putting on plastic gowns and gloves for every patient.  | 152 |
| Infection control | changing short stay day procedure patients into surgical gowns; | 153 |
| Infection control | Removing nail polish  | 154 |
| Infection control | Changing footwear when leaving the operating theatre  | 155 |
| Infection control | 1ST. THE NON SCRUB TEAM WEARING MASKS IN THEATRE.  | 156 |
| Infection control | Infection isolation nursing as only two rooms to house 3 babes only any others are in the main nursery with tape on the floor | 157 |
| Infection control | Excluding family member of elderly visitors  | 158 |
| Infection control | Controlling one visitor per day per patient. | 159 |
| Intentional rounding | Rounding for compliance rather than for patient need | 160 |
| Intentional rounding | Intentional Rounding | 161 |
| Intentional rounding | intentional rounding | 162 |
| Intentional rounding | Hourly Rounding, we are caring for our patients we don’t need another price of paper to say we are | 163 |
| Intentional rounding | Hourly rounding,  | 164 |
| Intentional rounding | Rounding,  | 165 |
| Managing staff | Managing staff sick leave | 166 |
| Managing staff | managing performance issues | 167 |
| Mandatory training | My health learning specifically anything with clinical content that is mandatory | 168 |
| Mandatory training | Most of the online training modules, the new IIMS training... we all know how to use a drop down box, fire training is probably legitimate  | 169 |
| Mandatory training | Mission values training at st vincent's public hospital. | 170 |
| Mandatory training | Having an overload of corporate training discussing the strategic plan of the organisation and the mission and values. This is completed at the beginning of your contract where it doesn't have much contextual reference. | 171 |
| Mandatory training | Mandatory training for non-relevant areas - "working with children check "in a hospital without a childrens ward". | 172 |
| Mandatory training | Competencies on skills that staff do not do in their role | 173 |
| Mandatory training | Mandatory Training for tasks not assigned to job or discipline  | 174 |
| Mandatory training | cultural safety | 175 |
| Mandatory training | Face to face theory based safety training (that has no practical component) e.g. how to use reporting systems | 176 |
| Mandatory training | Safety and other on line courses | 177 |
| Mandatory training | online learning for basic life support; etc  | 178 |
| Mandatory training | BLS training  | 179 |
| Mandatory training | Mandatory annual hand wash  | 180 |
| Mandatory training | Any credentialling that is YEARLY. eg online learning for: hand hygeine;  | 181 |
| Mandatory training | Hand hygiene, | 182 |
| Mandatory training | hand hygenie | 183 |
| Mandatory training | annual competencies | 184 |
| Mandatory training | Hand washing online training | 185 |
| Mandatory training | how to wash your hands online training module is ridiculous. | 186 |
| Mandatory training | mandatory hand hygiene elearning,  | 187 |
| Mandatory training | mandatory eblood training,  | 188 |
| Mandatory training | Resus4kids as expert in the field so unhelpful monkey learning | 189 |
| Mandatory training | many of the mandatory online HETI learning modules & competencies eg blood transfusion safety | 190 |
| Mandatory training | 1. HETI training  | 191 |
| Mandatory training | Fire training | 192 |
| Mandatory training | fire training doesn’t seem to stick so not well taught - probably useful; The targets are not set right for adult learning.  | 193 |
| Mandatory training | Mandatory fire training,  | 194 |
| Mandatory training | fire training etc | 195 |
| Mandatory training | Mandatory e learning modules | 196 |
| Mandatory training | Bullying & Harassment,  | 197 |
| Mandatory training | Emergency procedures, | 198 |
| Mandatory training | The emergency workshop, obstetric scenarios and resuscitation is fine to do, it is all those little extra ones the hospital adds are soul destroying and, for me, a waste of time. | 199 |
| Mandatory training | emergency procedures training | 200 |
| Mandatory training | aseptic technique, | 201 |
| Mandatory training | It is a waste of time completing violence, prevention and management training (self defence training for healthcare workers) | 202 |
| Mandatory training | Management of clinical aggression training; | 203 |
