

**AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE**

**National Safety and Quality
Health Service Standards
Version 2:**

Consultation draft



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Introduction

The implementation of the National Safety and Quality Health Service (NSQHS) Standards, together with the introduction of the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme, has been an unprecedented, transformational effort to improve health care in Australia. The transformation has come about because of the enormous commitment, hard work and innovation from clinicians, safety and quality managers, and executives and board members from health services nationally.

The NSQHS Standards were designed to protect the public from harm and to improve the quality of care for consumers. In implementing the NSQHS Standards, health services have put in place safety and quality systems to ensure that minimum standards of care are met. The NSQHS Standards have driven the alignment of policies, reporting, investment and programs for safety and quality improvement at local, jurisdictional and national levels.

By the end of 2015, all hospitals and day procedure services, and many other health services will have fully implemented the NSQHS Standards. Although the NSQHS Standards are not mandatory in these settings, increasingly dental practices, ambulance services, the Royal Flying Doctor Service, and community and practice-based care services are working to interpret and implement them.

Implementation of the NSQHS Standards has produced promising results, and generated widespread engagement and support among clinicians.

Initial findings from the evaluation of the impact of the NSQHS Standards on the care of consumers suggest that they have had a multiplier effect on existing safety and quality strategies, and improvements within health service organisations. The NSQHS Standards have prioritised areas of safety and quality, encouraging health service organisations to strengthen existing initiatives in these areas, and to prioritise areas where strategies were not in place. Evaluation of the NSQHS Standards is ongoing.

The Australian Commission on Safety and Quality in Health Care (the Commission) has legislative responsibility for maintaining and implementing the NSQHS Standards under the AHSSQA Scheme. To fulfil this role, the Commission began a review of the NSQHS Standards in 2014. Assessment against the next version of the NSQHS Standards (version 2) will begin in the 2017/18 financial year.

Version 1 of the NSQHS Standards was drafted between 2008 and 2010, and endorsed by health ministers in 2011. The evidence base and practice models have developed since that time, and further work by the Commission has identified areas that should be addressed by safety and quality standards.

The NSQHS Standards cover areas where it is known that consumers experience higher levels of harm, and where there is good evidence of how safer and better care could be provided. Version 2 of the NSQHS Standards places greater emphasis on partnerships with consumers as fundamental for ensuring safety and quality. There is now consistent evidence about the links between effective partnerships, good consumer experience, and safe and high-quality health care. The need to provide care that is based on partnerships and aligns with the expressed preferences and healthcare needs of consumers underpins all of the NSQHS Standards.

The NSQHS Standards specify what needs to be achieved to provide minimum requirements for safety and quality. The way that these actions are achieved will vary, depending on the context of each health service. Health services vary widely, and have

different functions, sizes, locations, structures and service delivery modes. Health services need to understand their context and the risks they face so that they can put in place appropriate strategies to meet the NSQHS Standards.

Review process

The review of the NSQHS Standards involves six stages.

1. Analysis of information on the performance of version 1 of the NSQHS Standards

This stage involved reviewing information submitted by accrediting agencies on the assessment of health services with respect to the NSQHS Standards; enquiries to the Commission's Advice Centre; and feedback from public and private health services, consumers, technical working groups and committees, clinicians and stakeholder organisations. For some areas, current literature was reviewed.

This information was used to identify areas in version 1 of the NSQHS Standards where:

- there are duplicated actions
- there are safety and quality gaps
- implementing actions have been challenging
- there are opportunities for improvements in version 2.

This stage took place between October 2014 and April 2015.

2. Consultation with clinicians on safety and quality issues encountered during the application of version 1 of the NSQHS Standards, and changes they would recommend

This stage involved more than 35 focus groups across Australia, including acute care, rehabilitation, community and mental health representatives from private and public health services.

This stage occurred between April and July 2015.

3. Recent work on safety and quality

Over the past three years, the Commission has worked with stakeholders, consumers and key organisations to identify strategies to improve the safety and quality of care for people in the areas of:

- mental health
- cognitive impairment
- end of life
- health literacy
- Aboriginal and Torres Strait Islander health.

The evidence and strategies that have been identified through this work have informed the structure and content of version 2 of the NSQHS Standards.

4. Drafting of version 2 of the NSQHS Standards

In conjunction with technical working groups, program committees and expert advisers, the Commission drafted version 2 of the NSQHS Standards for consideration by the external steering committee established to oversee the review. The draft was reviewed by the Commission's standing committees of the Board. Amendments were made based on input from these committees and the Board. Approval was sought from the Commission's Board before the final draft was released for consultation.

This stage took place between May and August 2015.

5. Consultation on the draft version 2 of the NSQHS Standards

Consultation will use a multi-method approach, involving:

- publication of the draft of version 2 of the NSQHS Standards on the Commission's web site and a call for written submissions
- focus groups with clinicians, consumers and representatives from health service organisations
- a survey of health service organisations, owners, jurisdictions and other interested organisations and individuals
- feedback from national piloting of the draft version 2 of the NSQHS Standards in a wide range of health service organisations.

Consultation is scheduled to occur between August and December 2015.

6. Finalisation of version 2 of the NSQHS Standards

Before being finalised, the NSQHS Standards will need to be endorsed by Australian health ministers. The final draft is due to be considered at the first meeting of the Council of Australian Governments Health Council in 2016. Version 2 of the NSQHS Standards will be published once approved.

Changes to the NSQHS Standards

The draft of version 2 of the NSQHS Standards has nine standards. Overall, there are fewer actions than in version 1, partly as a result of removing duplication and combining actions.

Examples of this are:

- combining Actions 3.1.2, 3.1.3, 3.1.4, 3.3.2, 3.4.1, 3.4.2, 3.4.3, 3.10.3, 3.11.3, 3.11.5 and 3.14.4 in NSQHS Standard 3: Preventing and controlling healthcare associated infections (version 1) into one requirement to have a comprehensive quality improvement program for healthcare-associated infections
- bringing together Actions 1.18.4 and 9.8.2 relating to advance care planning
- streamlining governance requirements that were duplicated in NSQHS Standards 3–10, which now appear only in NSQHS Standard GS: Governance for safety and quality – for example, Actions 3.3, 4.4, 5.2.1, 6.4, 7.3, 8.2.1 and 10.2.1, relating to reporting of incident monitoring (version 1) are covered in GS9 of version 2 of the NSQHS Standards.

Three standards have been removed as separate standards:

- The core parts of NSQHS Standard 5: Patient identification and procedure matching, requiring an organisation-wide identification and procedure matching system and three identifiers, have been incorporated into Standard CS: Communicating for safety. The remainder of NSQHS Standard 5 duplicated material in the same and other NSQHS Standards.
- Actions from both NSQHS Standard 8: Preventing and managing pressure injuries and NSQHS Standard 10: Preventing falls and harm from falls have been included in Standard GS: Governance for safety and quality, Standard CC: Comprehensive care and Standard RH: Reducing harm.

The content of NSQHS Standard 6: Clinical handover has been expanded to focus on clinical communication more broadly.

Two new standards have been added: NSQHS Standard CC: Comprehensive care and NSQHS Standard RH: Reducing harm.

The introduction to each standard is largely unchanged. Each NSQHS Standard has an intent statement, criteria, items and actions. In version 1, items were not always fully aligned with the actions. The items have been simplified and now appear as headings in the items column to help users to navigate the standards.

The numbering and ordering of standards in version 2 of the NSQHS Standards have been changed to improve the flow of the document and better reflect a consumer's journey through a service. As with version 1, the overarching standards on governance for safety and quality, and partnering with consumers appear first; the standards relating to consumer-centred care, managing harm where risks are high and communicating for safety are next; and the specific clinical standards on healthcare-associated infections, medication safety, recognising and responding to acute deterioration, and blood and blood products follow.

Each action in version 1 of the NSQHS Standards has a unique number. In version 2, instead of just a number, they have letters and a number. This is to prevent confusion with version 1 actions and to encourage the use of titles rather than numbers when referring to a standard.

To help people understand the basis for the changes in the NSQHS Standards when they are reviewing this draft, each standard starts with a summary of the changes to the standard. As well, an extra column has been added to each standard that maps actions from version 1 to version 2 of the NSQHS Standards.

Of the 256 actions in version 1 of the NSQHS Standards, 195 actions have been consolidated, 25 actions remain largely unchanged, 16 actions have been deleted and 19 actions have new components in version 2.

Whereas the intent of the retained actions has not changed, the wording has. Each action now identifies who is primarily responsible for implementing the action. This may be the highest level of governance, the health service organisation, clinicians or the entire workforce. The wording of some actions has also been amended to improve their clarity and ensure the consistent use of terminology, but their intent is unchanged.

