National Safety and Quality Health Service Standards

Second edition – 2021

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Contents

Introduction

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

There are eight NSQHS Standards, which cover high-prevalence adverse events, preventing and controlling infections, medication safety, comprehensive care, clinical communication, the prevention and management of pressure injuries, the prevention of falls, and responding to clinical deterioration. Importantly, these NSQHS Standards have provided a nationally consistent statement about the standard of care consumers can expect from their health service organisations.

The eight NSQHS Standards are:

Clinical Governance, which describes the clinical governance, and safety and quality systems that are required to maintain and improve the reliability, safety and quality of health care, and improve health outcomes for patients.

Partnering with Consumers, which describes the systems and strategies to create a person-centred health system by including patients in shared decision making, to ensure that patients are partners in their own care, and that consumers are involved in the development and design of quality health care.

Preventing and Controlling Infections, which describes the systems and strategies to prevent infection, manage infections effectively when they occur, limit the development of antimicrobial resistance through prudent use of antimicrobials (as part of effective antimicrobial stewardship), and promote appropriate and sustainable use of infection prevention and control resources.

Medication Safety, which describes the systems and strategies to ensure that clinicians safely prescribe, dispense and administer appropriate medicines to informed patients, and monitor use of the medicines.

Comprehensive Care, which describes the integrated screening, assessment and risk identification processes for developing an individualised care plan, to prevent and minimise the risks of harm in identified areas.

Communicating for Safety, which describes the systems and strategies for effective communication between patients, carers and families, multidisciplinary teams and clinicians, and across the health service organisation.

Blood Management, which describes the systems and strategies for the safe, appropriate, efficient and effective care of patients' own blood, as well as other supplies of blood and blood products.

Recognising and Responding to Acute Deterioration, which describes the systems and processes to respond effectively to patients when their physical, mental or cognitive condition deteriorates.

Each standard contains:

- A description of the standard
- A statement of intent
- A list of criteria that describe the key areas covered by the standard
- Explanatory notes on the content of the standard
- Item headings for groups of actions in each criterion
- Actions that describe what is required to meet the standard.

The NSQHS Standards require the implementation of organisation-wide systems for clinical governance, partnering with consumers, preventing and controlling infections, medication safety, comprehensive care, effective communication, blood management, and recognising and responding to acute deterioration.

The 2021 version of the NSQHS Standards (second edition) includes the Preventing and Controlling Infections Standard, which supersedes the NSQHS Preventing and Controlling Healthcare-Associated Infection Standard (2nd ed.). The revision accommodates lessons learned from the response to SARS-CoV-2 (COVID-19), and better supports health service organisations to prevent, control and respond to infections that cause outbreaks, epidemics or pandemics, including novel and emerging infections.

The Clinical Governance Standard and the Partnering with Consumers Standard set the overarching system requirements for the effective implementation of the remaining six standards, which consider specific high-risk clinical areas of patient care. The NSQHS Standards describe the patient care journey and are designed to be implemented in an integrated way. Similar implementation strategies apply to multiple actions across the NSQHS Standards. It is important to identify the links between actions across each of the eight NSQHS Standards. This will help health service organisations to ensure that their safety and quality systems are integrated, and reduce the duplication of effort in implementing the eight standards separately.

Important improvements in the safety and quality of patient care have been documented following implementation of the first edition of the NSQHS Standards from 2011, including:

- A decline in the *Staphylococcus aureus* bacteraemia rate per 10,000 patient days under surveillance between 2010 and 2014, from 1.1 to 0.87 cases
- A drop in the yearly number of methicillin-resistant *S. aureus* bacteraemia cases between 2010 and 2014, from 505 to 389
- A decline of almost one-half in the national rate of central line-associated bloodstream infections between 2012–13 and 2013–14, from 1.02 to 0.6 per 1,000 line days
- Greater prioritisation of antimicrobial stewardship activities in health service organisations

- Better documentation of adverse drug reactions and medication history
- Reduction in yearly red blood cell issues by the National Blood Authority between mid-2010 and mid-2015, from approximately 800,000 units to 667,000 units
- Declining rates of in-hospital cardiac arrest and intensive care unit admissions following cardiac arrests.

The Commission has worked closely with partners to review the NSQHS Standards and develop the second edition, embedding person-centred care and addressing the needs of people who may be at greater risk of harm. The NSQHS Standards (2nd ed.) set requirements for providing comprehensive care for all patients, and include actions related to health literacy, end-of-life care, care for Aboriginal and Torres Strait Islander people, and care for people with lived experience of mental illness or cognitive impairment.

More information

A range of other supporting resources to assist health service organisations to implement the NSQHS Standards are available on the Commission's website.

The Advice Centre provides support for health service organisations, surveyors and accrediting agencies on NSQHS Standards implementation.

Email: accreditation@safetyandquality.gov.au

Phone: 1800 304 056

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Clinical Governance Standard
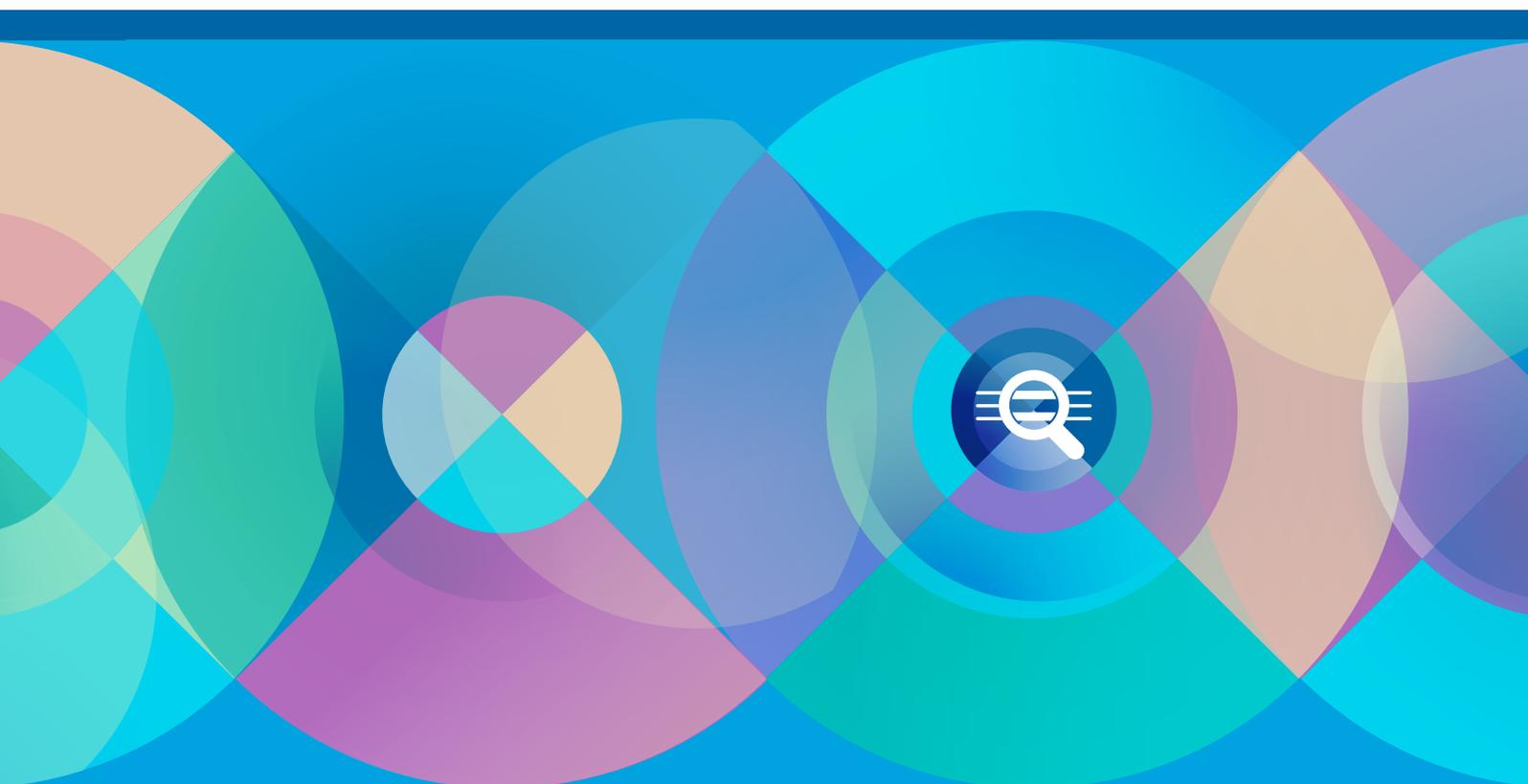
Clinical Governance Standard

Leaders of a health service organisation have a responsibility to the community for continuous improvement of the safety and quality of their services, and ensuring that they are person centred, safe and effective.

Intention of this standard

To implement a clinical governance framework that ensures that patients and consumers receive safe and high-quality health care.

Criteria

Governance, leadership and culture

Leaders at all levels in the organisation set up and use clinical governance systems to improve the safety and quality of health care for patients.

Patient safety and quality systems

Safety and quality systems are integrated with governance processes to enable organisations to actively manage and improve the safety and quality of health care for patients.

Clinical performance and effectiveness

The workforce has the right qualifications, skills and supervision to provide safe, high-quality health care to patients.

Safe environment for the delivery of care

The environment promotes safe and high-quality health care for patients.

Explanatory notes

Thorough research has identified the elements of an effective clinical governance system and the effect of good clinical governance on health service performance.[1] Research in Australia[2] and overseas[3] notes the importance of leaders in influencing the quality of care by supporting the workforce, shaping culture, setting direction, and monitoring progress in safety and quality performance. Engaging managers and clinicians in governance and quality improvement activities is important for aligning clinical and managerial priorities.[4]

Clinical governance is the set of relationships and responsibilities established by a health service organisation between its department of health (for the public sector), governing body, executive, clinicians, patients, consumers and other stakeholders to ensure good clinical outcomes.[5] It ensures that the community and health service organisations can be confident that systems are in place to deliver safe and high-quality health care and continuously improve services.

Clinical governance is an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of health services that are safe, effective, integrated, high quality and continuously improving.

Each health service organisation needs to put in place strategies for clinical governance that consider its local circumstances.

This standard includes actions related to the role of leaders and others in safety and quality, Aboriginal and Torres Strait Islander health, and e-health.

To support the delivery of safe and high-quality care for patients and consumers, the Australian Commission on Safety and Quality in Health Care (the Commission) has developed the National Model Clinical Governance Framework.[5] Health service organisations should refer to the framework for more details on clinical governance, and the associated roles and responsibilities.

Governance, leadership and culture

Leaders at all levels in the organisation set up and use clinical governance systems to improve the safety and quality of health care for patients.

Item	Action
Governance, leadership and culture	**1.01** The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews, reports and monitors the organisation's progress on safety and quality performance
	1.02 The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people
Organisational leadership	**1.03** The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality
	1.04 The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people
	1.05 The health service organisation considers the safety and quality of health care for patients in its business decision-making
Clinical leadership	**1.06** Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients

Patient safety and quality systems

Safety and quality systems are integrated with governance processes to enable organisations to actively manage and improve the safety and quality of health care for patients.

Item	Action	
Policies and procedures	1.07	The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements
Measurement and quality improvement	1.08	The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems
	1.09	The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations
Risk management	1.10	The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters

Item	Action	
Incident management systems and open disclosure	1.11	The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems
	1.12	The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework[6] b. Monitors and acts to improve the effectiveness of open disclosure processes
Feedback and complaints management	1.13	The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems
	1.14	The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system

Item	Action	
Diversity and high-risk groups	1.15	The health service organisation:
		a. Identifies the diversity of the consumers using its services
		b. Identifies groups of patients using its services who are at higher risk of harm
		c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care
Healthcare records	1.16	The health service organisation has healthcare record systems that:
		a. Make the healthcare record available to clinicians at the point of care
		b. Support the workforce to maintain accurate and complete healthcare records
		c. Comply with security and privacy regulations
		d. Support systematic audit of clinical information
		e. Integrate multiple information systems, where they are used
	1.17	The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that:
		a. Are designed to optimise the safety and quality of health care for patients
		b. Use national patient and provider identifiers
		c. Use standard national terminologies
	1.18	The health service organisation providing clinical information into the My Health Record system has processes that:
		a. Describe access to the system by the workforce, to comply with legislative requirements
		b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system

Clinical performance and effectiveness

The workforce has the right qualifications, skills and supervision to provide safe, high-quality health care to patients.

Item	Action	
Safety and quality training	1.19	The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation
	1.20	The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training
	1.21	The health service organisation has strategies to improve the cultural safety and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients
Performance management	1.22	The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system
Credentialing and scope of clinical practice	1.23	The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered
	1.24	The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process

Item	Action	
Safety and quality roles and responsibilities	1.25	The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff
	1.26	The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate
Evidence-based care	1.27	The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care
Variation in clinical practice and health outcomes	1.28	The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system

Safe environment for the delivery of care

The environment promotes safe and high-quality health care for patients.

Item	Action	
Safe environment	1.29	The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose
	1.30	The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required
	1.31	The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose
	1.32	The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so
	1.33	The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people

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Partnering with Consumers Standard

Partnering with Consumers Standard

Leaders of a health service organisation develop, implement and maintain systems to partner with consumers. These partnerships relate to the planning, design, delivery, measurement and evaluation of care. The workforce uses these systems to partner with consumers.

Intention of this standard

To create an organisation in which there are mutually valuable outcomes by having:

- Consumers as partners in planning, design, delivery, measurement and evaluation of systems and services
- Patients as partners in their own care, to the extent that they choose.

Criteria

Clinical governance and quality improvement systems to support partnering with consumers

Systems are designed and used to support patients, carers, families and consumers to be partners in healthcare planning, design, measurement and evaluation.

Partnering with patients in their own care

Systems that are based on partnering with patients in their own care are used to support the delivery of care. Patients are partners in their own care to the extent that they choose.