| Mandatory training | Mandatory training - don't have extra time to spend on it e.g. dealing with aggressive patients when we don’t have aggressive jobs. | 204 |
| Mandatory training | Medication examinations i.e. maths tests for nurses  | 205 |
| Mandatory training | Online modules that don’t support adult learning and professional development. For example, when eMeds was introduced a range of online modules were released that weren’t supported with sufficient practical sessions.  | 206 |
| Mandatory training | Manual handling, | 207 |
| Medical tests, procedures and treatments | Too many head CT scans in overdose patients | 208 |
| Medical tests, procedures and treatments | 1. This is more around a policy that was created and released without wide peer review in reaction to COVID. The policy is dangerous and has elements of euthanisia about it. It is for a continuous subcutaneous medication infusion and normally these infusions are individualised to the requirements of each patient. However, with this policy, the bags of morphine 50mg and midazolam 30mg are premade with the rate being the variable. Not all patients need midazolam and the risk of a drug error is high.  | 209 |
| Medical tests, procedures and treatments | 2. often the continous subcutanous medications infusions are run in non locked devices. Often the syringes contain S4 and S8 medications, and are not secured. | 210 |
| Medical tests, procedures and treatments | Banning heat wraps for back pain in hospitals on the grounds that they may burn the patient | 211 |
| Medical tests, procedures and treatments | lumbar imaging in people without suspected serious spinal diseases.  | 212 |
| Medical tests, procedures and treatments | clinical reviews | 213 |
| Medical tests, procedures and treatments | Obselete pathology tests | 214 |
| Medical tests, procedures and treatments | Attempting to treat residents that regularly refuse  | 215 |
| Medical tests, procedures and treatments | default CT scan on presentation to ED | 216 |
| Medical tests, procedures and treatments | 2ND. USING ABSOLUTE VALUES FOR BP IN 'BETWEEN THE FLAGS... 80-90 SYSTOLIC IS NOT AN ISSUE IN ITSELF FOR THOSE WHOSE BP IS NORMALLY 90-100. | 217 |
| Medical tests, procedures and treatments | 3RD ELIMINATING VARIOUS NARCOTICS FROM ACUTE PERI-OPERATIVE USE BECAUSE OF ISSUES RELATING TO MISUSE IN THE OUT OF HOSPITAL/LONG TERM/DISCHARGE USE. | 218 |
| Medical tests, procedures and treatments | 2 Doctor consent for abortion care | 219 |
| Medical tests, procedures and treatments | using anti thrombolitic devices on very short day procedure patients ; | 220 |
| Meetings | attending committees that aren't action based | 221 |
| Meetings | An enormous amount of meetings  | 222 |
| Meetings | Meetings about same topic regularly.  | 223 |
| Meetings | Moving to attend regular meetings (with set agenda) when there is nothing to talk about/ update on.  | 224 |
| Multiple improvement initiatives | Falls bracelet | 225 |
| Organisational culture | our current approach to case review re patient safety rather than proactive approach to safe culture | 226 |
| Paperwork (assessments) | falls risk charts | 227 |
| Paperwork (assessments) | Fall risk screen,  | 228 |
| Paperwork (assessments) | Many forms eg Falls risk are repetitive and do not allow for comments or explanations or adding information. | 229 |
| Paperwork (assessments) | Falls risk assessment,  | 230 |
| Paperwork (assessments) | 1.Falls Risk Assessment Tools - static assessment of a dynamic state thar is compliance driven. The nurses I talk to override the FRAT most of the time, upgrading falls risk to high.  | 231 |
| Paperwork (assessments) | Falls risk screening | 232 |
| Paperwork (assessments) | In terms of safety and optimal outcomes the following are just some examples of what could be reasonably perceived as a waste of time in my work place: Ontario Modified Stratify Falls Risk Screen; ; .  | 233 |
| Paperwork (assessments) | Falls risk assessments | 234 |
| Paperwork (assessments) | 1. Ontario Falls risk Assessment  | 235 |
| Paperwork (assessments) | paperwork such as ontarios | 236 |
| Paperwork (assessments) | In ED it is a waste of time doing falls risks as my primary concerns is doing a head to toe patient assessment and in the current emergency climate nursing staff just don't have the time.  | 237 |
| Paperwork (assessments) | Falls assesments on short stay. Just assume all at risk post procedure and dont need to complete paper work. | 238 |
| Paperwork (assessments) | 2. FRAMPS | 239 |