New actions

The new actions in the NSQHS Standards address the safety and quality gaps identified during the review process, and in research programs conducted by the Commission. These include actions relevant to the care of Aboriginal and Torres Strait Islander people, and people with a mental illness or cognitive impairment.

Aboriginal and Torres Strait Islander health

Health outcomes for Indigenous people differ significantly from those of the wider community. It is well known that Indigenous people experience significantly shorter life expectancy, higher rates of infant mortality and more avoidable deaths. These disparities exist not only in health status, health outcomes and the social determinants of health, but also in the way that people access and use health services.

In line with the national agenda on closing the gap on Indigenous health outcomes, it is important that the Commission has a focus on improving safety and quality of care for Indigenous people. For this reason, the Commission has included a number of actions in version 2 of the NSQHS Standards that focus specifically on Indigenous people. In addition, other actions that do not directly refer to Indigenous people in version 2 of the NSQHS Standards will also support safer and better quality care for Indigenous people.

The actions that specifically address Indigenous health begin with the phrase ‘where Aboriginal and Torres Strait Islander people receive care in the organisation...’. These actions apply to health service organisations for which care for Aboriginal and Torres Strait Islander people is commonplace, and that can reasonably expect to (and often do) provide care to Indigenous people. Health service organisations that rarely care for Indigenous people would manage the risks of harm to Indigenous people from care, and the provision of safe and high-quality care for Indigenous people, through the actions for improvement that relate to their whole consumer population.

Mental health and cognitive impairment

People with lived experience of mental health or cognitive impairment have poorer overall health outcomes and are at greater risk when receiving care. Version 2 of the NSQHS Standards includes a number of actions that specifically address the risks associated with mental health or cognitive impairment when receiving care. These actions apply to organisations that provide health care to people with either mental health conditions or cognitive impairment.

Standard GS: Governance for safety and quality

Status

This is an existing standard. It is an overarching standard that sets the requirements for governance for safety and quality across all standards.

What has changed and why?

- Existing actions have been streamlined to reduce duplication and improve flow.
- Previously, the NSQHS Standards listed specific policies and procedures that should be included in the governance system (Item 1.1 of version 1 of the NSQHS Standards). This approach has been changed so that it is less prescriptive, better reflecting the variety of organisations that may be using the NSQHS Standards and the contexts in which they operate.
- Actions regarding quality improvement have been expanded to better reflect the quality improvement cycle and to make explicit the need to take a quality improvement approach in addressing all the NSQHS Standards.
- Requirements about training are now less prescriptive, but have an explicit focus on meeting the requirements of the NSQHS Standards.
- Actions in version 1 of the NSQHS Standards relating to consumer rights and engagement (Actions 1.17.1–1.17.3) have been revised and moved to NSQHS Standard PC: Partnering with consumers. There is now an increased focus on partnering with consumers in their own care in NSQHS Standard PC.
- Actions in version 1 of the NSQHS Standards relating to informed consent (Actions 1.18.1 and 1.18.3) have been relocated to Standard PC because they are more closely aligned to partnering with consumers.
- Action 1.18.4 from version 1 of the NSQHS Standards relating to advance care directives is now included in Standard RR: Recognising and responding to acute deterioration (Action RR7.1).
- The importance of leaders in setting the safety and quality culture of an organisation is well known. A new criterion has been added (Leadership and governance) that includes explicit statements about the role of leaders and others in safety and quality.
- Action GS11.2 has been added regarding the safe use of clinical information systems, and their potential to improve the safety and quality of care through sharing of information with external organisations. When implementing systems, this will help to ensure that the electronic health records in use by some states and territories, and the My Health Record that it is now moving to an opt-out system, are being used effectively.
- There is considerable evidence about the poor health outcomes for Aboriginal and Torres Strait Islander people. There are also specific and identifiable safety and quality risks for Indigenous people. Closing the gap between Indigenous and non-Indigenous people is a national priority, and actions have been added to Standard GS and other standards to address this need.
- Existing actions have been streamlined to reduce duplication and improve flow.

Standard GS: Governance for safety and quality

Leaders of a health service organisation implement governance systems to set, monitor, and improve the safety and quality performance of the organisation. Leaders of a health service organisation communicate the importance of partnering with consumers and ongoing quality improvement. The workforce uses the governance systems.

Intention of this standard

Create integrated governance systems that maintain and improve the reliability, safety and quality of health care, and improve health outcomes for consumers.

Criteria

1. Leadership and governance

Safety and quality goals, values and objectives are set and acted on to improve the safety and quality of health care for consumers.

2. Safety and quality systems

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

3. Performance and skills management systems

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

4. Safe environment for the delivery of care

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

Leadership and governance

Safety and quality goals, values and objectives are set and acted on to improve the safety and quality of health care for consumers.

Item	Action required	Link to v1
GS1 Governance and strategic leadership	GS1.1 The highest level of governance: <ol style="list-style-type: none"> endorses safety and quality goals developed for the organisation provides leadership to promote a safety culture in the organisation provides leadership on partnering with consumers receives reports and monitors progress on safety and quality performance and culture provides direction on safety and quality actions taken by the health service organisation 	New components 1.2.1
	GS1.2 Where Aboriginal and Torres Strait Islander people receive care in the organisation, the highest level of governance ensures that the safety and quality goals address the specific health needs of these people	New action
GS2 Management and executive leadership	GS2.1 The health service organisation: <ol style="list-style-type: none"> develops the organisation's safety and quality goals establishes and maintains a clinical governance framework uses a quality improvement approach to achieve the organisation's goals supports clinicians to take action to improve the safety and quality of health care 	New components 1.1
	GS2.2 Where there are specific safety and quality goals for Aboriginal and Torres Strait Islander people, the health service organisation has targeted strategies to meet these goals	New action
	GS2.3 The health service organisation considers safety and quality in business decision making, including resource allocation relevant to service provision	1.1.2
GS3 Clinical leadership	GS3.1 Clinicians use the clinical governance framework to provide leadership in safety and quality	New action

Safety and quality systems

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

Item	Action required	Link to v1
GS4 Policies and procedures	GS4.1 The health service organisation has governance systems that: <ol style="list-style-type: none"> set out, review and maintain policies, procedures and protocols based on a risk management approach monitor compliance with policies, procedures and protocols take action to improve compliance 	1.1.1, 1.5.2, 3.1.1, 3.1.2, 4.1.2, 5.1.1, 6.1.1, 7.1.1, 8.1.1, 8.1.2, 9.1.2, 10.1.1, 10.1.2
	GS4.2 The health service organisation has systems to ensure compliance with legislation and regulation, and to meet jurisdictional requirements	1.1.1
GS5 Quality improvement systems	GS5.1 The health service organisation has organisation-wide quality improvement systems that: <ol style="list-style-type: none"> are used to audit clinical performance and outcomes regularly seek feedback from the workforce about the quality improvement systems and their performance involve consumers and the workforce in the review of safety and quality systems, and their performance 	1.2.2, 1.6.1, 1.6.2, 1.13.3, 1.20.1
	GS5.2 The health service organisation reports on safety and quality performance to: <ol style="list-style-type: none"> the highest level of governance the workforce consumers 	1.2.1, 2.7.1, 8.2.2
GS6 Variation in practice	GS6.1 The health service organisation has systems to: <ol style="list-style-type: none"> identify areas of risk associated with variation in practice monitor variation in practice in areas of risk provide feedback to clinicians on variation in practice take action to reduce unwarranted variation where it is identified 	1.7.2 New components
GS7 Risk management systems	GS7.1 The health service organisation has organisation-wide risk management systems that: <ol style="list-style-type: none"> identify and document organisational safety and quality risks use clinical and other data collections to inform risk assessments take action to address risks are regularly reviewed to improve their effectiveness 	1.5.1, 1.5.2

Standard GS: Governance for safety and quality

Item	Action required	Link to v1
GS8 Understanding diversity	GS8.1 The health service organisation understands the diversity of the consumers who use its services and, where relevant, the diversity of the local population	New action
GS9 Incident management systems	GS9.1 The health service organisation has organisation-wide incident management and investigation systems that: <ul style="list-style-type: none"> a. create a just culture to enable and support the workforce to recognise and report incidents and near misses b. involve the workforce and consumers in the analysis of incidents and near misses c. provide timely feedback on the analysis of incidents and near misses to the highest level of governance, the workforce and consumers d. use information from the analysis of near misses and incidents to inform improvements in safety and quality e. monitor the implementation and resolution of actions that result from the analysis of near misses and incidents 	1.14.1, 1.14.2, 1.14.3, 1.14.4, 1.14.5, 4.4.1, 4.4.2, 5.2.1, 5.2.2, 6.4.2, 6.4.1, 7.3.1, 7.3.2, 8.2.1, 8.2.2, 8.2.3, 8.2.4, 10.2.1, 10.2.2, 10.2.3, 10.2.4
	GS9.2 The health service organisation has an open disclosure program that is consistent with the Australian open disclosure framework(1)	1.16.1
GS10 Feedback systems	GS10.1 The health service organisation seeks regular feedback from consumers: <ul style="list-style-type: none"> a. about their experiences and outcomes b. to use this information to improve safety and quality systems, and their performance 	1.20.1
	GS10.2 The health service organisation has organisation-wide complaint handling systems that: <ul style="list-style-type: none"> a. encourage and support consumers and the workforce to report complaints b. involve the workforce and consumers in the analysis of complaints c. provide timely feedback on the analysis of complaints to the highest level of governance, the workforce and consumers d. use information from the analysis of complaints to inform improvements in safety and quality e. monitor the implementation and resolution of actions that result from the analysis of complaints 	1.15.1, 1.15.2, 1.15.3, 1.15.4