Health literacy

Health service organisations communicate with patients in a way that supports effective partnerships.

Partnering with consumers in organisational design and governance

Consumers are partners in the design and governance of the organisation.

Explanatory notes

Effective partnerships exist when people are treated with dignity and respect, information is shared with them, and participation and collaboration in healthcare processes are encouraged and supported to the extent that people choose.[7]

Different types of partnerships with patients and consumers exist within the healthcare system. These partnerships are not mutually exclusive, and are needed at all levels to ensure that a health service organisation achieves the best possible outcome for all parties.[8] Partnerships with patients and consumers comprise many different, interwoven practices that reflect the three key levels at which partnerships are needed[9]:

1. **At the level of the individual**
   Partnerships relate to the interaction between clinicians and patients when care is provided. At this level, a partnership involves providing care that is respectful; sharing information in an ongoing way; working with patients, carers and families to make decisions and plan care; and supporting and encouraging patients in their own care.

2. **At the level of a service, department or program of care**
   Partnerships relate to the organisation and delivery of care within specific areas. At this level, a partnership involves the participation of patients, carers, families and consumers in the overall design of the service, department or program. This could be as full members of quality improvement and redesign teams, and participating in planning, implementing and evaluating change.

3. **At the level of the health service**
   Partnerships relate to the involvement of consumers in overall governance, policy and planning. This level overlaps with the previous level, since a health service is made up of various services, departments and programs. At this level, partnerships relate to the involvement of consumers and consumer representatives as full members of key organisational governance committees in areas such as patient safety, facility design, quality improvement, patient or family education, ethics and research. This level can also involve partnerships with local community organisations and members of local communities.

Delivering care that is based on partnerships provides many benefits for patients, consumers, clinicians, health service organisations and the health system. Effective partnerships, a positive experience for patients, and high-quality health care and improved safety are linked.[9-11] The involvement of patients and consumers in planning, delivery, monitoring and evaluation can also have a positive effect on service planning and development, information development and dissemination, and the attitudes of healthcare providers.[9,12,13] Delivering health care that is based on partnerships can result in reduced hospital costs, lower cost per case and reduced length of stay.[14,15]

Clinical governance and quality improvement systems to support partnering with consumers

Systems are designed and used to support patients, carers, families and consumers to be partners in healthcare planning, design, measurement and evaluation.

Item		Action
Integrating clinical governance	2.01	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers
Applying quality improvement systems	2.02	The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers

Partnering with patients in their own care

Systems that are based on partnering with patients in their own care are used to support the delivery of care. Patients are partners in their own care to the extent that they choose.

Item	Action	
Healthcare rights and informed consent	2.03	The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights[16] b. Easily accessible for patients, carers, families and consumers
	2.04	The health service organisation ensures that its informed consent processes comply with legislation and best practice
	2.05	The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves
Sharing decisions and planning care	2.06	The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care
	2.07	The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care

Health literacy

Health service organisations communicate with consumers in a way that supports effective partnerships.

Item	Action	
Communication that supports effective partnerships	2.08	The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community
	2.09	Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review
	2.10	The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge

Partnering with consumers in organisational design and governance

Consumers are partners in the design and governance of the organisation.

Item	Action	
Partnerships in healthcare governance planning, design, measurement and evaluation	2.11	The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community
	2.12	The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation
	2.13	The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs
	2.14	The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce

Preventing and Controlling Infections Standard
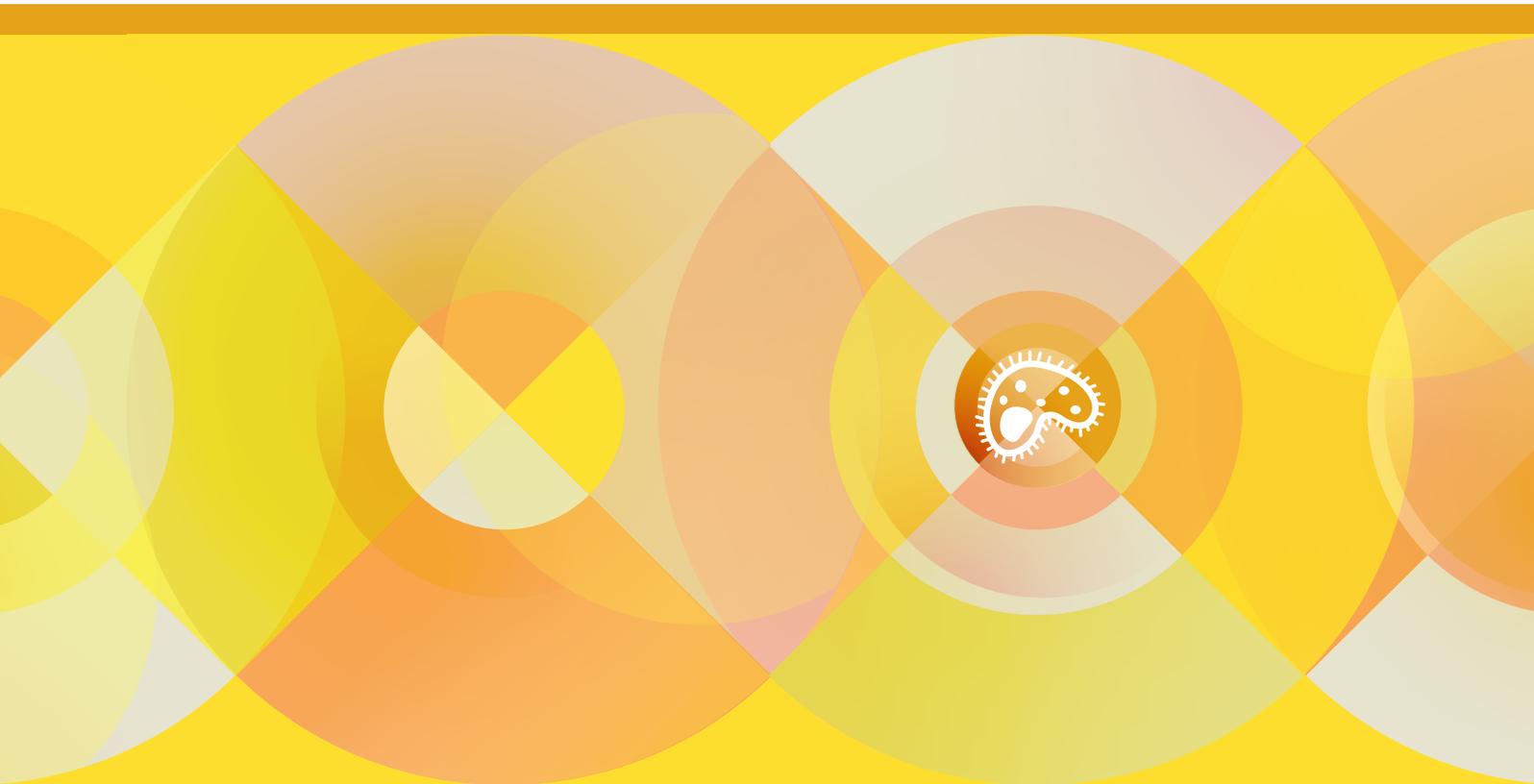
Preventing and Controlling Infections Standard

Leaders of a health service organisation develop, implement and monitor systems to prevent, manage and control infections and antimicrobial resistance; reduce harm for patients, consumers and members of the workforce; and achieve good health outcomes for patients. The workforce uses these systems to minimise and manage risks to patients and consumers.

Intention of this standard

To reduce the risk to patients, consumers and members of the workforce of acquiring preventable infections; effectively manage infections, if they occur; prevent and contain antimicrobial resistance; promote appropriate prescribing and use of antimicrobials as part of antimicrobial stewardship; and promote appropriate and sustainable use of infection prevention and control resources.

Criteria

Clinical governance and quality improvement systems are in place to prevent and control infections, and support antimicrobial stewardship and sustainable use of infection prevention and control resources

Systems are in place to support and promote prevention and control of infections, improve antimicrobial stewardship, and support appropriate, safe and sustainable use of infection prevention and control resources in the health service organisation.

Infection prevention and control systems

Evidence-based systems are used to mitigate the risk of infection. These systems account for individual risk factors for infection, as well as the risks associated with the clinical intervention and the clinical setting in which care is provided. A precautionary approach is warranted when evidence is emerging or rapidly evolving.

Patients, consumers and members of the workforce with suspected or confirmed infection are identified promptly, and appropriate action is taken. This includes persons with risk factors for transmitting or acquiring infection or colonisation with an organism of local, national or global significance.

The health service organisation is clean and hygienic, and has well-maintained and configured engineering systems for the delivery of effective models of care.

Reprocessing of reusable equipment and devices

Reprocessing of reusable equipment and devices meets current best practice and is consistent with current national standards.

Explanatory notes

Revision of this Standard – rationale and overview

This Standard supersedes the NSQHS Preventing and Controlling Healthcare-Associated Infection Standard (second edition). It was revised to accommodate lessons learned from the response to SARS-CoV-2 (COVID-19), and to better support health service organisations to prevent, control and respond to infections that cause outbreaks, epidemics or pandemics, including novel and emerging infections.

The amendments provide clarification of the scope of the standard, and additional information about actions, to better support implementation of policies, processes and systems that ensure a safe environment for patients, consumers and members of the workforce. The *Australian Guidelines for the Control and Prevention of Infection in Healthcare*[17] are appended to ensure ready access to the principal resource for development and implementation of systems to meet the requirements of this standard.

The revision extends the scope of the standard to prevention and control of any infection that may be transmitted within a health service organisation, regardless of where the infection was acquired. The revisions relate primarily to standard and transmission-based precautions; screening and management of healthcare workers with transmissible infections; environmental cleaning; environmental and engineering controls; and other controls to protect patients, consumers and members of the workforce from infection.

The revision also includes an item to emphasise protection and management of members of the workforce with transmissible infections, which was not explicit in the NSQHS Preventing and Controlling Healthcare-Associated Infection Standard (2nd ed.). This is not a new requirement in relation to either work health and safety or infection

Antimicrobial stewardship

The health service organisation implements systems for the safe and appropriate prescribing and use of antimicrobials as part of an antimicrobial stewardship program.

prevention and control. Meeting work health and safety obligations is clearly included in the following actions of the NSQHS Standards (2nd ed.):

- 1.07c (Policies and Procedures: Review compliance with legislation, regulation and jurisdictional requirements)
- 1.10c (Risk management: Acts to reduce risks)
- 1.10f (Plans for, and manages, internal and external emergencies and disasters).

In addition, Section 4.2.2 and Table 32 of the *Australian Guidelines for the Control and Prevention of Infection in Healthcare* provide guidance regarding exclusion periods for members of the workforce with infectious illnesses.

There are also well-established jurisdictional legislative and policy frameworks for work health and safety, which apply to clinical and non-clinical members of the workforce and consumers in health workplaces. These complement this standard, which is patient-focused, while acknowledging the complementary relationship between healthcare worker and patient safety in infection prevention and control.

Explicit reference to sustainable use of infection prevention and control resources has been included to highlight the importance of delivering high-quality health care by protecting natural, financial and human resources as much as possible, and minimising environmental damage. The concept of sustainability is implicit in the Clinical Governance Standard, especially in relation to the governance, leadership and culture; and organisational leadership items.

Infection prevention and control

In Australian healthcare settings, patients are often in close proximity to each other, and interact with a variety of clinical and non-clinical members of

the workforce. They may also undergo invasive procedures, have medical devices inserted, and receive antimicrobials and immunosuppressive therapies. All these conditions create ideal opportunities for the spread of infections and development of antimicrobial resistance.

Microorganisms evolve over time, and continue to present new challenges for infection prevention and control. An increasing proportion of infections that impact health service organisations originate in the community, including multidrug-resistant organisms. These organisms may affect patients, consumers and members of the workforce. Currently, some important areas of concern include the emergence and transmission of COVID-19, multidrug-resistant bacteria such as carbapenemase-producing *Enterobacterales*, methicillin-resistant *Staphylococcus aureus*, vancomycin-resistant *Enterococcus*, and increases in the burden of *Clostridioides difficile* infection presenting to, and emerging in, health service organisations.

Each year, many infections are associated with the provision of health care and affect a large number of patients[18], and, in some cases, consumers and members of the workforce. These infections:

- Cause considerable harm and may increase risk of morbidity, and death
- Increase use of health services – for example, extended length of stay, resulting in increased use of health resources such as inpatient beds, treatment options and investigations
- Place greater demands on the clinical workforce.

Infection prevention and control within healthcare settings aims to minimise the risk of transmission of infections and the development of resistant organisms.

Novel infections that cause outbreaks, epidemics or pandemics present new challenges, and require rapid responses to control and prevent further spread, while ensuring the safety of patients and members of the workforce, and sustainability of service provision.

An effective risk management system for infection prevention and control involves the identification of hazards, and assessment and control of risks for patients, visitors and members of the workforce, so far as is reasonably practicable (what can be done and what is possible in the circumstances

for ensuring health and safety and continuity of health service delivery). This approach requires consultation, cooperation and coordination between the health service organisation, patients, consumers and members of the workforce.

The 'hierarchy of controls' is a model used in work health and safety risk management. It is a step-by-step approach to controlling hazards that ranks controls from most to least reliable (see diagram below). The hierarchy of controls, used in conjunction with infection prevention and control systems, supports design of health service organisation infection prevention and control programs. If it is not reasonably practical to eliminate risks, then risks must be minimised as far as is reasonably practicable by using one or a combination of substitution, isolation or engineering controls. Administrative controls and personal protective equipment (PPE) should then be considered.