| Paperwork (assessments) | Checklists- all sorts be it FRAMP's or  | 240 |
| Paperwork (assessments) | FRAMPS. | 241 |
| Paperwork (assessments) | Post fall asssessments | 242 |
| Paperwork (assessments) | pressure area form | 243 |
| Paperwork (assessments) | 3. Waterlow | 244 |
| Paperwork (assessments) | Daily Waterlow assessment.  | 245 |
| Paperwork (assessments) | waterline pressure injury risk score,  | 246 |
| Paperwork (assessments) | Waterlow Braden  | 247 |
| Paperwork (assessments) | pressure injury assessments checklist | 248 |
| Paperwork (assessments) | Waterlows - collection everyday - should be more specific e.g. not for every patient. | 249 |
| Paperwork (assessments) | daily waterlows (For low rish patients), | 250 |
| Paperwork (assessments) | 2) water low daily for all patients : suggestion - only for high risk patient daily. Low risk patients only need initial assessment. | 251 |
| Paperwork (assessments) | pressure care assessment | 252 |
| Paperwork (assessments) | Waterlow Pressure Area Assessment  | 253 |
| Paperwork (assessments) | pressure injury screening | 254 |
| Paperwork (assessments) | daily waterlows | 255 |
| Paperwork (assessments) | Waterlow assessment. | 256 |
| Paperwork (assessments) | Waterlow | 257 |
| Paperwork (assessments) | pressure assesments | 258 |
| Paperwork (assessments) | Waterlow daily,  | 259 |
| Paperwork (assessments) | Daily waterlow | 260 |
| Paperwork (assessments) | waterlows | 261 |
| Paperwork (assessments) | Waterlow in the community it just does not work.  | 262 |
| Paperwork (assessments) | Doing waterlow assessment for obviously very low risk patients e.g fit and young, ambulatory patients | 263 |
| Paperwork (assessments) | Tick and Flicks'- Waterlow assesments - pretty well all 'assesments' that are used as a target by mangement. | 264 |
| Paperwork (assessments) | daily waterlow assessment (online document)  | 265 |
| Paperwork (assessments) | Daily waterlow assessment | 266 |
| Paperwork (assessments) | pressure area screening | 267 |
| Paperwork (assessments) | Risk screening in ED (pressure injury) | 268 |
| Paperwork (assessments) | doing pressure area risk assessments on outpatients, | 269 |
| Paperwork (assessments) | waterlow | 270 |
| Paperwork (assessments) | Assessment forms. Whilst important definitely there are too many complex and time consuming forms to complete It is not practical to complete all the assessment forms forms for every patient. It would be ideal to have a form like Ed sago where it is all in one place  | 271 |
| Paperwork (assessments) | assessments | 272 |
| Paperwork (assessments) | Assessment checklists  | 273 |
| Paperwork (assessments) | Risk Assessments | 274 |
| Paperwork (assessments) | Risk management | 275 |
| Paperwork (assessments) | Lodging riskman entries for environmental hazards in the workplace (from experience - they get ignored). | 276 |
| Paperwork (assessments) | completing any risk assessment sticker whatsoever | 277 |
| Paperwork (assessments) | risk assessment | 278 |
| Paperwork (assessments) | repetitious, sometimes daily risk assessments | 279 |
| Paperwork (assessments) | too many risk assessments | 280 |
| Paperwork (assessments) | too many assessments | 281 |
| Paperwork (assessments) | admission assessments (acute admission to ward)  | 282 |
| Paperwork (assessments) | Multiple screenings on admission to service - FROP com | 283 |
| Paperwork (assessments) | Filling in extra forms at patient admission | 284 |
| Paperwork (assessments) | admission checklists | 285 |
| Paperwork (assessments) | Admission paperwork for an injection Trastuzumab is given subcutaneously in the ambulant unit for patients with breast cancer. It doesn’t take too long and patients get used to the nature of the treatment fairly quickly. Under the guise of patient safety, we’re required to admit all these patients to the unit, adding to the paperwork, full admission, making sure everything is signed. Adding considerable time, to what should be a standard nursing procedure.  | 286 |
| Paperwork (assessments) | 2/ Completing nursing admission forms | 287 |
| Paperwork (assessments) | Huge amounts of paperwork for admissions. This takes so much time, exhausts patients and takes away time from actually care. If we didn’t have to discharge patients everytime they were admitted to hospital and then do a full admission again when they are discharged,it would save so much time. Patients are often only in hospital for a night or two and we have to do another full admission. Such a waste of our and their time. | 288 |