Standard GS: Governance for safety and quality

Item	Action required	Link to v1
<p>GS11 Healthcare records systems</p>	<p>GS11.1 The health service organisation has healthcare records systems that:</p> <ul style="list-style-type: none"> a. make the healthcare record available to clinicians at the point of care b. comply with security and privacy regulations c. enable systematic audit of clinical information d. integrate multiple information systems, where they are in use 	<p>1.9.1, 1.9.2, 1.19.1, 1.19.2, 4.6.2</p>
	<p>GS11.2 Where computerised clinical information systems are used in conjunction with a consumer e-health record, the health service organisation:</p> <ul style="list-style-type: none"> a. has systems that are designed, implemented and monitored to provide safe and high-quality care b. uses standard national identifiers and terminologies for secure transmission of information c. uses national standard secure messaging to generate standard national e-referrals, discharge summaries and event summaries, and issue them to electronic healthcare records and other healthcare providers d. is able to receive and view information from electronic healthcare records 	<p>New action</p>

Performance and skills management systems

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

Item	Action required	Link to v1
GS12 Safety and quality training	GS12.1 The health service organisation: a. assesses its safety and quality training needs b. provides access to training to address its safety and quality training needs	1.4.1, 1.4.2, 1.4.3, 1.4.4, 2.6.1, 3.9.1, 3.10.1, 9.6.1
	GS12.2 Where Aboriginal and Torres Strait Islander people receive care in the organisation, the health service organisation has strategies to improve the cultural awareness and competency of the workforce	New action
	GS12.3 The health service organisation provides orientation for the workforce, including relevant contractors, locums and agency staff	1.4.1, 1.4.3
GS13 Performance management	GS13.1 The health service organisation has performance review systems that: a. ensure that members of the workforce regularly participate in reviews of their performance b. identify and record professional and personal safety and quality development needs c. incorporate these needs into the systems for training	1.11.1, 1.11.2, 1.12.1
GS14 Credentialing and scope of clinical practice	GS14.1 The health service organisation has systems that: a. define the scope of clinical practice for clinicians b. consider the clinical service capacity and service planning of the organisation when determining scope of practice c. monitor relevant clinicians to ensure that they are operating within their designated scope of clinical practice d. review the scope of clinical practice of relevant clinicians whenever a new clinical service, procedure or technology is introduced or significantly altered	1.10.1, 1.10.2, 1.10.3, 1.10.4
	GS14.2 The health service organisation conducts a credentialing process for relevant clinicians	New action
	GS14.3 The health service organisation provides supervision for clinicians whenever it is necessary for individuals to fulfil their designated role	1.10.5

Standard GS: Governance for safety and quality

Item	Action required	Link to v1
<p>GS15 Delegating safety and quality roles and responsibilities</p>	<p>GS15.1 The health service organisation has systems that:</p> <ul style="list-style-type: none"> a. assign safety and quality roles, responsibilities and accountabilities to clinicians, including locums and agency staff b. support the workforce to understand and perform their roles and responsibilities 	<p>1.3.1, 1.3.2, 1.3.3</p>
<p>GS16 Evidence-based care</p>	<p>GS16.1 The health service organisation has systems that:</p> <ul style="list-style-type: none"> a. 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 b. provide clinicians with ready access to best-practice guidelines, pathways and decision support tools relevant to their clinical practice 	<p>1.7.1, 1.7.2</p>

Safe environment for the delivery of care

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

Item	Action required	Link to v1
GS17 Safe environment for the delivery of care	GS17.1 The health service organisation: a. designs the environment to maximise safe and high-quality care within the constraints of the existing facilities, where relevant b. provides a quiet and safe environment when it is clinically required c. protects consumers, the workforce and visitors from violence and other forms of abuse	New action
	GS17.2 The health service organisation provides clear signage and directions for locating services and facilities	New action
	GS17.3 Where consumers are admitted, the health service organisation has systems that allow for consumer-based visitation	New action
	GS17.4 Where Aboriginal and Torres Strait Islander people receive care in the organisation, the health service organisation demonstrates a welcoming environment with consideration of cultural beliefs	New action

	No. actions in version 1	No. actions in version 2
Existing	53	18
New action or new components in an action	Not applicable	14
Total	53	32

Standard PC: Partnering with consumers

Status

This is an existing standard. It is an overarching standard that sets the requirements for partnering with consumers in organisational design and governance, and in their own care across all standards.

What has changed and why?

- In version 1 of the NSQHS Standards, this standard focused only on partnerships in organisational design and governance. The application of actions to health service organisations in different settings was not always clear. These actions have now been streamlined to reduce duplication, and better reflect the variety of contexts to which the NSQHS Standards apply.
- A new criterion has been added about health literacy and health information. For partnerships to work, everyone involved in the partnership needs to be able to give, receive, interpret and act on information in an effective way. The associated actions are intended to support this by ensuring that health literacy is embedded in the organisation's systems.
- A new criterion has been added about partnering with consumers in their own care, which builds on and replaces criteria from the previous Standards 3, 4, 5, 6, 7, 8 and 10 in version 2 of the NSQHS Standards. Considerable evidence indicates that partnering with consumers in their own care is associated with a better care experience. A better care experience is associated with higher levels of adherence to recommended prevention and treatment, better clinical outcomes, better consumer safety within hospitals and less use of health care. In addition, a focus on partnering with consumers in their own care, in parallel with improved care coordination and organisational accountability for outcomes, can contribute to cost savings by preventing overuse and underuse of health care, and improving overall quality.
- An action has been added about quality improvement. There has generally been little evaluation of systems for partnering with consumers, even though this is a central part of providing safe and high-quality care.
- An action has been added about understanding the diversity of the consumers who use the services. This is important because it is not possible to form effective partnerships without understanding who the partnerships should be formed with. The information gained in this action also informs service delivery and the development of systems across all the NSQHS Standards.

Standard PC: Partnering with consumers

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 the systems to partner with consumers.

Intention of this standard

Create an organisation where consumers are partners in:

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

Criteria

1. Governance systems

Systems are designed and used to support consumers to be partners in healthcare design, delivery, measurement and evaluation.

2. Partnering with consumers in organisational design and governance

Health service organisations understand the diversity and needs of consumers who use their services and, where relevant, their local population. Consumers are partners in the design and governance of the organisation.

3. Health literacy

Health literacy is embedded in the systems of the health service organisation. Consumers receive information that supports safer care and better health outcomes, and is easy to understand and use.

4. Partnering with consumers in their own care

Systems that are based on partnerships with consumers about their own care are used to support the delivery of care. Consumers are partners in their own care to the extent that they choose.

Standard PC: Partnering with consumers

Governance systems

Systems are designed and used to support consumers to be partners in healthcare design, delivery, measurement and evaluation.

Item	Action required	Link to v1
PC1 Integrated safety and quality systems	PC1.1 The health service organisation integrates systems for partnering with consumers with the systems from Standard GS: Governance for safety and quality	New action
PC2 Quality improvement	PC2.1 The health service organisation and workforce use the organisation-wide quality improvement systems to: <ol style="list-style-type: none"> monitor the effectiveness of the systems for partnering with consumers take action to improve the systems and their performance for partnering with consumers report on effectiveness and outcomes 	New action

Partnering with consumers in organisational design and governance

Health service organisations understand the diversity and needs of consumers who use their services and, where relevant, their local population. Consumers are partners in the design and governance of the organisation.