Hierarchy of controls
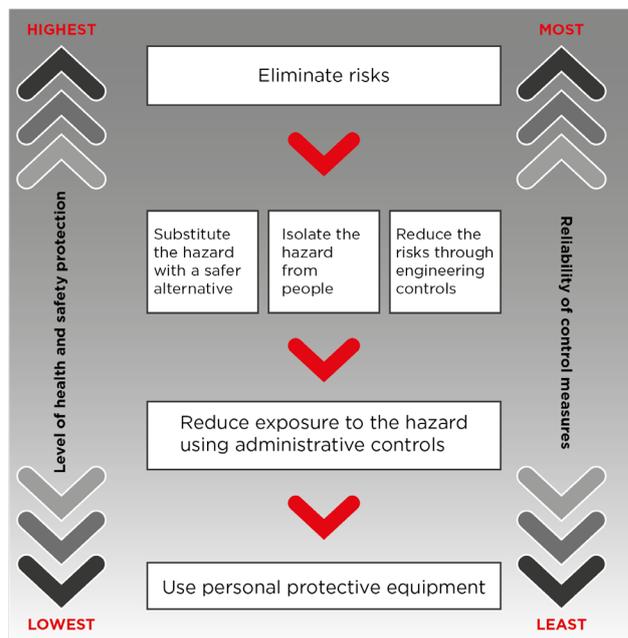
Source: Safe Work Australia. How to manage work health and safety risks: code of practice. Canberra: SWA; 2018:19, 'Hierarchy of control measures' licensed under CC BY-NC 4.0.

Examples of controls for each element of the hierarchy of controls are as follows:

- Eliminate risks – for example, use telemedicine for patient encounters
- Substitute the hazard with a safer alternative – for example, use spacers to administer aerosolised medicines instead of nebulisers
- Isolate people from the hazard – for example, place physical barriers such as glass or plastic screens in triage and reception areas where physical distancing is difficult to maintain
- Reduce the risk through engineering controls – for example, review and optimise ventilation, including air exchange rates, air flow and air filtration systems, temperature, and ambient humidity
- Reduce exposure to the hazard using administrative controls – for example, promote and support non-attendance at work by staff when unwell
- Use PPE – for example, effective education and communication on appropriate PPE use for standard and transmission-based precautions.

As with managing risks within any complex system, successful infection prevention and control in health service organisations requires the involvement of a range of experts, and multiple, integrated strategies across all levels of the healthcare system. These strategies encompass:

- Sound and integrated corporate and clinical governance
- Risk identification and practical management
- Surveillance to identify areas for action and quality improvement activities (such as auditing of compliance with hand hygiene, PPE use and aseptic technique requirements and environmental cleaning performance, surveillance of healthcare-associated infections, and water system surveillance)
- Safe and appropriate prescribing and use of antimicrobial agents, guided by antimicrobial stewardship and consumer engagement
- Safe and appropriate application of standard and transmission-based precautions, including patient placement and use of PPE.

Although all infection prevention and control programs have essential elements, as described in the *Australian Guidelines for the Prevention and*

Control of Infection in Healthcare[17], programs will be tailored across health service organisations to reflect local context and risks. Not all clinical environments or activities have the same risks, or practically lend themselves to the ideal conditions to prevent cross-infection. When there is a concern that a clinical activity is an infection risk for patients or members of the workforce, it is beneficial to map the clinical activity against points of risk and implement steps to reduce the transmission of organisms, without compromising safety.

Systems and governance for infection prevention and control and infection surveillance in healthcare settings must be consistent with relevant national guidance, including the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[17], and relevant jurisdictional law and policy, including work health and safety legislation.

The controls, and the infection prevention and control measures required to respond to infection risk, will be informed by assessment of available scientific evidence.

When there is emerging or rapidly evolving scientific knowledge around an infection, or aspects of its transmission, a precautionary approach aligned with patient risk factors and the relevant clinical procedure and setting is warranted. Infection prevention and control measures taken require ongoing careful review as the scientific body of knowledge develops.

Australian Government
National Health and Medical Research Council
Australian Commission on Safety and Quality in Health Care

Australian Guidelines for the Prevention and Control of Infection in Healthcare

NHMRC
AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Clinical governance and quality improvement systems are in place to prevent and control infections, and support antimicrobial stewardship and sustainable use of infection prevention and control resources

Systems are in place to support and promote prevention and control of infections, improve antimicrobial stewardship, and support appropriate, safe and sustainable use of infection prevention and control resources in the health service organisation.

Item	Action	
Integrating clinical governance	3.01	The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for infection prevention and control b. Identifying and managing risks associated with infections c. Implementing policies and procedures for antimicrobial stewardship d Identifying and managing antimicrobial stewardship risks
	3.02	The health service organisation: a. Establishes multidisciplinary teams to identify and manage risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems b. Identifies requirements for, and provides the workforce with, access to training to prevent and control infections c. Has processes to ensure that the workforce has the capacity, skills and access to equipment to implement systems to prevent and control infections d. Establishes multidisciplinary teams, or processes, to promote effective antimicrobial stewardship e. Identifies requirements for, and provides access to, training to support the workforce to conduct antimicrobial stewardship activities f. Has processes to ensure that the workforce has the capacity and skills to implement antimicrobial stewardship g. Plans for public health and pandemic risks

Item		Action
Applying quality improvement systems	3.03	The health service organisation applies the quality improvement system from the Clinical Governance Standard when:
		a. Monitoring the performance of infection prevention and control systems
		b. Implementing strategies to improve infection prevention and control systems
		c. Reporting to the governance body, the workforce, patients and other relevant groups on the performance of infection prevention and control systems
		d. Monitoring the effectiveness of the antimicrobial stewardship program
		e. Implementing strategies to improve antimicrobial stewardship outcomes
		f. Reporting to the governance body, the workforce, patients and other relevant groups on antimicrobial stewardship outcomes
		g. Supporting and monitoring the safe and sustainable use of infection prevention and control resources
Partnering with consumers	3.04	Clinicians use organisational processes consistent with the Partnering with Consumers Standard when assessing risks and preventing and managing infections, and implementing the antimicrobial stewardship program to:
		a. Actively involve patients in their own care
		b. Meet the patient's information needs
		c. Share decision-making
Surveillance	3.05	The health service organisation has a surveillance strategy for infections, infection risk, and antimicrobial use and prescribing that:
		a. Incorporates national and jurisdictional information in a timely manner
		b. Collects data on healthcare-associated and other infections relevant to the size and scope of the organisation
		c. Monitors, assesses and uses surveillance data to reduce the risks associated with infections
		d. Reports surveillance data on infections to the workforce, the governing body, consumers and other relevant groups
		e. Collects data on the volume and appropriateness of antimicrobial use relevant to the size and scope of the organisation
		f. Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing
		g. Monitors responsiveness to risks identified through surveillance
		h. Reports surveillance data on the volume and appropriateness of antimicrobial use to the workforce, the governing body, consumers and other relevant groups

Infection prevention and control systems

Evidence-based systems are used to mitigate the risk of infection. These systems account for individual risk factors for infection, as well as the risks associated with the clinical intervention and the clinical setting in which care is provided. A precautionary approach is warranted when evidence is emerging or rapidly evolving.

Patients, consumers and members of the workforce with suspected or confirmed infection are identified promptly, and appropriate action is taken. This includes persons with risk factors for transmitting or acquiring infection, or colonisation with an organism of local, national or global significance.

The health service organisation is clean and hygienic, and has well-maintained and configured engineering systems for the delivery of effective models of care.

Item	Action	
Standard and transmission-based precautions Standard precautions include hand hygiene, use of personal protective equipment (masks, gloves, gowns, protective eyewear) to prevent blood or body fluid exposure, routine environmental cleaning aligned to risk, safe use and disposal of sharps, reprocessing of reusable equipment and devices, respiratory hygiene and cough etiquette (including physical distancing), aseptic technique, linen and waste management. Transmission-based precautions include droplet, contact and airborne precautions, or a combination of these precautions based on the route of transmission of infection.	3.06	The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[17], jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws
	3.07	The health service organisation has: a. Collaborative and consultative processes for the assessment and communication of infection risks to patients and the workforce b. Infection prevention and control systems, in conjunction with the hierarchy of controls, in place to reduce transmission of infections so far as is reasonably practicable c. Processes for the use, training, testing and fitting of personal protective equipment by the workforce d. Processes to monitor and respond to changes in scientific and technical knowledge about infections, relevant national or jurisdictional guidance, policy and legislation e. Processes to audit compliance with standard and transmission-based precautions f. Processes to assess competence of the workforce in appropriate use of standard and transmission-based precautions g. Processes to improve compliance with standard and transmission-based precautions

Item	Action	
Standard and transmission-based precautions	3.08	Members of the workforce apply standard precautions and transmission-based precautions whenever required, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs and patient placement to prevent and manage infection risks d. The risks to the wellbeing of patients in isolation e. Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems; work flow design; facility design; surface finishes f. Precautions required when a patient is moved within the facility or between external services g. The need for additional environmental cleaning or disinfection processes and resources h. The type of procedure being performed i. Equipment required for routine care
	3.09	The health service organisation has processes to: a. Review data on and respond to infections in the community that may impact patients and the workforce b. Communicate details of a patient's infectious status during an episode of care, and at transitions of care c. Provide relevant information to a patient, their family and carers about their infectious status, infection risks and the nature and duration of precautions to minimise the spread of infection
Hand hygiene	3.10	The health service organisation has a hand hygiene program that is incorporated in its overarching infection prevention and control program as part of standard precautions and: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, the governing body, consumers and other relevant groups d. Uses the results of audits to improve hand hygiene compliance

Item	Action	
Aseptic technique	3.11	The health service organisation has processes for aseptic technique that: a. Identify the procedures in which aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique
Invasive medical devices	3.12	The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[17]
Clean and safe environment	3.13	The health service organisation has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[17] and jurisdictional requirements – to: a. Respond to environmental risks, including novel infections b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy e. Use the results of audits to improve environmental cleaning processes and compliance with policy
	3.14	The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Clinical and non-clinical areas, and workplace amenity areas c. Maintenance, repair and upgrade of buildings, equipment, furnishings and fittings d. Handling, transporting and storing linen e. Novel infections, and risks identified as part of a public health response or pandemic planning

Item	Action	
Workforce screening and immunisation	3.15	The health service organisation has a risk-based workforce vaccine-preventable diseases screening and immunisation policy and program that:
		a. Is consistent with the current edition of the *Australian Immunisation Handbook*[19]
		b. Is consistent with jurisdictional requirements for vaccine-preventable diseases
		c. Addresses specific risks to the workforce, consumers and patients
Infections in the workforce	3.16	The health service organisation has risk-based processes for preventing and managing infections in the workforce that:
		a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[17]
		b. Align with state and territory public health requirements for workforce screening and exclusion periods
		c. Manage risks to the workforce, patients and consumers, including for novel infections
		d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual
		e. Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and health service organisations
		f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection
		g. Provide for outbreak monitoring, investigation and management
		h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection

Reprocessing reusable equipment and devices

Reprocessing of reusable equipment and devices meets current best practice and is consistent with current national standards.

Item	Action	

Reprocessing of reusable equipment and devices	3.17	When reusable equipment and devices are used, the health service organisation has:
		
		a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines
		
		b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying
		  • the patient
		  • the procedure
		  • the reusable equipment, instruments and devices that were used for the procedure
		
		c. Processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections

Antimicrobial stewardship

The health service organisation has systems for the safe and appropriate prescribing and use of antimicrobials as part of an antimicrobial stewardship program.

Item	Action	
Antimicrobial stewardship	3.18	The health service organisation has an antimicrobial stewardship program that:
		a. Includes an antimicrobial stewardship policy
		b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing
		c. Has an antimicrobial formulary that is informed by current evidence-based Australian therapeutic guidelines and resources, and includes restriction rules and approval processes
		d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard[20]
		e. Acts on the results of antimicrobial use and appropriateness audits to promote continuous quality improvement
	3.19	The antimicrobial stewardship program will:
		a. Review antimicrobial prescribing and use
		b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing
		c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use
		d. Report to clinicians and the governing body regarding
		• compliance with the antimicrobial stewardship policy and guidance
		• areas of action for antimicrobial resistance
		• areas of action to improve appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing
		• the health service organisation's performance over time for use and appropriateness of use of antimicrobials