| Paperwork (assessments) | full 8 page admission paperwork for short stapatients | 289 |
| Paperwork (assessments) | health care assessment and aboriginal health care assessments because they don’t improve the status of people. | 290 |
| Paperwork (assessments) | aboriginal health care assessments | 291 |
| Paperwork (assessments) | Pre-procedural checklists ("time out") | 292 |
| Paperwork (assessments) | I work in both public AND private (~50/50). The following applies to both settings. “Time out” as it bears little resemblance in reality to the evidence based WHO safety check list | 293 |
| Paperwork (assessments) | Surgical timeout | 294 |
| Paperwork (assessments) | smoking cessation clinical pathway. | 295 |
| Paperwork (assessments) | anticoagulation check boxes on med charts on ambulant patients, | 296 |
| Paperwork (assessments) | Hunter 8 and MRS | 297 |
| Paperwork (assessments) | Psychosocial assessments  | 298 |
| Paperwork (assessments) | Delirium screening | 299 |
| Paperwork (assessments) | malnutrition screening | 300 |
| Paperwork (assessments) | heat vulnerable screening | 301 |
| Paperwork (assessments) | Delirium Screening Assessment Prevention Management Tool | 302 |
| Paperwork (assessments) | Clinical Opiate Withdrawal Scale; | 303 |
| Paperwork (assessments) | Tracheostomy Observation Chart; | 304 |
| Paperwork (assessments) | Fluid Balance charts;  | 305 |
| Paperwork (assessments) | Fluid balance charts; | 306 |
| Paperwork (assessments) | Wound Care Assessment  | 307 |
| Paperwork (assessments) | Wound Care Management Plan;  | 308 |
| Paperwork (audits) | Audits for evey action - it feels like audits are created to tick boxes and do not reflect the dynamic work environment we practice in. Following protocol which are not developed to reflect work as done and enable us as human beings to create safety dependant on the situation we are managing. | 309 |
| Paperwork (audits) | auditing for the sake of the national standards;  | 310 |
| Paperwork (audits) | Hand Hygiene audits. The requiremetn/ practice has been in place for quite a number of years. I have not seen any evidence that auditing, as well as any (usually unsustained) improvement in compliance rtaes, has had an effect on infection rates. Im not saying HH is not imporatnt (I am a nurse, so 100% appreciate the practice according to IP&C principles), rather that the auditing and use of performance data is very labour intensive and expensive to run, with no demonstrable effect on infection rates  | 311 |
| Paperwork (audits) | Contact stats. | 312 |
| Paperwork (audits) | Outcome Measures - HONOS | 313 |
| Paperwork (audits) | Outcome measures  | 314 |
| Paperwork (care plans) | Generic care plans | 315 |
| Paperwork (care plans) | Care plans  | 316 |
| Paperwork (care plans) | Paper care plans | 317 |
| Paperwork (care plans) | Paper nursing care plans  | 318 |
| Paperwork (care plans) | Documenting clear clinical plans that are then not read by other staff members | 319 |
| Paperwork (care plans) | 4. Nursing care plans | 320 |
| Paperwork (care plans) | Nursing Care Plans; | 321 |
| Paperwork (care plans) | Multiple care plans | 322 |
| Paperwork (care plans) | Chronic Disease Management Plans  | 323 |
| Paperwork (care plans) | It is a waste of time doing chronic diseases management plans,  | 324 |
| Paperwork (care plans) | Writing Chronic Disease Care Plans/  | 325 |
| Paperwork (care plans) | Writing Team Care Arrangements | 326 |
| Paperwork (care plans) | GPMPs | 327 |
| Paperwork (care plans) | TCAs | 328 |
| Paperwork (care plans) | Post Falls Management Form; | 329 |
| Paperwork (care plans) | Waterlow Pressure Area Management Plan; | 330 |
| Paperwork (checklists) | Handover checklists | 331 |
| Paperwork (checklists) | Safety checklists at handover (mandatory in NSW public hospitals). | 332 |
| Paperwork (checklists) | watching Psychologists do tasks safely | 333 |
| Paperwork (checklists) | completing a checklist watching Psychologists do tasks safely | 334 |
| Paperwork (checklists) | Isbar charts as use the anaesthetic and operating note to pass on information to ease or DSU staff. But I have been doing this for 30 years so I am fairly practiced at it | 335 |
| Paperwork (checklists) | Pre assessment risk calls | 336 |