Item	Action required	Link to v1
PC3 Partnerships in planning, design, delivery, measurement and evaluation	PC3.1 The health service organisation involves consumers in partnerships to plan, design, deliver, measure and evaluate health care	2.1.1, 2.2.1, 2.2.2, 2.5.1, 2.8.1, 2.8.2, 2.9.1, 2.9.2
	PC3.2 The health service organisation provides orientation, support and/or education to enable consumers to fully participate as partners with the organisation	1.18.3, 2.3.1
	PC3.3 The health service organisation involves consumers in partnerships that reflect the diversity of consumers who use the services or, where relevant, the local population	2.1.2
	PC3.4 Where Aboriginal and Torres Strait Islander people receive care in the organisation, the health service organisation works in partnership with the Aboriginal and Torres Strait Islander community to meet the needs of this group	New action
	PC3.5 The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	2.6.2
	PC3.6 The health service organisation provides information that is easy to understand and use to consumers about how: <ol style="list-style-type: none"> it partners with consumers consumers can be involved in partnerships with the organisation 	2.7.1

Standard PC: Partnering with consumers

Health literacy

Health literacy is embedded in the systems of the health service organisation. Consumers receive information that supports safer care and better health outcomes, and is easy to understand and use.

Item	Action required	Link to v1
PC4 Information that is easy to understand and use	PC4.1 The health service organisation provides information about health and health care that is tailored to the diversity of the consumers who use its services and, where relevant, the local population	New action
	PC4.2 Where information for consumers about health and health care is developed internally, the health service organisation involves consumers in its development and review	2.4.1, 2.4.2, 4.15.2
	PC4.3 Clinicians provide consumers with information about health and health care that: <ol style="list-style-type: none"> is easy to understand and use is in a format that meets their needs includes information about treatment and options, risks and benefits, the care plan, what they need to do after leaving the organisation, and managing their medicines, where relevant 	1.18.3, 3.19.1, 3.19.2, 4.15.1, 7.9.1, 8.9.1, 9.7.1, 9.9.2, 10.9.1

Partnering with consumers in their own care

Systems that are based on partnerships with consumers about their own care are used to support the delivery of care. Consumers are partners in their own care to the extent that they choose.

Item	Action required	Link to v1
PC5 Healthcare rights and informed consent	PC5.1 The health service organisation has a charter of rights that is: <ol style="list-style-type: none"> consistent with the Australian charter of healthcare rights(2) easily accessible for consumers 	1.17.1, 1.17.2, 1.17.3
	PC5.2 The health service organisation ensures that its informed consent systems comply with legislation and best practice	1.18.2, 7.11.1
	PC5.3 The health service organisation has systems to identify the capacity of a consumer to make decisions about their own care and provide informed consent	New action
	PC5.4 The health service organisation has systems to identify a substitute decision maker if a consumer does not have the capacity to make decisions for themselves	New action
PC6 Working together to share decisions and plan care	PC6.1 Clinicians work with consumers to plan, communicate, set goals and make decisions about their care	1.18.1, 6.5.1, 7.9.2, 8.10.1, 10.10.1

Standard PC: Partnering with consumers

Item	Action required	Link to v1
	PC6.2 Clinicians work in partnership with consumers or substitute decision makers to discuss and document preferences and goals for future care when the consumer is experiencing a mental illness, experiencing cognitive impairment or approaching the end of life	1.18.4
	PC6.3 The health service organisation has systems to identify any support people a consumer wants involved in communications and decision making about their care	New action
	PC6.4 The health service organisation has systems to ensure that carers are supported to participate in the provision of health care in accordance with the wishes of the consumer and the carer	New action
	PC6.5 The health service organisation builds the capacity of the workforce to form partnerships with consumers in their own care	2.6.1

	No. actions in version 1	No. actions in version 2
Existing	15	12
New action or new components in an action	Not applicable	8
Total	15	20

Standard CC: Comprehensive care

Status

This is a new standard.

Why has this standard been added?

Since the development of version 1 of the NSQHS Standards, the Commission has developed new program areas focusing on the safety and quality risks faced by people living with mental illness or cognitive impairment, or who are at the end of life. Concerns have also been raised with the Commission about issues such as the maintenance of personal hygiene, continence, skin integrity, mobility, and ambulation and nutritional status.

Safety and quality gaps are frequently reported as failures to provide adequate care for specific conditions or in specific situations or settings, or as a failure to achieve expected outcomes in particular populations. This kind of reporting can mean that the cross-cutting issues underlying such failures are not considered. It is possible to make improvements to the care of all consumers if underlying issues and processes are identified and targeted. That is the purpose of this standard.

Although the identified issues are numerous and diverse, common causative factors underpin failures to provide adequate care. Inadequate screening, assessment, risk identification and care planning can result in failures to deliver care that meets a consumer's needs. Unless clinicians work with consumers to identify what is important to them in the context of their healthcare needs, care cannot be delivered in a way that is consistent with the consumer's preferences. There is also clear evidence that the way that clinicians operate and collaborate can have a significant impact on the delivery of safe and high-quality care, as well as having implications for efficiency and cost.

Addressing these issues requires clinicians, consumers and other members of the healthcare workforce to work together to achieve the best possible outcome for the consumer. The best possible outcome can only be determined by understanding the preferences of the consumer and what is clinically appropriate. This standard is about creating a system for clinicians to identify a consumer's healthcare needs and work with them to identify shared goals for an episode of health care. Developing a comprehensive care plan based on clearly identified goals enables clinicians to work collaboratively to deliver care that is aligned with the consumer's preferences and clinical needs.

Standard CC: Comprehensive care

A range of projects and programs in Australia and internationally already support the delivery of this kind of comprehensive health care. Examples are the Essentials of Care program, integrating physical and mental health care, and improving teamwork through programs such as TeamSTEPPS. Key features of these types of initiatives include:

- understanding the broad range of needs of a consumer rather than focusing only on treatment of a disease or a set of symptoms
- providing care that aligns with the goals, needs and preferences of the consumer receiving care
- ensuring that care is always delivered with dignity and respect for the consumer
- supporting clinicians to enable provision of the desired care
- ensuring that care is integrated across clinicians, professions and settings.

Building these elements into the NSQHS Standards recognises the importance of having systems to support the delivery of health care, and ensuring that consumers receive care that is safe and of high quality.

Standard CC: Comprehensive care

Leaders of a health service organisation establish and maintain systems and processes to support clinicians to deliver comprehensive care. The workforce uses the systems to deliver comprehensive care.

Intention of this standard

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

Criteria

1. Systems to support comprehensive care

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

2. Development of comprehensive care plans

Integrated screening, assessment and risk identification processes are used to develop care plans that are based on agreed goals of care.

3. Delivery of comprehensive care

Safe care is delivered based on the comprehensive care plan.

Standard CC: Comprehensive care

Systems to support comprehensive care

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

Item	Action required	Link to v1
CC1 Integrated safety and quality systems	CC1.1 The health service organisation integrates systems for comprehensive care with the systems from Standard GS: Governance for safety and quality, and Standard PC: Partnering with consumers	New action
CC2 Quality improvement	CC2.1 The health service organisation and workforce use the organisation-wide quality improvement system to: <ol style="list-style-type: none"> a. monitor the delivery of comprehensive care b. take action to improve systems and their performance of comprehensive care c. report on effectiveness and outcomes 	New components 1.8.2, 8.5.2, 8.7.3, 8.7.4, 8.8.3, 8.8.4, 10.3.1, 10.5.2, 10.5.3, 10.6.2, 10.6.3
CC3 Designing systems to deliver comprehensive care	CC3.1 The health service organisation supports clinicians to apply organisation-wide systems to the local service context to deliver comprehensive care	New action
	CC3.2 The health service organisation has systems to match consumers with the clinical setting that addresses their care needs	New action
	CC3.3 The health service organisation has systems for timely referral and transfer of consumers with specialist healthcare needs to appropriate services	New action
CC4 Collaboration and teamwork	CC4.1 The health service organisation defines how clinicians responsible for coordinating a consumer's care and clinicians with decision-making authority will work collaboratively to deliver comprehensive care	New action
	CC4.2 The health service organisation has systems that: <ol style="list-style-type: none"> a. identify a clinician who can make definitive decisions about a consumer's care at all times b. clearly define the roles and responsibilities of each clinician working in a team c. support clinicians to work and communicate in a coordinated, accountable, multidisciplinary way 	New action

Development of comprehensive care plans

Integrated screening, assessment and risk identification processes are used to develop care plans that are based on agreed goals of care.