4

Medication Safety Standard
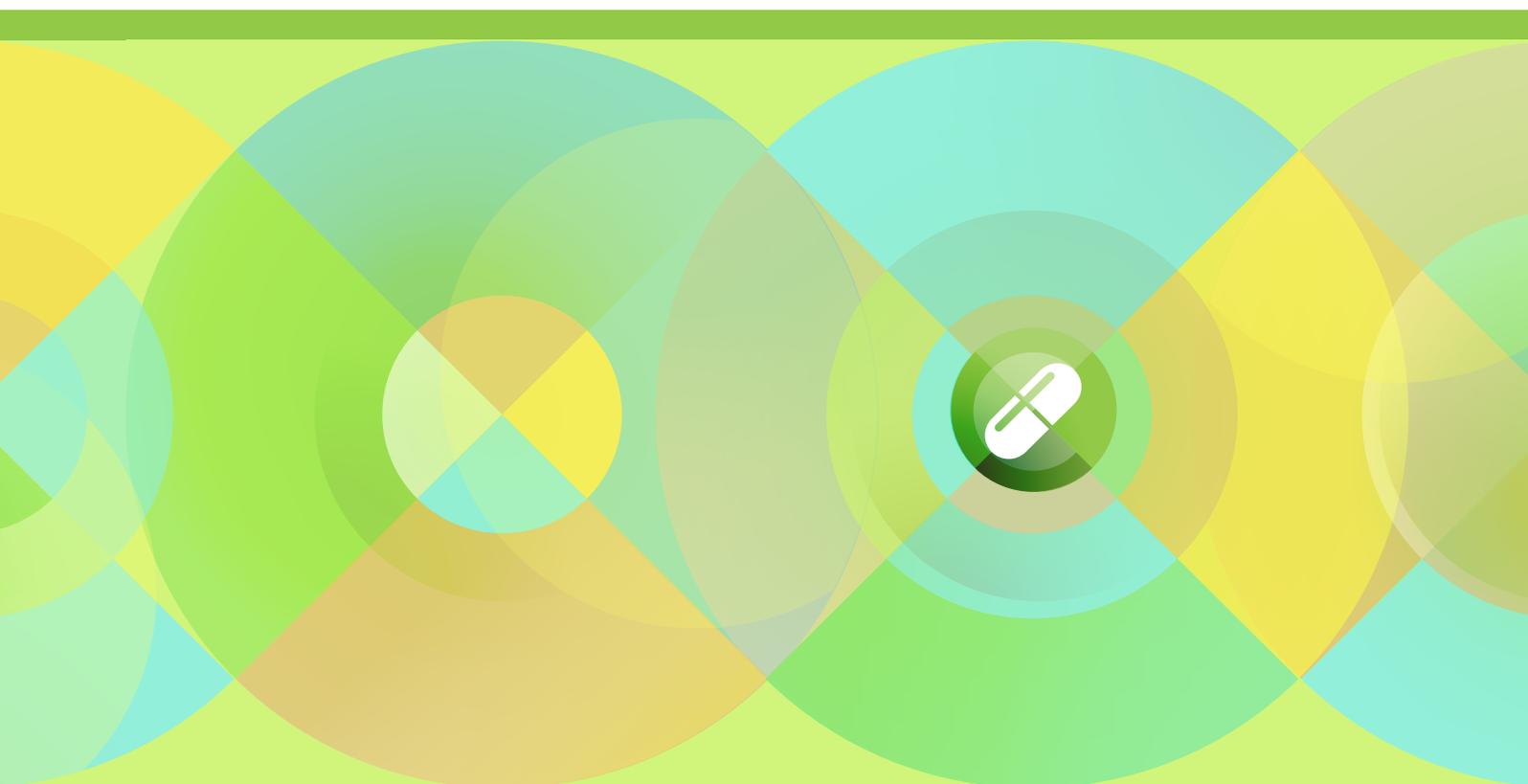
Medication Safety Standard

Leaders of a health service organisation describe, implement and monitor systems to reduce the occurrence of medication incidents, and improve the safety and quality of medication use. The workforce uses these systems.

Intention of this standard

To ensure clinicians are competent to safely prescribe, dispense and administer appropriate medicines and to monitor medicine use. To ensure consumers are informed about medicines and understand their individual medicine needs and risks.

Criteria

Clinical governance and quality improvement to support medication management

Organisation-wide systems are used to support and promote safety for procuring, supplying, storing, compounding, manufacturing, prescribing, dispensing, administering and monitoring the effects of medicines.

Documentation of patient information

A patient's best possible medication history is recorded when commencing an episode of care. The best possible medication history, and information relating to medicine allergies and adverse drug reactions are available to clinicians.

Continuity of medication management

A patient's medicines are reviewed, and information is provided to them about their medicine needs and risks. A medicines list is provided to the patient and the receiving clinician when handing over care.

Medication management processes

Health service organisations procure medicines for safety. Clinicians are supported to supply, store, compound, manufacture, prescribe, dispense, administer, monitor and safely dispose of medicines.

Explanatory notes

Medicines are the most common treatment used in health care. Although appropriate use of medicines contributes to significant improvements in health, medicines can also be associated with harm.[21] Because they are so commonly used, medicines are associated with a higher incidence of errors and adverse events than other healthcare interventions. Some of these adverse events are costly, and up to 50% are potentially avoidable.[22]

The proportion of medicine-related hospital admissions has been estimated at approximately 2–3%.[23] This proportion remains consistent, and, based on 2011–12 Australian hospital data of 9.3 million separations, suggests a medicine-related hospital admission rate of 230,000 annually. Some subpopulations have higher estimates – for example, 12% of medical admissions and 20–30% of admissions for those aged 65 years and over.[21] Studies have also revealed an average of three medicine-related problems per resident in aged care facilities[24], and 40–50% of residents being prescribed potentially inappropriate medicines.[25,26]

In general practice, 8.5–12% of patients are reported to have experienced an adverse medicine event within the previous six months[27-29], consistent with previous estimates of 10% of patients.[30]

Errors affect both health outcomes for consumers and healthcare costs. The cost of such adverse events to individual patients and the healthcare system is significant. A study published in 2009 reported that medication-related hospital admissions in Australia were estimated to cost $660 million.[21] Estimates, with an average cost per separation of $5,204 in 2011–12, place this figure closer to $1.2 billion.[21] The effects on patients' quality of life are more difficult to quantify.

Standardising and systemising processes can improve medication safety by preventing medication incidents. Other recognised solutions for reducing common causes of medication incidents include:

- Improving governance and quality measures relating to medication safety
- Improving clinician–workforce communication and clinical handover
- Improving clinician–patient communication and partnership
- Using technology to support information recording and transfer
- Providing better access to patient information and clinical decision support.

Clinical governance and quality improvement to support medication management

Organisation-wide systems are used to support and promote safety for procuring, supplying, storing, compounding, manufacturing, prescribing, dispensing, administering and monitoring the effects of medicines.

Item	Action	
Integrating clinical governance	4.01	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management
Applying quality improvement systems	4.02	The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management
Partnering with consumers	4.03	Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Medicines scope of clinical practice	4.04	The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians

Documentation of patient information

A patient's best possible medication history is recorded when commencing an episode of care. The best possible medication history, and information relating to medicine allergies and adverse drug reactions are available to clinicians.

Item	Action	
Medication reconciliation	4.05	Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care
	4.06	Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care
Adverse drug reactions	4.07	The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation
	4.08	The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system
	4.09	The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements

Continuity of medication management

A patient's medicines are reviewed, and information is provided to them about their medicines needs and risks. A medicines list is provided to the patient and the receiving clinician when handing over care.

Item	Action	
Medication review	4.10	The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication–related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result
Information for patients	4.11	The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks
Provision of a medicines list	4.12	The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes

Medication management processes

Health service organisations procure medicines for safety. Clinicians are supported to supply, store, compound, manufacture, prescribe, dispense, administer, monitor and safely dispose of medicines.

Item	Action	
Information and decision support tools for medicines	4.13	The health service organisation ensures that information and decision support tools for medicines are available to clinicians
Safe and secure storage and distribution of medicines	4.14	The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines
High-risk medicines	4.15	The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely

Comprehensive Care Standard

Comprehensive Care Standard

Leaders of a health service organisation set up and maintain systems and processes to support clinicians to deliver comprehensive care. They also set up and maintain systems to prevent and manage specific risks of harm to patients during the delivery of health care. The workforce uses the systems to deliver comprehensive care and manage risk.

Intention of this standard

To ensure that patients receive comprehensive care – that is, coordinated delivery of the total health care required or requested by a patient. This care is aligned with the patient's expressed goals of care and healthcare needs, considers the effect of the patient's health issues on their life and wellbeing, and is clinically appropriate.

To ensure that risks of harm for patients during health care are prevented and managed. Clinicians identify patients at risk of specific harm during health care by applying the screening and assessment processes required in this standard.

Criteria

Clinical governance and quality improvement to support comprehensive care

Systems are in place to support clinicians to deliver comprehensive care.

Developing the comprehensive care plan

Integrated screening and assessment processes are used in collaboration with patients, carers and families to develop a goal-directed comprehensive care plan.

Delivering comprehensive care

Safe care is delivered based on the comprehensive care plan, and in partnership with patients, carers and family. Comprehensive care is delivered to patients at the end of life.

Minimising patient harm

Patients at risk of specific harm are identified, and clinicians deliver targeted strategies to prevent and manage harm.

Explanatory notes

Comprehensive care

Safety and quality gaps are often reported as failures to provide adequate care for specific conditions, or in specific situations or settings, or to achieve expected outcomes in certain populations. The purpose of the Comprehensive Care Standard is to address the cross-cutting issues underlying many adverse events. These issues often include failures to:

- Provide continuous and collaborative care
- Work in partnership with patients, carers and families to adequately identify, assess and manage patients' clinical risks, and find out their preferences for care
- Communicate and work as a team (that is, between members of the healthcare team).

Processes for delivering comprehensive care will vary, even within a health service organisation. Take a flexible approach to standardisation so that safety and quality systems support local implementation and innovation. Target screening, assessment, comprehensive care planning and delivery processes to improve the safety and quality of care delivered to the population that the organisation serves.

Although this standard refers to actions needed within a single episode of patient care, it is fundamental that each single episode or period of care is considered as part of the continuum of care for a patient. Meaningful implementation of this standard requires attention to the processes for partnering with patients in their own care, and for safely managing transitions between episodes of care. This requires that the systems and processes necessary to meet the requirements of this standard also meet the requirements of the Partnering with Consumers Standard and the Communicating for Safety Standard.

Minimising patient harm

Implement targeted, best-practice strategies to prevent and minimise the risk of specific harms identified in this standard.

Pressure injuries

Pressure injuries can occur to patients of any age who have one or more of the following risk factors: immobility, older age, lack of sensory perception, poor nutrition or hydration, excess moisture or dryness, poor skin integrity, reduced blood flow, limited alertness or muscle spasms. Evidence-based strategies to prevent pressure injuries exist and should be applied if screening identifies that a patient is at risk.

Falls

Falls also occur in all age groups. However, the risk of falls and the harm from falls vary between individuals as a result of differences in factors such as eyesight, balance, cognitive impairment, muscle strength, bone density and medicine use. The Australian Commission on Safety and Quality in Health Care has developed evidence-based guidelines for older people.[31-33] Policies and procedures for other age groups need to be based on available evidence and best practice.

Poor nutrition and malnutrition

Patients with poor nutrition, including malnutrition, are at greater risk of pressure injuries and their pressure injuries are more severe.[8,34] They are also at greater risk of healthcare-associated infections and mortality in hospital, and for up to three years following discharge.[35-39] Malnutrition significantly increases length of hospital stay and unplanned readmissions.[37,38,40] Ensure that patients at risk of poor nutrition are identified and that strategies are put in place to reduce these risks.

Cognitive impairment

People with cognitive impairment who are admitted to hospital are at a significantly increased risk of preventable complications such as falls, pressure injuries, delirium and failure to return to premorbid function, as well as adverse outcomes such as unexpected death, or early and unplanned entry into residential care.[41] People with cognitive impairment may also experience distress in unfamiliar and busy environments. Although cognitive impairment is a common condition experienced by people in health service organisations, it is often not detected, or is dismissed or misdiagnosed. Delirium can be prevented with the right care[42], and harm can be minimised if systems are in place to identify cognitive impairment and the risk of delirium, so that strategies can be incorporated in the comprehensive care plan and implemented.

Unpredictable behaviours

People in healthcare settings can exhibit unpredictable behaviours that may lead to harm. Health service organisations need systems to identify situations where there is higher risk of harm, and strategies to mitigate or prevent these risks. They also need systems to manage situations in which harm relating to unpredictable behaviour occurs. For the purpose of this standard, unpredictable behaviours include self-harm, suicide, aggression and violence. It is important that systems designed to respond to the risks of unpredictable behaviour minimise further trauma to patients and others. This relates to both the material practices and the attitude with which care is delivered.

Processes to manage people who have thoughts of harming themselves, with or without suicidal intent, or who have actually harmed themselves are needed. These processes need to provide physical safety, and support to deal with psychological and other issues contributing to self-harm. The health service organisation is responsible for ensuring that follow-up services are arranged before the person leaves the health service, because of the known risks of self-harm after discharge.[43]

Some people are at higher risk of aggressive behaviour as a result of impaired coping skills relating to intoxication, acute physical deterioration or mental illness. Healthcare-related situations, such as waiting times, crowded or high-stimulus environments, and conflicts regarding treatment decisions, can precipitate aggression. Members of the workforce need skills to identify the risk of aggression, and strategies to safely manage aggression and violence when they do occur.

Restrictive practices

Minimising and, where possible, eliminating the use of restrictive practices (including restraint and seclusion) are key parts of national mental health policy.[44,45] Minimising the use of restraint in other healthcare settings besides mental health has also been identified as a clinical priority. Identifying risks relating to unpredictable behaviour early and using tailored response strategies can reduce the use of restrictive practices. Restrictive practices must only be implemented by members of the workforce who have been trained in their safe use. The health service organisation needs processes to benchmark and review the use of restrictive practices.

Key links with other standards

To implement systems that meet the requirements of the Comprehensive Care Standard, identify where there are synergies with the other NSQHS Standards. This will help ensure that the organisation's safety and quality systems, policies and processes are integrated, and will reduce the risk of duplication of effort arising from attempts to implement the eight standards separately.

Clinical governance and quality improvement to support comprehensive care

Systems are in place to support clinicians to deliver comprehensive care.

Item	Action	
Integrating clinical governance	5.01	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care
Applying quality improvement systems	5.02	The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care
Partnering with consumers	5.03	Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Designing systems to deliver comprehensive care	5.04	The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care
Collaboration and teamwork	5.05	The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team
	5.06	Clinicians work collaboratively to plan and deliver comprehensive care

Developing the comprehensive care plan

Integrated screening and assessment processes are used in collaboration with patients, carers and families to develop a goal-directed comprehensive care plan.

Item	Action	
Planning for comprehensive care	5.07	The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion
	5.08	The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems
	5.09	Patients are supported to document clear advance care plans
Screening of risk	5.10	Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks
Clinical assessment	5.11	Clinicians comprehensively assess the conditions and risks identified through the screening process
Developing the comprehensive care plan	5.12	Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record
	5.13	Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence

Delivering comprehensive care

Safe care is delivered based on the comprehensive care plan, and in partnership with patients, carers and families. Comprehensive care is delivered to patients at the end of life.

Item	Action	
Using the comprehensive care plan	5.14	The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur
Comprehensive care at the end of life	5.15	The health service organisation has processes to identify patients who are at the end of life that are consistent with the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*[46]
	5.16	The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice
	5.17	The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record
	5.18	The health service organisation provides access to supervision and support for the workforce providing end-of-life care
	5.19	The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care
	5.20	Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*[46]

Minimising patient harm

Patients at risk of specific harm are identified, and clinicians deliver targeted strategies to prevent and manage harm.