| Paperwork (checklists) | All the tick sheets of have you done this have you done that and there is no time for the staff to actually do them listed as within say a Dementia area of ten residents all need individual attention and responses, if you spend all your time advising management of the done check list the care would not get done or you are working unpaid overtime to do their paperwork. | 337 |
| Paperwork (checklists) | Gastrointestinal endoscopy (gastroscopy, colonoscopy etc.) comes under theatre administration. This means that we have to perform a team time-out before each procedure. This is done as a tick box exercise and adds no value to safety. I understand its requirement for surgery but you have to draw the line at some point on the interventional scale and I think the barrier for this is too low. | 338 |
| Paperwork (checklists) | All of the check lists to check everything is done. Results in more paperwork, less time spent with women and more things that are missed because of the duplication. Treating a maternity facility the same as a general hospital results in seeing women having a baby as an abnormality and increases their morbidity. Safety and Quality requirements have so much with the result of increasing induction of labour of women with no need for it and an alarmingly high LUSCS rate  | 339 |
| Paperwork (checklists) | Patient belongings checklists,  | 340 |
| Paperwork (checklists) | Special or Close Obs Checklist for New Staff; | 341 |
| Paperwork (checklists) | Completing multiple checklists without really doing it properly  | 342 |
| Paperwork (checklists) | The checklists of questions for patients which are completed at each stage of a patient's journey from arrival to operating theatre on the day of surgery contain many items which are not actionable by the person asking the question and are repeated many times. Each item may have been added for a good reason at some time, but there appears to be no process to review items and potentially to remove them. | 343 |
| Paperwork (checklists) | Generic checklists that don’t have clear actions | 344 |
| Paperwork (checklists) | Increase in check lists forms | 345 |
| Paperwork (checklists) | checklists | 346 |
| Paperwork (checklists) | safety checklists each shift | 347 |
| Paperwork (checklists) | ticking off safety checks, either in the EMR or on the wall. It doesn't mean it was actually done - in fact more often I think that it means it wasn't done! Same with food record charts and screening postural BPs - the data doesn't get used unless it's actually initiated by the clinician that wants to know.  | 348 |
| Paperwork (checklists) | The Patient Safty Checklist | 349 |
| Paperwork (checklists) | Procedural safety checklist | 350 |
| Paperwork (duplication) | Paperwork in triplicate,  | 351 |
| Paperwork (duplication) | Duplicated paperwork | 352 |
| Paperwork (duplication) | Writing the same piece of information in three different documents is a waste of time.  | 353 |
| Paperwork (duplication) | Documentation which is duplicating other forms | 354 |
| Paperwork (duplication) | double documentation | 355 |
| Paperwork (duplication) | Documentation duplication | 356 |
| Paperwork (duplication) | documenting the same things in different places just incase, | 357 |
| Paperwork (duplication) | Having three places to record bowel motions; SAGO chart, Nursing Care Plan and a bowel chart. Where you record this information is dependent on the patient's clinical situation.  | 358 |
| Paperwork (duplication) | duplicating mother and baby notes for parenting groups | 359 |
| Paperwork (duplication) | CARS forms- clinical assessment rounds | 360 |
| Paperwork (duplication) | Conducting Observations on colour coded charts and not the ED MR1 | 361 |
| Paperwork (duplication) | multiple variants of covid assessments | 362 |
| Paperwork (duplication) | completing information multiple times to achieve referral to a service - referrals for Commonwealth TACP ( Transitional Age Care Package worst example.  | 363 |
| Paperwork (duplication) | Completing a dedicated care plan for skin integrity in addition to the patient care plan every day | 364 |
| Paperwork (duplication) | Writing reports (duplication) | 365 |
| Paperwork (duplication) | Separate documents for documentation | 366 |
| Paperwork (duplication) | documenting the patient obs online for the lats 6 hours prior to the patient being discharged from ICU to the ward, it is double documenting;  | 367 |
| Paperwork (duplication) | PCA paper referal form | 368 |