Item	Action required	Link to v1
CC5 Screening and assessment of risks	CC5.1 The health service organisation has systems for integrated and timely screening, assessment and risk identification relevant to the consumers who use its services	New components 1.8.1
	CC5.2 The health service organisation has systems to routinely ask consumers if they identify as Aboriginal or Torres Strait Islander, and to record this information in administrative and clinical information systems	New action
	CC5.3 Clinicians, as part of a formal screening process or during clinical examination and history taking: <ul style="list-style-type: none"> a. screen for cognitive, behavioural, mental and physical conditions and risks relevant to the consumers who use the organisation's services b. use agreed, validated and/or best-practice tools, where available c. gather information about the consumer's socioeconomic status, and their social and geographic circumstances 	8.5.1, 8.5.3, 10.5.1, 10.5.3
	CC5.4 Clinicians comprehensively assess: <ul style="list-style-type: none"> a. conditions and risks identified through the screening process b. where relevant, risks associated with: <ul style="list-style-type: none"> o pressure injuries o falls o malnutrition and dehydration o cognitive impairment and delirium o end-of-life care o challenging behaviours and self-harm 	10.6.1
	CC5.5 Clinicians document the findings of the screening, risk identification and assessment processes, including any relevant alerts, in the healthcare record	8.6.1, 10.7.1

Standard CC: **Comprehensive care**

Item	Action required	Link to v1
<p>CC6 Comprehensive care planning</p>	<p>CC6.1 Clinicians develop and document an integrated and individualised care plan that includes:</p> <ul style="list-style-type: none"> a. consideration of the consumer’s preferences, personal circumstances and information from carers b. strategies and actions for managing identified clinical risks c. clearly articulated goals for the consumer’s episode of care d. the treatment plan and actions to be taken to achieve the goals e. a discharge plan that is commenced at the beginning of the episode of care 	<p>New components 8.7.1, 8.8.2, 10.8.1.</p>

Standard CC: **Comprehensive care**

Delivery of comprehensive care

Safe care is delivered based on the comprehensive care plan.

Item	Action required	Link to v1
CC7 Use of the care plan	<p>CC7.1 Clinicians work in partnership with the consumer, and their family and carers to:</p> <ul style="list-style-type: none"> a. implement the comprehensive care plan in a timely way b. use the plan as the basis for ongoing care c. monitor the effectiveness of the plan d. reassess the consumer's needs if changes in diagnosis, behaviour, cognition, mental state or physical condition occur e. review and adapt the plan if it is not meeting the consumer's needs 	New components 8.7.2

	No. actions in version 1	No. actions in version 2
Existing	0	3
New action or new components in an action	Not applicable	11
Total	0	14

Standard RH: Reducing harm

Status

This is a new standard. It incorporates elements from version 1 of the NSQHS Standards relating to pressure injuries and falls.

Why has this standard been added?

A number of additional safety and quality risks have been identified by the Commission since the development of version 1 of the NSQHS Standards. Standard RH addresses specific risks that can cause serious harm to consumers.

The NSQHS Standard CC: Comprehensive care addresses some of the factors that contribute to unsafe and poor-quality care for everyone, with a specific focus on integrated screening, assessment and risk identification processes to develop an individualised care plan. Screening and assessment may identify specific risks of harm that need to be managed in particular ways. Actions to address some of these specific risks are included in Standard RH.

This standard includes actions to prevent and manage harm in six specific risk areas: pressure injuries, falls, nutrition and hydration, cognitive impairment, end-of-life care, and challenging behaviour and self-harm.

Two of these areas, pressure injuries and falls, were stand-alone standards in version 1 of the NSQHS Standards. They remain important safety issues, particularly in organisations that deliver inpatient care. Many of the actions that were in version 1 of the NSQHS Standards are now reflected in the broader screening, assessment and care planning processes required under Standard CC. The remaining actions are reflected in this standard.

The third area relates to nutrition and hydration. There is clear evidence that nutrition and hydration are important in preventing safety and quality problems in health care. Malnutrition is associated with a twofold increase in the risk of pressure injuries, hospital-acquired infections and mortality. The estimated prevalence of malnutrition in adults receiving care in acute and subacute settings is 30%, highlighting the need to address this safety and quality issue in the NSQHS Standards.

The three remaining areas are informed by the Commission's work on the safety and quality issues facing consumers who live with cognitive impairment or mental illness, or who are at the end of life. This work, which involved broad consultation, identified that a significant proportion of such people are at specific risk of harm when they receive health care. Actions to address key aspects of these risks are reflected in this standard.

Standard RH: Reducing harm

Leaders of a health service organisation establish and maintain systems to prevent and manage specific risks of harm for consumers during the delivery of health care. The workforce uses the systems to prevent harm and deliver safe care.

Intention of this standard

Ensure that risks of harm for consumers during health care are prevented and managed. Clinicians identify consumers at risk of specific harm during health care by applying the screening and assessment processes required in Standard CC: Comprehensive care.

Criteria

1. Governance systems

Systems are in place to prevent and manage risks of harm for consumers during health care.

2. Pressure injuries

Systems are used to prevent pressure injuries. Where injuries occur, they are managed effectively.

3. Falls

Systems are used to reduce the risk of consumers falling, and minimise harm from falls.

4. Malnutrition and dehydration

Systems are used to recognise and meet the nutrition and hydration needs of consumers.

5. Cognitive impairment and delirium

Systems are used to recognise and prevent delirium, and to manage risks of harm from cognitive impairment.

6. End-of-life care

Systems are used to identify consumers at the end of life, and to provide safe and high-quality care.

7. Challenging behaviours and self-harm

Systems are used to manage and prevent harm that results from the behaviour of consumers. Use of restrictive practices is minimised. Where used, such practices are implemented in accordance with legislation.

Standard RH: Reducing harm

Governance systems

Systems are in place to prevent and manage risks of harm for consumers during health care.

Item	Action required	Link to v1
RH1 Integrated safety and quality systems	RH1.1 The health service organisation integrates systems for reducing harm with the systems from Standard GS: Governance for safety and quality, and Standard PC: Partnering with consumers	8.1.1, 8.1.2, 8.9.1, 8.10.1, 10.1.1, 10.1.2, 10.9.1, 10.10.1
RH2 Quality improvement	RH2.1 The health service organisation and workforce use the organisation-wide quality improvement system to: <ol style="list-style-type: none"> monitor the effectiveness of relevant systems to prevent specific risks of harm take action to improve the systems and their performance of reducing harm report on effectiveness and outcomes 	8.3.1, 8.5.3, 8.6.2, 8.6.3, 10.7.2, 10.7.3

Pressure injuries

Systems are used to prevent pressure injuries. Where injuries occur, they are managed effectively.

Item	Action required	Link to v1
RH3 Pressure injuries	RH3.1 The health service organisation has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines	8.8.1
	RH3.2 Where care is provided to consumers at risk of pressure injuries, clinicians conduct comprehensive skin inspections, and provide pressure injury prevention and care in accordance with the timeframes and frequency set out in best-practice guidelines	8.6.1, 8.7.1
	RH3.3 Where care is provided to consumers at risk of, or with, pressure injuries, the health service organisation ensures that equipment and devices are available to reduce the risks and effectively manage pressure injuries	8.4.1

Standard RH: Reducing harm

Falls

Systems are used to reduce the risk of consumers falling, and minimise harm from falls.

Item	Action required	Link to v1
RH4 Falls	RH4.1 The health service organisation has multifactorial falls prevention and harm minimisation systems that are consistent with best practice	10.7.1
	RH4.2 Where care is provided to consumers at risk of falling, the health service organisation ensures that equipment and devices are available to promote safe mobility and manage the risks of falls	10.4.1
	RH4.3 Clinicians work in partnership with consumers to: <ol style="list-style-type: none"> provide information about the risk of falls refer consumers at risk of falling to appropriate services, where available 	10.8.1

Malnutrition and dehydration

Systems are used to recognise and meet the nutrition and hydration needs of consumers.

Item	Action required	Link to v1
RH5 Malnutrition and dehydration	RH5.1 Where a health service organisation admits consumers and provides overnight care, it has systems for the preparation and distribution of food and fluids to the consumer that are consistent with the care plan, and suitable for the consumer's needs and preferences	New action
	RH5.2 Where a health service organisation admits consumers and provides overnight care, the organisation, clinicians, and the workforce preparing and distributing food and fluids use systems to support consumers who: <ol style="list-style-type: none"> require assistance with eating and drinking require special diets are malnourished or at risk of becoming malnourished 	New action
	RH5.3 Where a health service organisation admits consumers and provides overnight care, it has systems to identify and provide access to nutritional support for consumers who cannot meet their nutritional requirements with food alone	New action

Cognitive impairment

Systems are used to recognise and prevent delirium, and to manage risks of harm from cognitive impairment.

Item	Action required	Link to v1
RH6 Cognitive impairment	<p>RH6.1 Where care is provided to consumers at risk of delirium, or with cognitive impairment, the health service organisation has systems that:</p> <ul style="list-style-type: none"> a. incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan b. recognise and minimise consumers' distress while they are receiving care c. avoid the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation 	New action

End-of-life care

Systems are used to identify consumers at the end of life, and to provide safe and high-quality care.