Item	Action	
Preventing and managing pressure injuries	5.21	The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines
	5.22	Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency
	5.23	The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries
Preventing falls and harm from falls	5.24	The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management
	5.25	The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls
	5.26	Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies
Nutrition and hydration	5.27	The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice
	5.28	The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking

Item	Action	
Preventing delirium and managing cognitive impairment	5.29	The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard[47], where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation
	5.30	Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care
Predicting, preventing and managing self-harm and suicide	5.31	The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed
	5.32	The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts
Predicting, preventing and managing aggression and violence	5.33	The health service organisation has processes to identify and mitigate situations that may precipitate aggression
	5.34	The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce

Item		Action
Minimising restrictive practices: restraint	5.35	Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body
Minimising restrictive practices: seclusion	5.36	Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation c. Report use of seclusion to the governing body

Communicating for Safety Standard
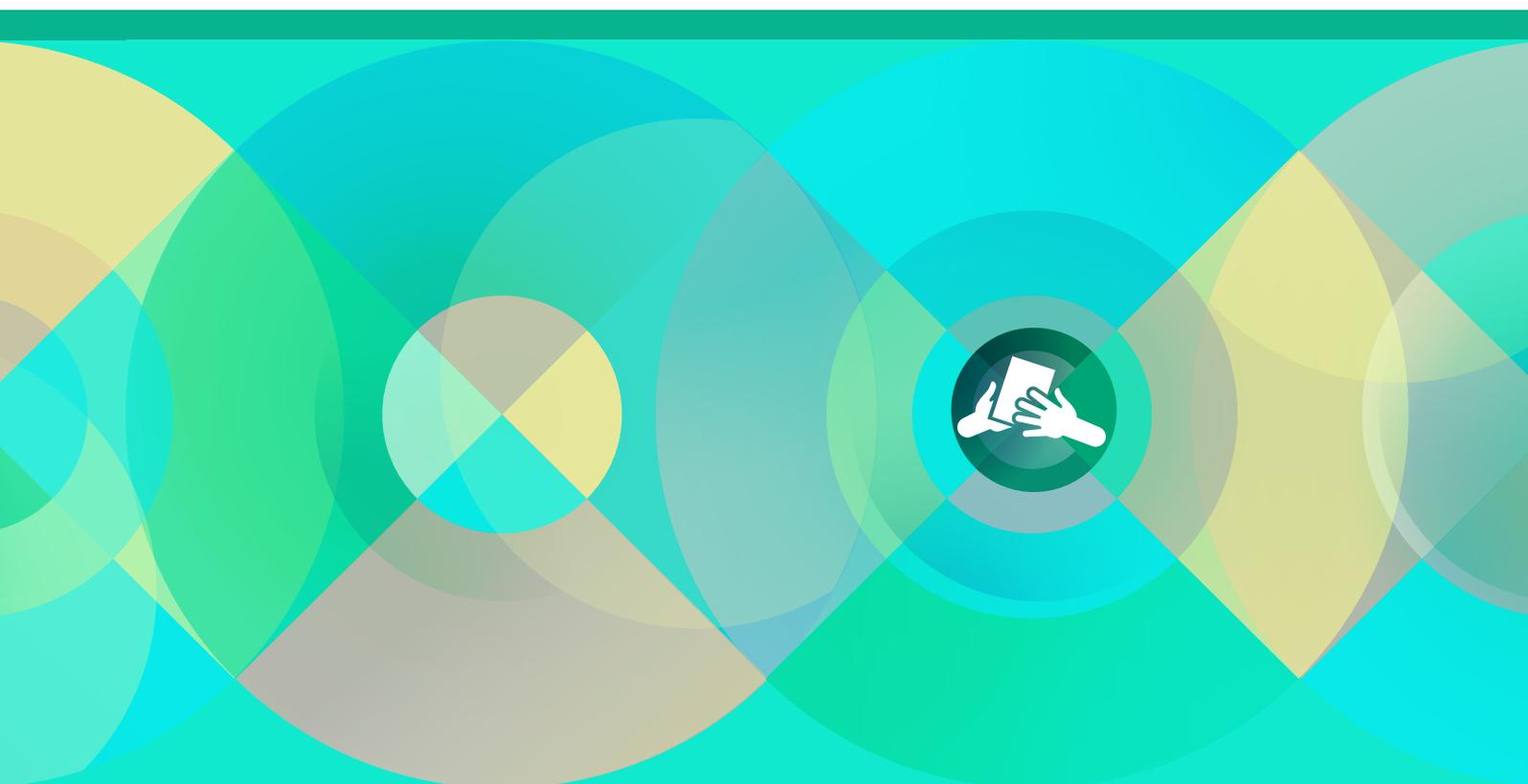
Communicating for Safety Standard

Leaders of a health service organisation set up and maintain systems and processes to support effective communication with patients, carers and families; between multidisciplinary teams and clinicians; and across health service organisations. The workforce uses these systems to effectively communicate to ensure safety.

Intention of this standard

To ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for patients.

Criteria

Clinical governance and quality improvement to support effective communication

Systems are in place for effective and coordinated communication that supports the delivery of continuous and safe care for patients.

Correct identification and procedure matching

Systems to maintain the identity of the patient are used to ensure that the patient receives the care intended for them.

Communication at clinical handover

Processes for structured clinical handover are used to effectively communicate about the health care of patients.

Communication of critical information

Systems to effectively communicate critical information and risks when they emerge or change are used to ensure safe patient care.

Documentation of information

Essential information is documented in the healthcare record to ensure patient safety.

Explanatory notes

Communication is a key safety and quality issue. This standard recognises the importance of effective communication and its role in supporting continuous, coordinated and safe patient care.

Actions in this standard outline the high-risk situations in which effective communication and documentation are required. They include transitions of care (clinical handover), when critical information about a patient's care emerges or changes, and when it is important to ensure that a patient is correctly identified and matched to their intended care.

To meet this standard, health service organisations are required to have systems and processes in place to support effective communication and documentation at these high-risk times. Recognising that communication is a variable process, organisations will need to develop, describe and adapt these systems to their service context to ensure that communication processes are flexible, and appropriate for the nature of the organisation and the consumers who use their service.

Communication is inherent to patient care, and informal communications will occur throughout care delivery. It is not intended that this standard will apply to all communications within an organisation. Rather, the intention is to ensure that systems and processes are in place at key times when effective communication and documentation are critical to patient safety.

Communication is relevant across all of the NSQHS Standards, and many of the actions in this standard rely on, and are linked to, actions in the other NSQHS Standards. In particular, this standard should be applied in conjunction with the Clinical Governance, Partnering with Consumers, Medication Safety, Comprehensive Care, and Recognising and Responding to Acute Deterioration standards.

The review of the NSQHS Standards found that Standard 6: Clinical Handover (1st ed.) was often interpreted narrowly as only referring to shift-to-shift handover. However, because effective communication is critical at other key times throughout the delivery of health care, changes have been made to this standard to deal with clinical communications more broadly.

Clinical governance and quality improvement to support effective communication

Systems are in place for effective and coordinated communication that supports the delivery of continuous and safe care for patients.

Item	Action	
Integrating clinical governance	6.01	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication
Applying quality improvement systems	6.02	The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes
Partnering with consumers	6.03	Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Organisational processes to support effective communication	6.04	The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes

Correct identification and procedure matching

Systems to maintain the identity of the patient are used to ensure that the patient receives the care intended for them.

Item	Action	
Correct identification and procedure matching	6.05	The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated
	6.06	The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care

Communication at clinical handover

Processes for structured clinical handover are used to effectively communicate about the health care of patients.

Item	Action	
Clinical handover	6.07	The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover
	6.08	Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care

Communication of critical information

Systems to effectively communicate critical information and risks when they emerge or change are used to ensure safe patient care.

Item	Action	
Communicating critical information	6.09	Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient
	6.10	The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians

Documentation of information

Essential information is documented in the healthcare record to ensure patient safety.

Item	Action	
Documentation of information	6.11	The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan

7

Blood Management Standard
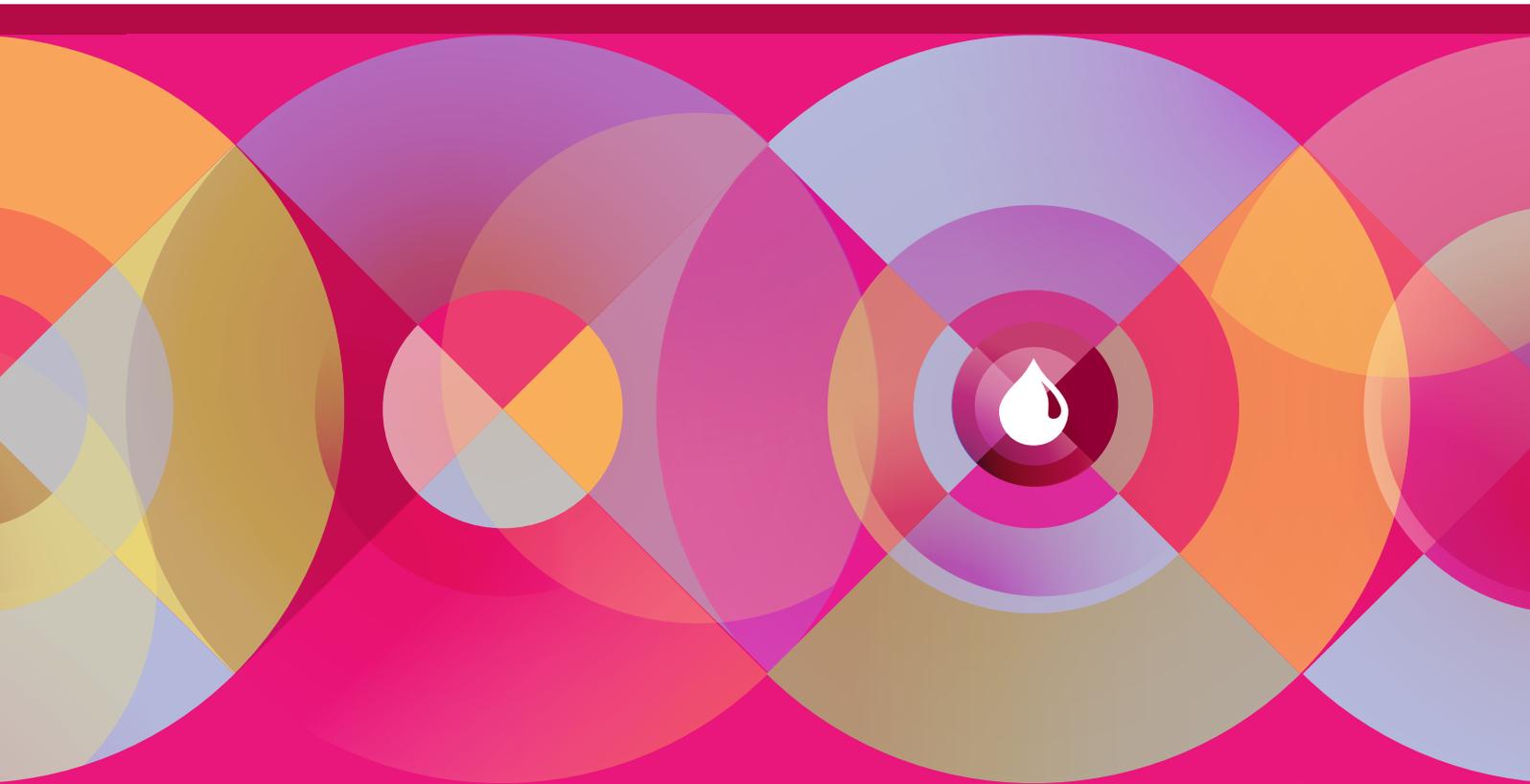
Blood Management Standard

Leaders of a health service organisation describe, implement and monitor systems to ensure the safe, appropriate, efficient and effective care of patients' own blood, as well as other blood and blood products. The workforce uses the blood product safety systems.

Intention of this standard

To identify risks, and put in place strategies, to ensure that a patient's own blood is optimised and conserved, and that any blood and blood products the patient receives are appropriate and safe.

Criteria

Clinical governance and quality improvement to support blood management

Organisation-wide governance and quality improvement systems are used to ensure safe and high-quality care of patients' own blood, and to ensure that blood product requirements are met.

Prescribing and clinical use of blood and blood products

The clinical use of blood and blood products is appropriate, and strategies are used to reduce the risks associated with transfusion.

Managing the availability and safety of blood and blood products

Strategies are used to effectively manage the availability and safety of blood and blood products.

Explanatory notes

This standard is a revision of Standard 7: Blood and Blood Products in the NSQHS Standards (1st ed.). The actions in this standard have been refined to:

- Focus on the patient receiving blood and blood products, rather than only on the blood and blood products
- Focus on effectively optimising and conserving a patient's own blood, reducing the unnecessary risk of exposure to blood products and associated adverse events
- More explicitly consider identified gaps in practice
- Remove duplications in the standard
- More specifically reflect national policy agreements about blood and blood products.

Treatment with blood and blood products can be lifesaving. However, using biological materials, blood and blood products has some inherent risks. Actions to minimise these risks include screening and testing donors and donated blood; and ensuring that all treatment options, and their risks and benefits, are considered before deciding to transfuse.

The scope of this standard covers all elements of the clinical process, including:

- Making clinical decisions
- Obtaining recipient samples and assessing compatibility with donated products
- Safely administering the products to the intended recipient
- Storing and disposing of blood and blood products
- Reporting and investigating any adverse reactions or incidents.

This standard also aims to ensure that safe, appropriate, effective and efficient blood management systems are in place.