| Paperwork (duplication) | having to send two separate forms | 369 |
| Paperwork (evidencing care) | Completing forms just to have evidence for accreditation | 370 |
| Paperwork (evidencing care) | Completing a discharge letter for planned simple admissions e.g. "admission for MRI under GA" within 48 hours | 371 |
| Paperwork (evidencing care) | Entering activity stats into PAS to account for which patients are seen and how time is used everyday. This is done by all Allied Health at all Victorian hospitals. It is time consuming and does not add to patient care at all, let alone make it safer. | 372 |
| Paperwork (evidencing care) | Coding | 373 |
| Paperwork (evidencing care) | Clinical coding. If it doesn't feature in the text of the discharge summary, it has not been deemed relevant for communication to another doctor or healthcare colleague. Coding is purely for financial purposes and is a drain on the ability of JMOs and RMOs to do their jobs effectively. Trained coding staff should be able to conduct this job independently. The criteria for whether a diagnosis is included in the coding or not is whether it was relevant/acted upon, which should be self-evident from the medical record (and is the source we normally use to code anyway).  | 374 |
| Paperwork (evidencing care) | Statistics on time spent with patient (allied health process)  | 375 |
| Paperwork (evidencing care) | logging stats on the electronic medical system re contact hours/minutes.  | 376 |
| Paperwork (evidencing care) | Logging patient contact hours. | 377 |
| Paperwork (evidencing care) | Writing detailed progress notes | 378 |
| Paperwork (evidencing care) | Writing up mandatory MH engagement notes. | 379 |
| Paperwork (evidencing care) | Mandatory MH engagement notes, details on MH observation charts when there's cameras,  | 380 |
| Paperwork (evidencing care) | an IVC sticker or PIVAS in notes. | 381 |
| Paperwork (evidencing care) | Putting Falls Huddle in paper form. It needs to be visible and accesible to anyone, rather than looking at each forlder. | 382 |
| Paperwork (evidencing care) | The amount of forms to fill out, eg, Hourly rounding form it takes you away from patient care to just tick a box. | 383 |
| Paperwork (evidencing care) | Intentional rounding sheets | 384 |
| Paperwork (evidencing care) | Intentional Rounding Care Plan; | 385 |
| Paperwork (evidencing care) | The hour rounding signature sheet | 386 |
| Paperwork (evidencing care) | Adding more pieces of paper - hourly rounding documentation | 387 |
| Paperwork (evidencing care) | Intentional rounding document | 388 |
| Paperwork (evidencing care) | Document Hourly rounding. There is no point to do it. E.g. most patient can buzzer you they need help to toilet, you do not need to find the folder and then find the column to take it and signature .Imaging if you have 5 patients, this one toilet, the other one reposition, the other one drink water, or giving medicine, you need to document while the other one is waiting for medication, It waste precious time  | 389 |
| Paperwork (evidencing care) | Filling out 5Ps form,  | 390 |
| Paperwork (evidencing care) | Intentional rounding form.  | 391 |
| Paperwork (evidencing care) | Rounding logs;  | 392 |
| Paperwork (evidencing care) | Hourly rounding form, it’s a waste of time of filling it as you atten to patient all the time more than it is document. It just adds extra work (special) paperwork. | 393 |
| Paperwork (evidencing care) | For instance, on a busy shift, it is not unusual for nurses to not have the time to fill in the "Hourly Rounding" (Clinical Assessment Rounds) checkboxes as they go about their work. However, as it is a requirement for them to fill it in and to sign a box, these forms are being filled in retrospectively at the end of their shift. | 394 |
| Paperwork (evidencing care) | Intentional rounding/  | 395 |
| Paperwork (evidencing care) | 1) intentional rounding: repeat job to progress notes  | 396 |
| Paperwork (evidencing care) | It is not the most efficient use of time having more checkboxes (more paper work) as "safety checks" as nurses working on the ward are already overwhelmed by the amount of documentation that they need to complete. These checkboxes might then end up as a paperwork that is filled in retrospectively as nurses juggle between prioritising clinical care and forms to fill in.  | 397 |
| Paperwork (evidencing care) | Intentional rounding forms | 398 |