Item	Action required	Link to v1
RH7 End-of-life care	<p>RH7.1 Where end-of-life care is provided, the health service organisation has systems to identify people who are approaching the end of life</p>	New action
	<p>RH7.2 Where end-of-life care is provided, the health service organisation has systems to ensure that advance care plans:</p> <ul style="list-style-type: none"> a. can be received from consumers b. are documented in the healthcare record c. are easily available at the point of care 	9.8.1, 9.8.2
	<p>RH7.3 Where end-of-life care is provided, the health service organisation has systems that:</p> <ul style="list-style-type: none"> a. define the criteria and processes for clinicians to access help when managing end-of-life issues b. provide access to specialist palliative care advice that is readily available c. provide access to supervision and support for clinicians delivering end-of-life care d. support organ and tissue donations e. review the safety and quality of end-of-life care that is provided against the planned goals of care 	New action

Challenging behaviours and self-harm

Systems are used to manage and prevent harm that results from the behaviour of consumers. Use of restrictive practices is minimised. Where used, such practices are implemented in accordance with legislation.

Item	Action required	Link to v1
RH8 Challenging behaviours and self-harm	RH8.1 The health service organisation has systems to ensure that consumers at risk of suicide and self-harm are monitored, in accordance with best practice and the consumer's clinical acuity	New action
	RH8.2 The health service organisation has systems to monitor and respond to consumers who are at risk of challenging behaviours that may cause harm to themselves or others	New action
	RH8.3 The health service organisation has systems to promote and maintain the sexual safety of consumers, the workforce and visitors	New action
RH9 Restraint	RH9.1 Where care is provided to consumers with challenging behaviours and/or restraint is used, the health service organisation has systems that: <ol style="list-style-type: none"> minimise and, where possible, eliminate the use of restraint govern the use of restraint in accordance with legislation require clinicians to obtain authorisation for, and document, all instances of restraint report rates of restraint to the highest level of governance 	New action
RH10 Seclusion	RH10.1 Where a health service organisation is allowed under legislation to use seclusion: <ol style="list-style-type: none"> clinicians use seclusion in accordance with that legislation there are strategies to minimise and, where possible, eliminate the use of seclusion 	New

	No. actions in version 1	No. actions in version 2
Existing	0	9
New action or new components in an action	Not applicable	11
Total	0	20

Standard CS: Communicating for safety

Status

This is an existing standard. The scope has been changed.

What has changed and why?

- The scope has been expanded from a focus on clinical handover to communication more broadly. In version 1 of the NSQHS Standards, Standard 6: Clinical handover was often interpreted narrowly as only referring to shift-to-shift handover. However, it is known that, to ensure safe and high-quality health care, effective communication is critical at all points where information is transferred. The standard now focuses on ensuring safe care by supporting the principles of continuity and coordination of care. This includes communicating when information emerges that requires a change in care for the consumer.
- To reflect this change in scope, actions have been added that more explicitly outline where communication is critical for safe care.
- There is now clearer delineation in the standard about the organisation-wide governance processes that are needed to support communication, and the need to develop or adapt processes locally to reflect the context of the organisation. Communication is a variable process, and flexibility is needed to ensure that it is appropriate for the nature of the organisation and the consumers who use the service.
- One part of ensuring effective communication is ensuring that consumers are correctly identified throughout their care. With the removal of NSQHS Standard 5: Consumer identification and procedure matching from version 1 of the NSQHS Standards, a criterion has been added to Standard CS about the need for an organisation-wide consumer identification system.

Standard CS: Communicating for safety

Leaders of a health service organisation establish and maintain systems for structured and effective communication between health service organisations, within health service organisations, between clinicians, and between clinicians and consumers. The workforce uses these systems to communicate to ensure safety.

Intention of this standard

Ensure there is timely, purpose-driven and structured communication that supports continuous, coordinated and safe care for consumers.

Criteria

1. Governance and organisational systems for effective communication

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

2. Communication at clinical handover

Systems for structured clinical handover are used to effectively communicate about the care of consumers.

3. Communication of critical information

Systems to communicate new and critical information and clinical concerns or risks are used to effectively communicate with clinicians who can make decisions about the care of consumers.

4. Documentation of information

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

5. Correct identification

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

Standard CS: **Communicating for safety**

Governance and organisational systems for effective communication

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

Item	Action required	Link to v1
CS1 Integrated safety and quality systems	CS1.1 The health service organisation integrates systems for communicating for safety with the systems in Standard GS: Governance for safety and quality, and Standard PC: Partnering with consumers	New action
CS2 Quality improvement	CS2.1 The health service organisation and workforce use the organisation-wide quality improvement systems to: <ol style="list-style-type: none"> a. monitor the effectiveness and performance of clinical communication systems b. take action to improve the systems and their performance for communicating for safety c. report on effectiveness and outcomes 	5.1.2, 5.5.3, 6.1.2, 6.1.3, 6.3.1, 6.3.2, 6.3.3, 6.3.4
CS3 Communication systems	CS3.1 The health service organisation has systems to: <ol style="list-style-type: none"> a. identify the clinical communication needs of the organisation b. address these communication needs 	New action
CS4 Application of communication systems in the local service context	CS4.1 Clinicians apply organisation-wide systems for communication to the local service context to enable communication, collaboration and coordination between clinicians and between organisations, to ensure continuity of care	New action

Communication at clinical handover

Systems for structured clinical handover are used to effectively communicate about the care of consumers.

Item	Action required	Link to v1
<p>CS5 Clinical handover</p>	<p>CS5.1 The health service organisation has systems for structured clinical handover, at times when all or part of the care of a consumer is transferred between organisations, within the organisation and between clinicians</p>	<p>6.1.1</p>
	<p>CS5.2 The health service organisation and clinicians define the minimum dataset of information to be communicated at clinical handover, based on the risks relevant to the local context, consumers who use the service and best practice</p>	<p>New action</p>
	<p>CS5.3 Clinicians use structured clinical handover processes that include:</p> <ul style="list-style-type: none"> a. preparing and planning for handover, including setting the location, time and mode of communication b. having information from all relevant sources c. organising relevant clinicians and others to participate d. supporting consumers, family members and carers to be involved in handover e. being aware of the clinical context and the consumer's goals and preferences f. ensuring that handover results in the transfer of responsibility and accountability for care 	<p>6.2.1</p>

Standard CS: Communicating for safety

Communication of critical information

Systems to communicate new critical information, concerns or risks are used to effectively communicate with clinicians who can make decisions about the care of consumers.

Item	Action required	Link to v1
CS6 Communicating critical information	CS6.1 The health service organisation has systems to communicate new critical information and clinical concerns or risks about a consumer's care in a timely manner to clinicians who can make decisions about care	New action
	CS6.2 Clinicians use the systems to communicate new or critical information, and clinical concerns to clinicians who can make decisions about care, the consumer, and family and carers identified as support people	New action

Documentation of information

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

Item	Action required	Link to v1
CS7 Documentation of information	CS7.1 The health service organisation has systems to contemporaneously document information in the healthcare record when: a. new critical information and clinical concerns or risks are identified b. changes occur in the care plan	New action

Correct identification

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

Item	Action required	Link to v1
CS8 Correct identification	<p>CS8.1 The health service organisation has organisation-wide systems that:</p> <ul style="list-style-type: none"> a. define approved identifiers for consumers b. require at least three approved identifiers on registration and admission; when care, therapy and other services are provided; and whenever clinical handover, transfer or discharge documentation is generated c. specify the mechanisms used to correctly match consumers with their care d. ensure that these mechanisms align with nationally agreed policies, where they exist e. specify what information should be documented about the process of identification and procedure matching 	5.1.1, 5.3.1, 5.4.1, 5.5.1, 5.5.2

	No. actions in version 1	No. actions in version 2
Existing	11	4
New action or new components in an action	Not applicable	7
Total	11	11

Standard IP: Healthcare-associated infection prevention

Status

This is an existing standard.

What has changed and why?

- The standard has an increased focus on risk management, so that the actions taken are appropriate for the context of the organisation and consumers.
- Criteria and actions have been streamlined and reordered to better reflect the components of a comprehensive infection control program.
- Actions have been made more specific to address known gaps in practice.
- A stronger focus is placed on antimicrobial stewardship to reflect the importance of this strategy in addressing antimicrobial resistance. Actions to address antimicrobial stewardship have been extended to include the Antimicrobial Stewardship Clinical Care Standard(3), which was released in 2014. This supports organisations to further develop their own antimicrobial stewardship programs.
- In version 1 of the NSQHS Standards, environmental cleaning was included in a criterion about cleaning, disinfection and sterilisation. Environmental cleaning is now included with infection prevention and control strategies, leaving reprocessing of reusable medical devices as a stand-alone criterion.

Standard IP: Preventing and controlling healthcare-associated infections

Leaders of a health service organisation describe, implement and monitor systems to prevent and manage healthcare-associated infections and antimicrobial resistance, to achieve good health outcomes for consumers. The workforce uses these systems.