The standard supports the principles of good patient blood management that provide for clinically appropriate and safe management of patients while avoiding transfusion of blood and blood products, and its associated risks.

Research and practice show that the dual approach of implementing governance structures and evidence-based clinical guidelines is the most effective way to ensure the appropriate and safe use of blood and blood products.

Clinical governance and quality improvement to support blood management

Organisation-wide governance and quality improvement systems are used to ensure safe and high-quality care of patients' own blood, and to ensure that blood product requirements are met.

Item	Action	
Integrating clinical governance	7.01	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management
Applying quality improvement systems	7.02	The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management
Partnering with consumers	7.03	Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making

Prescribing and clinical use of blood and blood products

The clinical use of blood and blood products is appropriate, and strategies are used to reduce the risks associated with transfusion.

Item	Action	
Optimising and conserving patients' own blood	7.04	Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks
Documenting	7.05	Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record
Prescribing and administering blood and blood products	7.06	The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria
Reporting adverse events	7.07	The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria
	7.08	The health service organisation participates in haemovigilance activities, in accordance with the national framework

Managing the availability and safety of blood and blood products

Strategies are used to effectively manage the availability and safety of blood and blood products.

Item	Action	
Storing, distributing and tracing blood and blood products	7.09	The health service organisation has processes: a. That comply with manufacturers' directions, legislation and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer
Availability of blood	7.10	The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage

Recognising and Responding to Acute Deterioration Standard
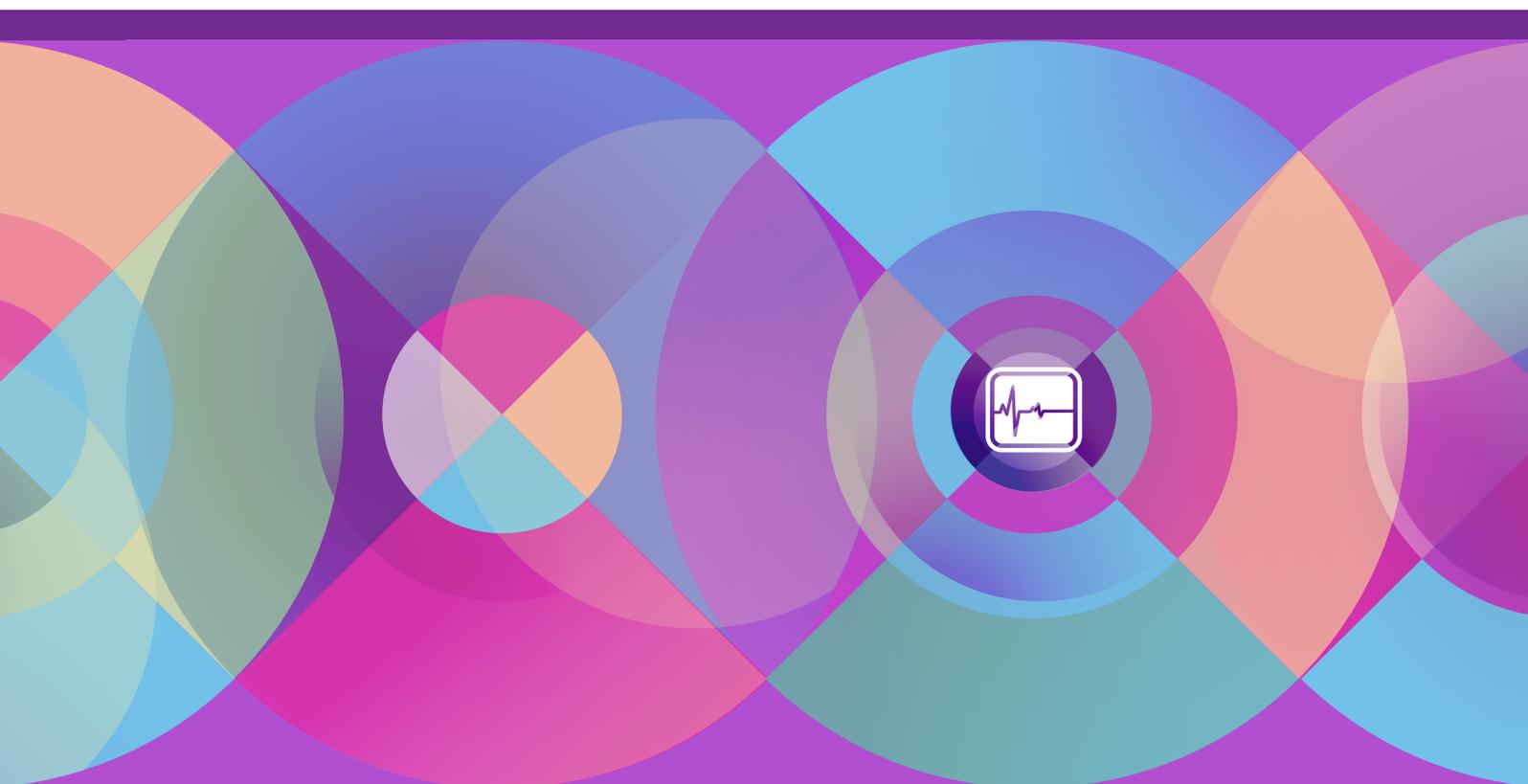
Recognising and Responding to Acute Deterioration Standard

Leaders of a health service organisation set up and maintain systems for recognising and responding to acute deterioration. The workforce uses the recognition and response systems.

Intention of this standard

To ensure that a person's acute deterioration is recognised promptly and appropriate action is taken. Acute deterioration includes physiological changes, as well as acute changes in cognition and mental state.

Criteria

Clinical governance and quality improvement to support recognition and response systems

Organisation-wide systems are used to support and promote detection and recognition of acute deterioration, and the response to patients whose condition acutely deteriorates. These systems are consistent with the *National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration*[48], the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*[46], the *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state* and the Delirium Clinical Care Standard.[47]

Detecting and recognising acute deterioration, and escalating care

Acute deterioration is detected and recognised, and action is taken to escalate care.

Responding to acute deterioration

Appropriate and timely care is provided to patients whose condition is acutely deteriorating.

Explanatory notes

Serious adverse events such as unexpected death and cardiac arrest are often preceded by observable physiological and clinical abnormalities.[49] Other serious events such as suicide or aggression are also often preceded by observed or reported changes in a person's behaviour or mood that can indicate a deterioration in their mental state.

Early identification of deterioration may improve outcomes and lessen the intervention required to stabilise patients whose condition deteriorates in hospital.[50]

There is evidence that the warning signs of clinical deterioration are not always identified or acted on appropriately.[51] The organisation and workforce factors that contribute to a failure to recognise and respond to a deteriorating patient are complex and overlapping. They include[52-54]:

- Not monitoring physiological observations consistently or not understanding observed changes in physiological observations
- Lack of knowledge of signs and symptoms that could signal deterioration
- Lack of awareness of the potential for a person's mental state to deteriorate
- Lack of awareness of delirium, and the benefits of early recognition and treatment[55]
- Lack of formal systems for responding to deterioration
- Lack of skills to manage patients who are deteriorating
- Failure to communicate clinical concerns, including during clinical handover
- Attributing physical or mental symptoms to an existing condition, such as dementia or a mental health condition.[56,57]

Systems to recognise deterioration early and respond to it appropriately need to deal with all of these factors, and need to be applied across a healthcare facility. The *National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration*[48], which was developed by the Australian Commission on Safety and Quality in Health Care (the Commission), has been endorsed by Australian health ministers as the national approach for recognising and responding to clinical deterioration in acute care facilities in Australia. It provides a consistent national model to support clinical, organisational and strategic efforts to improve recognition and response systems. This standard builds on the national consensus statement to drive implementation in acute care facilities.

The Commission's *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state* outlines the principles that underpin safe and effective responses to deterioration in a person's mental state, and provides information about the interrelated components that a health service organisation can implement to provide this care.

This standard applies to all patients – adults, adolescents, children and babies – in acute healthcare facilities, and to all types of patients, including medical, surgical, maternity and mental health patients. Acute healthcare facilities range from large tertiary referral centres to small district and community hospitals.

The Commission's Delirium Clinical Care Standard[47] highlights the importance of being alert to, and assessing, delirium with any reported or observed changes in a person's mental state.

Clinical governance and quality improvement to support recognition and response systems

Organisation-wide systems are used to support and promote detection and recognition of acute deterioration, and the response to patients whose condition acutely deteriorates. These systems are consistent with the *National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration*[48], the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*[46], the *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state* and the Delirium Clinical Care Standard.[47]

Item	Action
Integrating clinical governance	8.01 Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration
Applying quality improvement systems	8.02 The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems
Partnering with consumers	8.03 Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making

Detecting and recognising acute deterioration, and escalating care

Acute deterioration is detected and recognised, and action is taken to escalate care.

Item	Action	
Recognising acute deterioration	8.04	The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient
	8.05	The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state
Escalating care	8.06	The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration
	8.07	The health service organisation has processes for patients, carers or families to directly escalate care
	8.08	The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance
	8.09	The workforce uses the recognition and response systems to escalate care

Responding to acute deterioration

Appropriate and timely care is provided to patients whose condition is acutely deteriorating.

Item	Action	
Responding to deterioration	8.10	The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration
	8.11	The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support
	8.12	The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated
	8.13	The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration

Glossary

If appropriate, glossary definitions from external sources have been adapted to fit the context of the NSQHS Standards.

acute deterioration: physiological, psychological or cognitive changes that may indicate a worsening of the patient's health status; this may occur across hours or days.

advance care plan: a plan that states preferences about health and personal care, and preferred health outcomes. An advance care planning discussion will often result in an advance care plan. Plans should be made on the person's behalf and prepared from the person's perspective to guide decisions about care.[58]

advanced life support: the preservation or restoration of life by the establishment and/or maintenance of airway, breathing and circulation using invasive techniques such as defibrillation, advanced airway management, intravenous access and drug therapy.[48]

adverse drug reaction: a response to a medicine that is noxious and unintended, and occurs at doses normally used or tested in humans for the prophylaxis, diagnosis or therapy of disease, or for the modification of physiological function.[59] An allergy is a type of adverse drug reaction.

adverse event: an incident that results, or could have resulted, in harm to a patient or consumer. A near miss is a type of adverse event. *See also* near miss

alert: warning of a potential risk to a patient.

allergy: occurs when a person's immune system reacts to allergens in the environment that are harmless for most people. Typical allergens include some medicines, foods and latex.[60] An allergen may be encountered through inhalation, ingestion, injection or skin contact.[61] A medicine allergy is one type of adverse drug reaction.

antimicrobial: a chemical substance that inhibits or destroys bacteria, viruses or fungi, and can be safely administered to humans and animals.[62]

antimicrobial resistance: failure of an antimicrobial to inhibit a microorganism at the antimicrobial concentrations usually achieved over time with standard dosing regimens.[62]

antimicrobial stewardship: an ongoing effort by a health service organisation to reduce the risks associated with increasing antimicrobial resistance and to extend the effectiveness of antimicrobial treatments. It may incorporate several strategies, including monitoring and review of antimicrobial use.[62]

approved identifiers: items of information accepted for use in identification, including family and given names, date of birth, sex, address, healthcare record number and Individual Healthcare Identifier. Health service organisations and clinicians are responsible for specifying the approved items for identification and procedure matching. Identifiers such as room or bed number should not be used.

aseptic technique: a technique that aims to prevent microorganisms on hands, surfaces and equipment from being introduced to susceptible sites. Unlike sterile techniques, aseptic techniques can be achieved in typical ward and home settings.[63]

assessment: a clinician's evaluation of a disease or condition based on the patient's subjective report of the symptoms and course of the illness or condition, and the clinician's objective findings. These findings include data obtained through laboratory tests, physical examination and medical history; and information reported by carers, family members and other members of the healthcare team. The assessment is an essential element of a comprehensive care plan.[41]

audit (clinical): a systematic review of clinical care against a predetermined set of criteria.[64]

Australian Charter of Healthcare Rights: specifies the key rights of patients when seeking or receiving healthcare services. It was endorsed by health ministers in 2008.[16]

Australian Open Disclosure Framework: endorsed by health ministers in 2013, it provides a framework for health service organisations and clinicians to communicate openly with patients when health care does not go to plan.[6]

best possible medication history: a list of all the medicines a patient is using at presentation. The list includes the name, dose, route and frequency of the medicine, and is documented on a specific form or in a specific place. All prescribed, over-the-counter and complementary medicines should be included. This history is obtained by a trained clinician interviewing the patient (and/or their carer) and is confirmed, where appropriate, by using other sources of medicines information.[65]

best practice: when the diagnosis, treatment or care provided is based on the best available evidence, which is used to achieve the best possible outcomes for patients.

best-practice guidelines: a set of recommended actions that are developed using the best available evidence. They provide clinicians with evidence-informed recommendations that support clinical practice, and guide clinician and patient decisions about appropriate health care in specific clinical practice settings and circumstances.[66]

blood management: a process that improves outcomes for patients by improving their medical and surgical management in ways that boost and conserve their own blood, and ensure that any blood and blood products patients receive are appropriate and safe.

blood products: the products derived from fresh blood – red blood cells and platelets, fresh frozen plasma, cryoprecipitate and cryodepleted plasma, plasma-derived blood products, and recombinant blood products.

business decision-making: decision-making regarding service planning and management for a health service organisation. It covers the purchase of building finishes, equipment and plant; program maintenance; workforce training for safe handling of equipment and plant; and all issues for which business decisions are taken that might affect the safety and wellbeing of patients, visitors and the workforce.

care pathway: a complex intervention that supports mutual decision-making and organisation of care processes for a well-defined group of patients during a well-defined period.[67]

carer: a person who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail or aged. An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are paid, a volunteer for an organisation, or caring as part of a training or education program.[68]

clinical care standards: nationally relevant standards developed by the Australian Commission on Safety and Quality in Health Care, and agreed by health ministers, that identify and define the care people should expect to be offered or receive for specific conditions.