| Paperwork (evidencing care) | Documentation takes an hour post- fall. "ticking boxes" and reactive rather than proactive".  | 399 |
| Paperwork (evidencing care) | Time spend on documenting costs money that could be spend on another staff member.  | 400 |
| Paperwork (evidencing care) | From the perspective of a ward pharmacist: 1) paper notes --> reading them, writing htem, trying to locate the folder on the wrad (doctors sometimes take to their locked "reg room" and leave them there). Electronic progress notes are much more efficient.  | 401 |
| Paperwork (specific forms) | there are a lot of forms but not always filled in ; signatures not always eligible - one way this leads to lost time is the area of trying to track down lost property. need to guard against theft too for unconscious patients due to risk of someone having a patients ID, Wallet, and house keys! | 402 |
| Paperwork (specific forms) | safe for d/c form | 403 |
| Paperwork (specific forms) | transfer form | 404 |
| Paperwork (specific forms) | Low Negligible Risk Ethics Applications | 405 |
| Paperwork (specific forms) | Paper ANZICs forms,  | 406 |
| Paperwork (specific forms) | A full set of vital signs for AEDOC form and complete AEDOC form for all patients presenting to Emergency Departments. | 407 |
| Paperwork (specific forms) | Statement of choices A and B - B in particular. | 408 |
| Paperwork (specific forms) | X is filling in many screens on the computer programme especially when a new patient is being admitted. It can take a couple of hours to ask all the questions. | 409 |
| Paperwork (specific forms) | Patient handover forms; | 410 |
| Paperwork (specific forms) | Bedside handover,  | 411 |
| Paperwork (specific forms) |  I/C Nurse handover | 412 |
| Paperwork (specific forms) | I/C Shift Handover Form;  | 413 |
| Paperwork (specific forms) | At the end of the day and 4 questions to fill out at the end of each day. Not anonymous. Question set-out to "gain info" - what other motives of these questions? Has to be sent everyday - can't be left until the next day BUT last hour is the busiest time period. Beig asked to do something that doesn't fit into workflow.  | 414 |
| Paperwork (specific forms) | Safescript | 415 |
| Paperwork (writing reports) | Also good if there isn't so much middle layer of people to answer to, who constantly request for reports upon reports, which were purportedly going to be submitted to 3-4 layers bureaucrats above, but not knowing what kind of actual clinical impact on patient safety would have resulted from these reports, other than just satisfying the tickboxes of executives or the ministry.  | 416 |
| Paperwork (writing reports) | Statistics for case base funding | 417 |
| Paperwork (writing reports) | reporting to the board (board reports regarding services being delivered/programs) | 418 |
| Paperwork (writing reports) | sending out reports/graphs etc re PI prevention practices that have not been completed  | 419 |
| Paperwork (writing reports) | laborious reporting to Department when you never get any feedback or they just ask for in another way  | 420 |
| Paperwork (writing reports) | Writing multiple reports for multiple different Committees, Various reports are provided to you Eg: Performance review and mandatory training but need to 'clean up report' as it does not filter out long term leave staff, work cover staff etc | 421 |
| Paperwork (writing reports) | Reporting of safety and quality information | 422 |
| Paperwork (writing reports) | Continual reporting of areas that don't need following | 423 |
| Patient Safety Initiative | Falls huddles - not because it is an inappropriate medium, but because staff that are involved may not implement/ pass on to implement suggestions.  | 424 |
| Patient Safety Initiative | ENCORE; | 425 |
| Patient Safety Initiative | Orientation boards (when not attended to) --> can be restrictive or even harmful when the previous patients' information is inaccurate. | 426 |
| Policy | Expected to read 100's od policys with 30 to 60 and more pages that you will never remember...better to have cheat sheets and read before doing something for the first time, that way you will remember | 427 |
| Policy | 3) Waiting for amendments on charts and discharge scripts that a doctor has verbal agreed to but doesn;t have time to channge and often delays medication supply --> provision for pharmacist transcription or phone order charting may help? | 428 |
| Policy | the between the flags for doctors | 429 |