Intention of this standard

Reduce the risk of consumers acquiring preventable healthcare-associated infections, effectively manage infections if they occur, and limit the development of antimicrobial resistance through prudent use of antimicrobials as part of antimicrobial stewardship.

Criteria

1. Governance and quality improvement for preventing and controlling healthcare-associated infections

Systems are in place to support and promote infection prevention and control.

2. Infection prevention and control systems

Evidence-based systems are used to prevent and control healthcare-associated infections. Consumers presenting with, or with risk factors for, infection or colonisation with an organism of local, national or global significance are identified promptly, and receive the necessary management and treatment. The health service organisation is clean and hygienic.

3. Antimicrobial stewardship

Systems are in place for the safe and appropriate prescribing and use of antimicrobials.

4. Reprocessing of reusable medical devices

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

Governance and quality improvement for preventing and controlling healthcare-associated infections

Systems are in place to support and promote infection prevention and control.

Item	Action required	Link to v1
<p>IP1 Integrated safety and quality systems</p>	<p>IP1.1 The health service organisation integrates systems for preventing and controlling healthcare-associated infections with systems in Standard GS: Governance for safety and quality, and Standard PC: Partnering with consumers</p>	<p>New action</p>
<p>IP2 Quality improvement</p>	<p>IP2.1 The health service organisation and workforce use the organisation-wide quality improvement systems to:</p> <ul style="list-style-type: none"> a. monitor the systems for healthcare-associated infection prevention, control and performance b. take action to improve the systems and their performance of healthcare-associated infection prevention c. report on effectiveness and outcomes 	<p>3.1.2, 3.1.3, 3.1.4, 3.3.2, 3.4.1, 3.4.2, 3.4.3, 3.10.3, 3.11.2, 3.11.3, 3.11.4, 3.11.5, 3.14.4, 3.15.3</p>
<p>IP3 Risk management</p>	<p>IP3.1 The health service organisation uses information from the risk management systems to reduce the risk of healthcare-associated infections</p>	<p>3.1.1</p>
<p>IP4 Surveillance</p>	<p>IP4.1 The health service organisation's infection prevention and control systems have a surveillance strategy for healthcare-associated infections that:</p> <ul style="list-style-type: none"> a. collects data on healthcare-associated infections relevant to the size and scope of the organisation b. monitors, assesses and uses surveillance data to reduce the risks associated with healthcare-associated infections c. reports surveillance data on healthcare-associated infections to the workforce, the highest level of governance, consumers and other relevant groups 	<p>3.2.1, 3.2.2, 3.3.1, 3.3.2</p>

Infection prevention and control systems

Evidence-based systems are used to prevent and control healthcare-associated infections. Consumers presenting with, or with risk factors for, infection or colonisation with an organism of local, national or global significance are identified promptly, and receive the necessary management and treatment. The health service organisation is clean and hygienic.

Item	Action required	Link to v1
IP5 Standard and transmission-based precautions	IP5.1 The health service organisation has systems to apply standard and transmission-based precautions that are consistent with the current edition of the <i>Australian guidelines for the prevention and control of infection in healthcare</i> (4), and jurisdictional requirements	3.11.1
	IP5.2 Clinicians assess the need for transmission-based precautions that are based on risk of transmission of infectious agents, including consideration of each of the following: <ul style="list-style-type: none"> a. consumers' needs at referral, admission or presentation for care, and whenever clinically required b. whether a consumer's pre-existing colonisation or infection is with organisms of local or national significance, or a communicable disease c. accommodation needs d. environmental controls required e. precautions required when the consumer needs to be moved f. environmental cleaning procedures g. equipment requirements 	3.12.1, 3.13.1
	IP5.3 The health service organisation has systems for communicating relevant details of a consumer's infectious status whenever responsibility for care is transferred between clinicians or health service organisations	3.13.2
IP6 Hand hygiene	IP6.1 The health service organisation has a hand hygiene program that: <ul style="list-style-type: none"> a. is consistent with the current national hand hygiene initiative and jurisdictional requirements b. addresses noncompliance or inconsistency with the current national hand hygiene initiative 	3.5.1, 3.5.2, 3.5.3
IP7 Aseptic technique	IP7.1 The health service organisation has protocols for aseptic technique and assesses competence	3.10.1, 3.10.2, 3.10.3

Standard IP: Healthcare-associated infection prevention

Item	Action required	Link to v1
IP8 Invasive devices	IP8.1 The health service organisation has systems for the appropriate use and management of invasive devices that are consistent with the current edition of the <i>Australian guidelines for the prevention and control of infection in healthcare</i> (4)	3.8.1
IP9 Clean environment	IP9.1 The health service organisation has systems to maintain a clean and hygienic environment that: <ul style="list-style-type: none"> a. respond to the environmental risks b. require cleaning and disinfection in line with recommended cleaning frequencies in the current edition of the <i>Australian guidelines for the prevention and control of infection in healthcare</i>(4), and jurisdictional requirements c. include maintenance, repair and upgrade of buildings, equipment, furnishings and fittings d. include training in the appropriate use of personal protective equipment for the workforce 	3.15.1, 3.15.3
IP10 Workforce immunisation	IP10.1 The health service organisation has a risk-based workforce immunisation program that: <ul style="list-style-type: none"> a. is consistent with the current edition of <i>The Australian immunisation handbook</i>(5) b. is consistent with jurisdictional requirements for vaccine-preventable diseases c. addresses specific risks to clinicians and consumers 	3.6.1

Antimicrobial stewardship

Systems are in place for the safe and appropriate prescribing and use of antimicrobials.

Item	Action required	Link to v1
<p>IP11 Antimicrobial stewardship</p>	<p>IP11.1 The health service organisation has an antimicrobial stewardship program that:</p> <ul style="list-style-type: none"> a. includes an antimicrobial stewardship policy that incorporates recommendations and principles from the Antimicrobial Stewardship Clinical Care Standard(3) 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 includes restriction rules and approval processes d. monitors antimicrobial prescribing and use e. evaluates performance of the program, identifies areas for improvement, and takes action to improve the appropriateness of antimicrobial prescribing and use f. uses surveillance data on antimicrobial resistance to support appropriate prescribing g. reports to clinicians and the highest level of governance in relation to <ul style="list-style-type: none"> o compliance with the antimicrobial stewardship policy o antimicrobial use and resistance o appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobials 	<p>3.14.1, 3.14.2, 3.14.3, 3.14.4</p>

Reprocessing of reusable medical devices

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

Item	Action required	Link to v1
IP12 Reprocessing of reusable devices	<p>IP12.1 Where reusable equipment, instruments and devices are used, the health service organisation has:</p> <ul style="list-style-type: none"> a. systems for reprocessing that are consistent with relevant national and international standards and in conjunction with manufacturers' guidelines b. a traceability system that is capable of identifying the consumer, the procedure; and the reusable equipment, instruments and devices that were used for the procedure 	3.16.1, 3.17.1

	No. actions in version 1	No. actions in version 2
Existing	41	13
New action or new components in an action	Not applicable	1
Total	41	14

Standard MS: Medication safety

Status

This is an existing standard.

What has changed and why?

- In version 1 of the NSQHS Standards, much of the information about what was required for this standard was included at the item level, rather than the action level. Most of the information that was at the item level has now been included in the actions to make them more specific.
- Actions have been clarified and made more specific to address identified areas of confusion.
- Actions have been added about medication review to address identified gaps in the standard about assessment of a person's ongoing medication management. This change supports the Australian Pharmaceutical Advisory Council's *Guiding principles to achieve continuity in medication management*(6).

Standard MS: Medication safety

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 medicines use. The workforce uses these systems.

Intention of this standard

Ensure clinicians are competent to safely prescribe, dispense, administer and monitor appropriate medicines.

Criteria

1. Governance and quality improvement for medication management

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

2. Documentation of consumer information

A consumer's medication history is accurately recorded, and the history is available throughout the episode of care.

3. Continuity of medication management

A consumer's medicines are reviewed, and a medicines list is provided to them and the receiving clinician when handing over care or changing medicines.

4. Medication management processes

Clinicians are supported to safely prescribe, dispense, administer, store, manufacture, distribute, compound, monitor and dispose of medicines.

Standard MS: **Medication safety**

Governance and quality improvement for medication management

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

Item	Action required	Link to v1
MS1 Integrated safety and quality systems	MS1.1 The health service organisation integrates systems for medication safety with the systems in Standard GS: Governance for safety and quality, and Standard PC: Partnering with consumers	4.1.1
MS2 Quality improvement	MS2.1 The health service organisation and workforce use the organisation-wide quality improvement system to: <ol style="list-style-type: none"> a. monitor the effectiveness of the medication management systems and their performance b. take action to improve the systems and their performance of medication safety c. report on effectiveness and outcomes 	4.2.1, 4.2.2, 4.3.2, 4.3.3, 4.5.1, 4.5.2, 4.7.2, 4.9.2, 4.9.3, 4.10.2, 4.10.6, 4.12.4
MS3 Medicines scope of clinical practice	MS3.1 The health service organisation has systems to define the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians	4.3.1

Standard MS: **Medication safety**

Documentation of consumer information

A consumer's medication history is accurately recorded, and the history is available throughout the episode of care.