clinical communication: the exchange of information about a person's care that occurs between treating clinicians, patients, carers and families, and other members of a multidisciplinary team. Communication can be through several different channels, including face-to-face meetings, telephone, written notes or other documentation, and electronic means. *See also* effective clinical communication, clinical communication process

clinical communication process: the method of exchanging information about a person's care. It involves several components, and includes the sender (the person who is communicating the information), the receiver (the person receiving the information), the message (the information that is communicated) and the channel of communication. Various channels of communication can be used, including verbal (face to face, over the phone, through Skype), written and electronic.[69] Sending and receipt of the information can occur at the same time, such as verbal communication between two clinicians, or at different times, such as non-verbal communication during which a clinician documents a patient's goals, assessments and comprehensive care plan in the healthcare record, which is later read by another clinician.

clinical governance: an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of safe, effective and high-quality services. Clinical governance systems provide confidence to the community and the healthcare organisation that systems are in place to deliver safe and high-quality health care.

clinical handover: the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.[70]

clinical information system: a computerised healthcare record and management system that is used by clinicians in healthcare settings. Clinical information systems are typically organisation-wide, have high levels of security and access, and have roles and rights (for example, prescribing medicines, reviewing laboratory results, administering intravenous fluids) specified for each clinical and administrative user. Clinical information systems enable electronic data entry and data retrieval by clinicians.[71]

clinical leaders: clinicians with management or leadership roles in a health service organisation who can use their position or influence to change behaviour, practice or performance. Examples are directors of clinical services, heads of units and clinical supervisors.

clinician: a healthcare provider, trained as a health professional, including registered and non-registered practitioners. Clinicians may provide care within a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They include nurses, midwives, medical practitioners, allied health practitioners, technicians, scientists and other clinicians who provide health care, and students who provide health care under supervision.

cognitive impairment: deficits in one or more of the areas of memory, communication, attention, thinking and judgement. This can be temporary or permanent. It can affect a person's understanding, their ability to carry out tasks or follow instructions, their recognition of people or objects, how they relate to others and how they interpret the environment. Dementia and delirium are common forms of cognitive impairment seen in hospitalised older patients.[41] Cognitive impairment can also be a result of several other conditions, such as acquired brain injury, a stroke, intellectual disability, licit or illicit drug use, or medicines.

cold chain management: the system of transporting and storing temperature-sensitive medicines and other therapies, such as blood and blood products, within their defined temperature range at all times, from point of origin (manufacture) to point of administration, to ensure that the integrity of the product is maintained.

communicable: an infection that can be transferred from one person or host to another.

comprehensive care: health care that is based on identified goals for the episode of care. These goals are aligned with the patient's expressed preferences and healthcare needs, consider the impact of the patient's health issues on their life and wellbeing, and are clinically appropriate.

comprehensive care plan: a document describing agreed goals of care, and outlining planned medical, nursing and allied health activities for a patient. Comprehensive care plans reflect shared decisions made with patients, carers and families about the tests, interventions, treatments and other activities needed to achieve the goals of care. The content of comprehensive care plans will depend on the setting and the service that is being provided, and may be called different things in different health service organisations. For example, a care or clinical pathway for a specific intervention may be considered a comprehensive care plan.

consumer: a person who has used, or may potentially use, health services, or is a carer for a patient using health services. A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision-making processes.[72]

contemporaneously (documenting information): recording information in the healthcare record as soon as possible after the event that is being documented.[73]

credentialing: the formal process used by a health service organisation to verify the qualifications, experience, professional standing, competencies and other relevant professional attributes of clinicians, so that the organisation can form a view about the clinician's competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments.[74]

critical equipment: items that confer a high risk for infection if they are contaminated with any microorganism, and must be sterile at the time of use. They include any objects that enter sterile tissue or the vascular system, because any microbial contamination could transmit disease.[18]

critical information: information that has a considerable impact on a patient's health, wellbeing or ongoing care (physical or psychological). The availability of critical information may require a clinician to reassess or change a patient's comprehensive care plan.

current medicines list: *See* medicines list

decision support tools: tools that can help clinicians and consumers to draw on available evidence when making clinical decisions. The tools have a number of formats. Some are explicitly designed to enable shared decision making (for example, decision aids). Others provide some of the information needed for some components of the shared decision-making process (for example, risk calculators, evidence summaries), or provide ways of initiating and structuring conversations about health decisions (for example, communication frameworks, question prompt lists).[75] *See also* shared decision making

de-escalation strategies: psychosocial techniques that aim to reduce violent or disruptive behaviour. They are intended to reduce or eliminate the risk of violence during the escalation phase, using verbal and non-verbal communication skills. De-escalation is about establishing rapport to gain the patient's trust, minimising restriction to protect their self-esteem, appearing externally calm and self-aware in the face of aggressive behaviour, and intuitively identifying creative and flexible interventions that will reduce the need for aggression.[76]

definitive management: the treatment plan for a disease or disorder that has been chosen as the best one for the patient after all other choices have been considered.[77]

delirium: an acute disturbance of consciousness, attention, cognition and perception that tends to fluctuate during the day.[78] It is a serious condition that can be prevented in 30–40% of cases, and should be treated promptly and appropriately. Hospitalised older people with existing dementia are at the greatest risk of developing delirium. Delirium can be hyperactive (the person has heightened arousal; or can be restless, agitated and aggressive) or hypoactive (the person is withdrawn, quiet and sleepy).[79]

deterioration in mental state: a negative change in a person's mood or thinking, marked by a change in behaviour, cognitive function, perception or emotional state. Changes can be gradual or acute; they can be observed by members of the workforce, or reported by the person themselves, or their family or carers. Deterioration in a person's mental state can be related to several predisposing or precipitating factors, including mental illness, psychological or existential stress, physiological changes, cognitive impairment (including delirium), intoxication, withdrawal from substances, and responses to social context and environment.

diversity: the varying social, economic and geographic circumstances of consumers who use, or may use, the services of a health service organisation, as well as their cultural backgrounds, religions, beliefs, practices, languages spoken and sexualities (diversity in sexualities is currently referred to as lesbian, gay, bisexual, transgender and intersex, or LGBTI).

effective clinical communication: two-way, coordinated and continuous communication that results in the timely, accurate and appropriate transfer of information. Effective communication is critical to, and supports, the delivery of safe patient care.

emergency assistance: clinical advice or assistance provided when a patient's condition has deteriorated severely. This assistance is provided as part of the rapid response system, and is additional to the care provided by the attending clinician or team.[48]

end of life: the period when a patient is living with, and impaired by, a fatal condition, even if the

trajectory is ambiguous or unknown. This period may be years in the case of patients with chronic or malignant disease, or very brief in the case of patients who suffer acute and unexpected illnesses or events, such as sepsis, stroke or trauma.[80]

environment: the physical surroundings in which health care is delivered, including the building, fixtures, fittings, and services such as air and water supply. Environment can also include other patients, consumers, visitors and the workforce.

episode of care: a phase of treatment. There may be more than one episode of care within the one hospital stay. An episode of care ends when the principal clinical intent changes or when the patient is formally separated from the facility.[81]

escalation protocol: the protocol that sets out the organisational response required for different levels of abnormal physiological measurements or other observed deterioration. The protocol applies to the care of all patients at all times.[48]

fall: an event that results in a person coming to rest inadvertently on the ground or floor, or another lower level.[82]

goals of care: clinical and other goals for a patient's episode of care that are determined in the context of a shared decision-making process.

governance: the set of relationships and responsibilities established by a health service organisation between its executive, workforce and stakeholders (including patients and consumers). Governance incorporates the processes, customs, policy directives, laws and conventions affecting the way an organisation is directed, administered or controlled. Governance arrangements provide the structure for setting the corporate objectives (social, fiscal, legal, human resources) of the organisation and the means to achieve the objectives. They also specify the mechanisms for monitoring performance. Effective governance provides a clear statement of individual accountabilities within the organisation to help align the roles, interests and actions of different participants in the organisation to achieve the organisation's objectives. In the NSQHS Standards, governance includes both corporate and clinical governance.

governing body: a board, chief executive officer, organisation owner, partnership or other highest level of governance (individual or group of individuals) that has ultimate responsibility for strategic and operational decisions affecting safety and quality in a health service organisation.

guidelines: clinical practice guidelines are systematically developed statements to assist clinician and consumer decisions about appropriate health care for specific circumstances.[83]

haemovigilance: a set of surveillance procedures covering the entire blood transfusion chain, from the donation and processing of blood and its components, to their provision and transfusion to patients, to their follow-up. It includes monitoring, reporting, investigating and analysing adverse events related to the donation, processing and transfusion of blood, as well as development and implementation of recommendations to prevent the occurrence or recurrence of adverse events.[84]

hand hygiene: a general term referring to any action of hand cleansing.

health care: the prevention, treatment and management of illness and injury, and the preservation of mental and physical wellbeing through the services offered by clinicians, such as medical, nursing and allied health professionals.[6]

healthcare-associated infections: infections that are acquired in healthcare facilities (nosocomial infections) or that occur as a result of healthcare interventions (iatrogenic infections). Healthcare-associated infections may manifest after people leave the healthcare facility.[18]

healthcare record: includes a record of the patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care.

health literacy: the Australian Commission on Safety and Quality in Health Care separates health literacy into two components – individual health literacy and the health literacy environment.

Individual health literacy is the skills, knowledge, motivation and capacity of a consumer to access, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action.

The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the healthcare system, which affect the ways in which consumers

access, understand, appraise and apply health-related information and services.[85]

health service organisation: a separately constituted health service that is responsible for implementing clinical governance, administration and financial management of a service unit or service units providing health care at the direction of the governing body. A service unit involves a group of clinicians and others working in a systematic way to deliver health care to patients. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.

hierarchy of controls: a model used in work health and safety risk management. It is a step-by-step approach to controlling hazards that ranks controls from most to least reliable.

higher risk (patients at higher risk of harm): a patient with multiple factors or a few specific factors that result in their being more vulnerable to harm from health care or the healthcare system. Risk factors may include having chronic clinical conditions; having language barriers; being of Aboriginal or Torres Strait Islander background; having low health literacy; being homeless; or being of diverse gender identities and experiences, bodies, relationships and sexualities (currently referred to as lesbian, gay, bisexual, transgender and intersex, or LGBTI).

high-risk medicines: medicines that have an increased risk of causing significant patient harm or death if they are misused or used in error. High-risk medicines may vary between hospitals and other healthcare settings, depending on the types of medicines used and patients treated. Errors with these medicines are not necessarily more common than with other medicines. Because they have a low margin of safety, the consequences of errors with high-risk medicines can be more devastating.[86,87] At a minimum, the following classes of high-risk medicines should be considered:

- Medicines with a narrow therapeutic index
- Medicines that present a high risk when other system errors occur, such as administration via the wrong route.

hygienic environment: an environment in which practical prevention and control measures are used to reduce the risk of infection from contamination by microbes.

incident (clinical): an event or circumstance that resulted, or could have resulted, in unintended or unnecessary harm to a patient or consumer; or a complaint, loss or damage. An incident may also be a near miss. *See also* near miss

infection: the invasion and reproduction of pathogenic (disease-causing) organisms inside the body. This may cause tissue injury and disease.[88]

informed consent: a process of communication between a patient and clinician about options for treatment, care processes or potential outcomes. This communication results in the patient's authorisation or agreement to undergo a specific intervention or participate in planned care.[89] The communication should ensure that the patient has an understanding of the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.[90]

injury: damage to tissues caused by an agent or circumstance.[91]

invasive medical devices: devices inserted through skin, mucosal barrier or internal cavity, including central lines, peripheral lines, urinary catheters, chest drains, peripherally inserted central catheters and endotracheal tubes.

jurisdictional requirements: systematically developed statements from state and territory governments about appropriate healthcare or service delivery for specific circumstances.[83] Jurisdictional requirements encompass a number of types of documents from state and territory governments, including legislation, regulations, guidelines, policies, directives and circulars. Terms used for each document may vary by state and territory.

leadership: having a vision of what can be achieved, and then communicating this to others and evolving strategies for realising the vision. Leaders motivate people, and can negotiate for resources and other support to achieve goals.[92]

local community: the people living in a defined geographic region or from a specific group who receive services from a health service organisation.

mandatory: required by law or mandate in regulation, policy or other directive; compulsory.[93]

medication management: practices used to manage the provision of medicines. Medication management has also been described as a cycle, pathway or system, which is complex and involves a number of different clinicians. The patient is the central focus. The system includes manufacturing, compounding, procuring, dispensing, prescribing, storing, administering, supplying and monitoring the effects of medicines. It also includes decision-making, and rules, guidelines, support tools, policies and procedures that are in place to direct the use of medicines.[94]

medication reconciliation: a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines, and matching the medicines the patient should be prescribed to those they are actually prescribed. Any discrepancies are discussed with the prescriber, and reasons for changes to therapy are documented and communicated when care is transferred. Medication review may form part of the medication reconciliation process.

medication review: a systematic assessment of medication management for an individual patient that aims to optimise the patient's medicines and outcomes of therapy by providing a recommendation or making a change.[95] Medication review may be part of medication reconciliation.

medicine: a chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental wellbeing of people. These include prescription, non-prescription, investigational, clinical trial and complementary medicines, irrespective of how they are administered.[96]

medicine-related problem: any event involving treatment with a medicine that has a negative effect on a patient's health or prevents a positive outcome. Consideration should be given to disease-specific, laboratory test–specific and patient-specific information. Medicine-related problems include issues with medicines such as:

- Underuse
- Overuse
- Use of inappropriate medicines (including therapeutic duplication)
- Adverse drug reactions, including interactions (medicine–medicine, medicine–disease, medicine–nutrient, medicine–laboratory test)
- Noncompliance.[97,98]

medicines list: prepared by a clinician, a medicines list contains, at a minimum:

- All medicines a patient is taking, including over-the-counter, complementary, prescription and non-prescription medicines; for each medicine, the medicine name, form, strength and directions for use must be included[94]
- Any medicines that should not be taken by the patient, including those causing allergies and adverse drug reactions; for each allergy or adverse drug reaction, the medicine name, the reaction type and the date on which the reaction was experienced should be included.