| Policy | Much of the requirements to comply with accrediation and licencing in my opinion does not make care safer. | 430 |
| Policy | Developing policies and procedures. | 431 |
| Policy | writing protocols and guidelines that replace common sense and good teaching | 432 |
| Policy | Writing policies / procedures / protocols | 433 |
| Policy | Nurse escort taking a nurse off the ward, if you have one nurse on a break. Need to have pool nurses on light duties for escort.  | 434 |
| Preventative measure | treating patients on low dose once weekly MTX as "lepers" in hospitals - the MTX is not detectable in any of their secretions yet $1000s are spent on isolating them and double gloving  | 435 |
| Staff events | Token wellness activities  | 436 |
| Targets | I do not believe that meeting KPIs make patient care safer! | 437 |
| Targets | key performance indicators | 438 |
| Task allocation | It is a waste of time in community pharmacy to call the precriber to 4) refer to the GP when the pharmacist can manage, for example long term use of statins to be titrated according to chloesterol profile, insulin titrated according to BSL (of note diabetes educators, who are not pharmacist, can advise on the dose of insulin when pharmacists, who are medication experts, are not allowed to do so, | 439 |
| Task allocation | Also bed can be made by any other person other than a RN. To make bed people don't need to receive much training. | 440 |
| Task allocation | EMR VTE risk assessment | 441 |
| Task allocation | answering the phones when a person from the community has called the hospital for advice on there child- even though not a patient on the ward but we do it so we give the ward a good reputation in the community or are scared to appear rude even though it is not our job,  | 442 |
| Task allocation | Making beds | 443 |
| Task allocation | Centralising patient safety, having non-clinicians in patient safety roles | 444 |
| Task allocation | SW staff are asked to risk assess for services attending people's homes on discharge form hospital.This should be the services themselves conducting these assessments.It wastes time and does little to build safety. | 445 |
| Task allocation | Sorting patient food preferences  | 446 |
| Task allocation | Being called to remove a person from the premises when we are not allowed to physically remove them. | 447 |
| Task allocation | Sorting of printer problems/ fax problems.  | 448 |
| Task allocation | I believe 'X' is assisting the nursing staff in getting patients to appointments and discharges to where the patient can complete their care (either at home or rehab). This takes work off the nusing staff and transfer to me. However, the patient gets involved with the best transport option. | 449 |
| Task allocation | 2. Nurses taking responsibility for all sorts of non-nursing, non-clinical issues like monitoring the temperature of medication fridges. | 450 |
| Task allocation | Organising & booking pts in for Virtual pre-admission appointments. It's a non-clinical role and takes many hours over a number of days to: find out if they have an email address; have computer/webcam/microphone/etc; send instructions; ensure they can download and understand the App & instructions; ask admin staff to book pt onto Core PAS and into clinic session for V. appointm't; request the medical records for the day of the V. appointm't; set-up equipment on day of appointm't. | 451 |
| Task allocation | doing administrative tasks like returning emails | 452 |
| Task allocation | work that could be done by admin and non-RN staff | 453 |
| Task allocation | Having nurses spending time doing imprest for items such as medication or stores. This is often done once or twice a week. If there is no stock of an item nurses are the ones to have to order and schedule delivery, this is a task that is not often able to be delegated to other healthcare roles.  | 454 |
| Task allocation | Ordering imprest medication | 455 |
| Task allocation | We are called upon every day to do tasks which would be better performed by less highly qualified staff | 456 |
| Task allocation | Registered nurse collect patient labels for unwell patients in the emergency department  | 457 |
| Task allocation | roster creation | 458 |
| Task allocation | Managing stock and storeroom items | 459 |
| Transport | 5) Waiting for lifts to get to/ from the wards --> very slow moving and now limited people per journey.  | 460 |