Ideally, a medicines list also includes the intended use (indication) for each medicine.

It is expected that the medicines list is updated and correct at the time of transfer (including clinical handover) or when services cease, and that it is tailored to the audience for whom it is intended (that is, patient or clinician).[99]

mental state: *See* deterioration in mental state

minimum information content: the content of information that must be contained and transferred in a particular type of clinical handover. What is included as part of the minimum information content will depend on the context and reason for the handover or communication.[100]

multidisciplinary team: a team including clinicians from multiple disciplines who work together to deliver comprehensive care that deals with as many of the patient's health and other needs as possible. The team may operate under one organisational umbrella or may be from several organisations brought together as a unique team. As a patient's condition changes, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient.[101] Multidisciplinary care includes interdisciplinary care. (A discipline is a branch of knowledge within the health system.[102])

My Health Record (formerly known as a personally controlled electronic device): the secure online summary of a consumer's health information, managed by the System Operator of the national My Health Record system (the Australian Digital Health Agency). Clinicians are able to share health clinical documents to a consumer's My Health Record, according to the consumer's access controls. These may include information on medical history and treatments, diagnoses, medicines and allergies.[103]

national patient identifier: a unique 16-digit number that is used to identify individuals who receive or may receive health care in the Australian healthcare system. Also known as an Individual Healthcare Identifier (IHI).[103]

national provider identifier: a unique 16-digit number that is used to identify individual clinicians or organisations that deliver health care in the Australian healthcare setting. For individuals, it is also known as a Healthcare Provider Identifier – Individual (HPI-I); for organisations, it is also known as a Healthcare Provider Identifier – Organisation (HPI-O).[103]

near miss: an incident or potential incident that was averted and did not cause harm, but had the potential to do so.[104]

nutrition care plan: a plan to meet the nutrition and hydration needs of a patient. The nutrition care plan is developed for the patient after their nutrition and hydration needs have been assessed.

open disclosure: an open discussion with a patient and carer about an incident that resulted in harm to the patient while receiving health care. The criteria of open disclosure are an expression of regret, and a factual explanation of what happened, the potential consequences, and the steps taken to manage the event and prevent recurrence.[105]

organisation-wide: intended for use throughout the health service organisation.

orientation: a formal process of informing and training a worker starting in a new position or beginning work for an organisation, which covers the policies, processes and procedures applicable to the organisation.

outcome: the status of an individual, group of people or population that is wholly or partially attributable to an action, agent or circumstance.[91]

partnership: a situation that develops when patients and consumers are treated with dignity and respect, when information is shared with them, and when participation and collaboration in healthcare processes are encouraged and supported to the extent that patients and consumers choose. Partnerships can exist in different ways in a health service organisation, including at the level of individual interactions; at the level of a service, department or program; and at the level of the organisation. They can also exist with consumers and groups in the community. Generally, partnerships at all levels are necessary to ensure that the health service organisation is responsive to patient and consumer input and needs, although the nature of the activities for these different types of partnership will depend on the context of the health service organisation.

patient: a person who is receiving care in a health service organisation.

person-centred care: an approach to the planning, delivery and evaluation of health care that is founded on mutually beneficial partnerships among clinicians and patients.[106] Person-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of person-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care.[9] Also known as patient-centred care or consumer-centred care.

point of care: the time and location of an interaction between a patient and a clinician for the purpose of delivering care.

policy: a set of principles that reflect the organisation's mission and direction. All procedures and protocols are linked to a policy statement.

pressure injuries: injuries of the skin and/or underlying tissue, usually over a bony prominence, caused by unrelieved pressure, friction or shearing. They occur most commonly on the sacrum and heel, but can develop anywhere on the body. Pressure injury is a synonymous term for pressure ulcer.

procedure: the set of instructions to make policies and protocols operational, which are specific to an organisation.

procedure matching: the processes of correctly matching patients to their intended care.

process: a series of actions or steps taken to achieve a particular goal.[107]

program: an initiative, or series of initiatives, designed to deal with a particular issue, with resources, a time frame, objectives and deliverables allocated to it.

protocol: an established set of rules used to complete tasks or a set of tasks.

purpose-driven communication: communication in which all the parties involved in the communication process have a shared understanding of why the communication is taking place (for example, to gather, share, receive or check information), what action needs to be taken and who is responsible for taking that action.

quality improvement: the combined efforts of the workforce and others – including consumers, patients and their families, researchers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development.[108] Quality improvement activities may be undertaken in sequence, intermittently or continually.

regularly: occurring at recurring intervals. The specific interval for regular review, evaluation, audit or monitoring needs to be determined for each case. In the NSQHS Standards (2nd ed.), the interval should be consistent with best practice, risk based, and determined by the subject and nature of the activity.

responsibility and accountability for care: accountability includes the obligation to report and be answerable for consequences. Responsibility is the acknowledgement that a person has to take action that is appropriate to a patient's care needs and the health service organisation.[109]

restraint: the restriction of an individual's freedom of movement by physical or mechanical means.[110]

reusable device: a medical device that is designated by its manufacturer as suitable for reprocessing and reuse.[111]

risk: the chance of something happening that will have a negative impact. Risk is measured by the consequences of an event and its likelihood.

risk assessment: assessment, analysis and management of risks. It involves recognising which events may lead to harm in the future, and minimising their likelihood and consequences.[112]

risk management: the design and implementation of a program to identify and avoid or minimise risks to patients, employees, volunteers, visitors and the organisation.

safety culture: a commitment to safety that permeates all levels of an organisation, from the clinical workforce to executive management.

Features commonly include acknowledgement of the high-risk, error-prone nature of an organisation's activities; a blame-free environment in which individuals are able to report errors or near misses without fear of reprimand or punishment; an expectation of collaboration across all areas and levels of an organisation to seek solutions to vulnerabilities; and a willingness of the organisation to direct resources to deal with safety concerns.[113]

scope of clinical practice: the extent of an individual clinician's approved clinical practice within a particular organisation, based on the clinician's skills, knowledge, performance and professional suitability, and the needs and service capability of the organisation.[74]

screening: a process of identifying patients who are at risk, or already have a disease or injury. Screening requires enough knowledge to make a clinical judgement.[114]

seclusion: the confinement of a patient, at any time of the day or night, alone in a room or area from which free exit is prevented.[110]

self-harm: includes self-poisoning, overdoses and minor injury, as well as potentially dangerous and life-threatening forms of injury. Self-harm is a behaviour and not an illness. People self-harm to cope with distress or to communicate that they are distressed.[115]

semi-critical equipment: items that come into contact with mucous membranes or non-intact skin, and should be single use or sterilised after each use. If this is not possible, high-level disinfection is the minimum level of reprocessing that is acceptable.[18]

service context: the particular context in which care is delivered. Health service delivery occurs in many different ways, and the service context will depend on the organisation's function, size and organisation of care regarding service delivery mode, location and workforce.[116]

shared decision making: a consultation process in which a clinician and a patient jointly participate in making a health decision, having discussed the options, and their benefits and harms, and having considered the patient's values, preferences and circumstances.[75]

standard: agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.[91]

standard national terminologies: a structured vocabulary used in clinical practice to accurately describe the care and treatment of patients. Healthcare providers around the world use specialised vocabulary to describe diseases, operations, clinical procedures, findings, treatments and medicines. In Australia, terminologies include SNOMED CT-AU and Australian Medicines Terminology.[117] Standard national terminologies are also referred to as clinical terminologies.

standard precautions: work practices that provide a first-line approach to infection prevention and control, and are used for the care and treatment of all patients.[111]

structured clinical handover: a structured format used to deliver information (the minimum information content), enabling all participants to know the purpose of the handover, and the information that they are required to know and communicate.[64]

substitute decision-maker: a person appointed or identified by law to make health, medical, residential and other personal (but not financial or legal) decisions on behalf of a patient whose decision-making capacity is impaired. A substitute decision-maker may be appointed by the patient, appointed for (on behalf of) the person, or identified as the default decision-maker by legislation, which varies by state and territory.[41]

surveillance: an epidemiological practice that involves monitoring the spread of disease to establish progression patterns. The main roles of surveillance are to predict and observe spread; to provide a measure for strategies that may minimise the harm caused by outbreak, epidemic and pandemic situations; and to increase knowledge of the factors that might contribute to such circumstances.[88]

system: the resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish a stated goal. A system:

- Brings together risk management, governance, and operational processes and procedures, including education, training and orientation
- Deploys an active implementation plan; feedback mechanisms include agreed protocols and guidelines, decision support tools and other resource materials

- Uses several incentives and sanctions to influence behaviour and encourage compliance with policy, protocol, regulation and procedures.

The workforce is both a resource in the system and involved in all elements of systems development, implementation, monitoring, improvement and evaluation.

timely (communication): communication of information within a reasonable time frame. This will depend on how important or time critical the information is to a patient's ongoing care or wellbeing, the context in which the service is provided and the clinical acuity of the patient.

traceability: the ability to trace the history, application or location of reusable medical devices. Some professional groups may refer to traceability as tracking.[111]

training: the development of knowledge and skills.

transfusion history: a list of transfusions a patient has had before presentation, including details of any adverse reactions to the transfusion and any special transfusion requirements. The completeness of the history will depend on the availability of information. It is expected that information will be obtained by reviewing any available referral information and interviewing the patient or their carer.

transitions of care: situations when all or part of a patient's care is transferred between healthcare locations, providers, or levels of care within the same location, as the patient's conditions and care needs change.[118]

transmission-based precautions: extra work practices used in situations when standard precautions alone may not be enough to prevent transmission of infection. Transmission-based precautions are used in conjunction with standard precautions.[18]

workforce: all people working in a health service organisation, including clinicians and any other employed or contracted, locum, agency, student, volunteer or peer workers. The workforce can be members of the health service organisation or medical company representatives providing technical support who have assigned roles and responsibilities for care of, administration of, support of, or involvement with patients in the health service organisation. *See also* clinician

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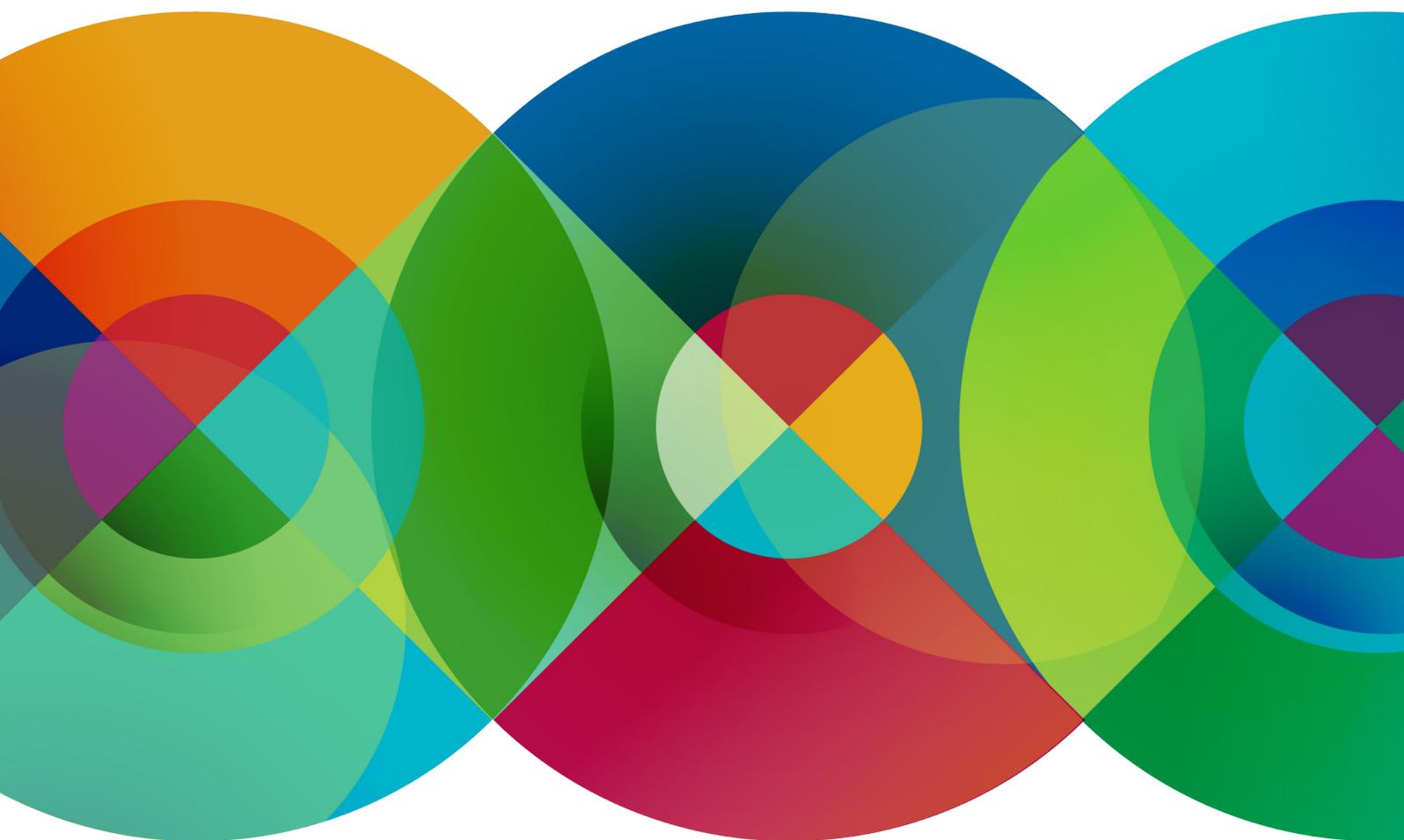
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