Item	Action required	Link to v1
MS4 Medication reconciliation	MS4.1 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	4.6.1
	MS4.2 Clinicians review a consumer's current medicine orders against their medication history and the medication plan, and reconcile any discrepancies on presentation and at transitions of care	4.8.1
MS5 Adverse drug reactions	MS5.1 The health service organisation has systems for documenting a consumer's history of medicine allergies and adverse drug reactions in the healthcare record on presentation	4.7.1
	MS5.2 The health service organisation has systems for documenting adverse drug reactions that occur during an episode of care in the healthcare record and in the organisation-wide incident reporting system	4.7.1
	MS5.3 The health service organisation has systems for reporting adverse drug reactions to the Therapeutic Goods Administration in accordance with its requirements	4.7.3

Continuity of medication management

A consumer's medicines are reviewed, and a medicines list is provided to them and the receiving clinician when handing over care or changing medicines.

Item	Action required	Link to v1
MS6 Medication review	MS6.1 The health service organisation has systems: <ol style="list-style-type: none"> a. to undertake medication reviews for consumers, in line with evidence and best practice b. to prioritise medication reviews based on the clinical acuity of a consumer c. that specify the requirements for documentation of medication reviews 	New components 4.8.1
MS7 Provision of a medicines list	MS7.1 The health service organisation has systems to: <ol style="list-style-type: none"> 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 consumers at discharge with a current medicines list and the reasons for any changes 	4.8.1, 4.12.1, 4.12.2, 4.12.3

Standard MS: Medication safety

Medication management processes

Clinicians are supported to safely prescribe, dispense, administer, store, manufacture, distribute, compound, monitor and dispose of medicines.

Item	Action required	Link to v1
MS8 Medicines information and decision support tools	MS8.1 The health service organisation ensures that information and decision support tools for medicines are available to clinicians at the point of care	4.9.1
MS9 Safe and secure storage and distribution of medicines	MS9.1 The health service organisation complies with manufacturers' directions, legislation and jurisdictional requirements: <ol style="list-style-type: none"> a. for the safe and secure storage and distribution of medicines b. for storage of temperature-sensitive medicines and cold chain management c. for the disposal of unused, unwanted or expired medicines 	4.10.1, 4.10.2, 4.10.3, 4.10.4, 4.10.5, 4.10.6
MS10 High-risk medicines	MS10.1 The health service organisation: <ol style="list-style-type: none"> a. identifies high-risk medicines used within the organisation b. has a system to store, prescribe, dispense and administer high-risk medicines safely 	4.11.1, 4.11.2

	No. actions in version 1	No. actions in version 2
Existing	37	12
New action or new components in an action	Not applicable	1
Total	37	13

Standard RR: Recognising and responding to acute deterioration

Status

This is an existing standard. The scope has been changed.

What has changed and why?

- In version 1 of the NSQHS Standards, this standard applied to deterioration in acute health care. The standard has been revised, and the scope is now on acute deterioration, which can occur in many different settings.
- The scope now includes deterioration in mental state, which was explicitly excluded from this standard in version 1. This change was made to address identified issues about the process of recognising and responding to deterioration in mental state. Some actions have been modified to reflect this change in scope. In many cases, the actions did not need to be modified because they already applied to deterioration in mental state.
- Actions have been added to provide more specific guidance about the responsibilities of clinicians in recognising and responding to clinical deterioration. This has been done because failures to recognise and respond to clinical deterioration still occur, even with the introduction of recognition and response systems.
- Acute suffering has been added as an aspect of acute deterioration that needs to be acted on. This is in response to findings, including those from the inquiry into the Mid-Staffordshire Foundation Trust in England, that highlighted the risks of poor-quality care where acute suffering was not addressed.
- An action from version 1 relating to the clinical workforce being trained and proficient in basic life support has been removed. All requirements about safety and quality training are now reflected in Standard GS: Governance for safety and quality. Rather than requiring competence in a particular area, health services now need to ensure that clinicians are able to provide an initial response to acute deterioration. This could be done in various ways, including through training.
- With the greater focus on end-of-life care across the NSQHS Standards, in this standard, actions relating to end-of-life care have been modified to reflect the specific association of this type of care with acute deterioration.

Standard RR: Recognising and responding to acute deterioration

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

Intention of this standard

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

Criteria

1. Recognition and response systems

Organisation-wide systems are used to support and promote recognition of, and response to, consumers whose condition deteriorates. These systems are consistent with the *National consensus statement: essential elements for recognising and responding to clinical deterioration*(7) and the *National consensus statement: essential elements for safe and high-quality end-of-life care*(8).

2. Recognising acute deterioration and escalating care

Consumers whose condition is acutely deteriorating are recognised, and action is taken to escalate care.

3. Responding to acute deterioration

Appropriate and timely care is provided to consumers whose condition is deteriorating.

Standard RR: Recognising and responding to acute deterioration

Recognition and response systems

Organisation-wide systems are used to support and promote recognition of, and response to, consumers whose condition deteriorates. These systems are consistent with the *National consensus statement: essential elements for recognising and responding to clinical deterioration*(7), and the *National consensus statement: essential elements for safe and high-quality end-of-life care*(8).

Item	Action required	Link to v1
RR1 Integrated safety and quality systems	RR1.1 The health service organisation integrates systems for recognising and responding to acute deterioration with the systems in Standard GS: Governance for safety and quality, and Standard PC: Partnering with consumers	9.1.1, 9.1.2
RR2 Quality improvement	RR2.1 The health service organisation and the workforce use the organisation-wide quality improvement system to: <ul style="list-style-type: none"> a. monitor the recognition and response systems, and their performance b. take action to improve the recognition and response systems, and their performance c. report on effectiveness and outcomes 	9.2.1, 9.2.2, 9.2.3, 9.2.4, 9.3.2, 9.3.3, 9.4.2, 9.4.3, 9.5.2, 9.9.3, 9.9.4
	RR2.2 The health service organisation supports clinicians to identify any failures in the performance or use of the recognition and response systems when serious adverse events are reviewed, and to use this information for improvement	9.2.2

Recognising acute deterioration and escalating care

Consumers whose condition is acutely deteriorating are recognised, and action is taken to escalate care.

Item	Action required	Link to v1
RR3 Recognising acute deterioration	<p>RR3.1 The health service organisation has systems for clinicians to:</p> <ul style="list-style-type: none"> a. document individualised plans outlining the monitoring requirements for consumers b. document any limitations on medical treatment that have been agreed c. monitor consumers as required by their individualised plan (which may include mental, cognitive and other criteria to indicate acute deterioration) d. graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the consumer e. escalate care as required, based on agreed criteria f. include acute suffering that is not able to be managed using available treatment as a criterion for escalating care g. include worry or concern about acute deterioration as a trigger for escalating care 	9.3.1
RR4 Escalating care	<p>RR4.1 The health service organisation:</p> <ul style="list-style-type: none"> a. provides the workforce with mechanisms to escalate care and call for emergency assistance b. has escalation protocols that include criteria for triggering a call for emergency assistance 	1.8.3, 9.4.1
	<p>RR4.2 Clinicians take action to escalate care when agreed triggers that indicate acute deterioration are breached or when they are concerned about the condition of a consumer</p>	New action
RR5 Escalation by consumers	<p>RR5.1 The health service organisation has systems that:</p> <ul style="list-style-type: none"> a. provide consumers, family members and carers with a mechanism to directly escalate care b. monitor and improve consumers' experiences of using the escalation systems 	9.9.1, 9.9.2, 9.9.3, 9.9.4

Standard RR: Recognising and responding to acute deterioration

Responding to acute deterioration

Appropriate and timely care is provided to consumers whose condition is deteriorating.

Item	Action required	Link to v1
RR6 Responding to deterioration	RR6.1 The health service organisation has systems that enable clinicians to provide an initial response to episodes of acute deterioration and suffering in a timely way, as appropriate for their role	New action
	RR6.2 The health service organisation has systems to ensure rapid access: a. at all times to at least one clinician, either on-site or in close proximity, who can deliver advanced life support b. to appropriate services for definitive management of the acute deterioration	New components 9.6.2
RR7 Advance care plans	RR7.1 If consumers are unable to participate in decision making about their care, clinicians use existing advance care plans, treatment-limiting orders, the consumer's previously expressed preferences, and other relevant documentation to guide decision making when responding to deterioration	New action
RR8 Involuntary treatment	RR8.1 For consumers who experience a deterioration in mental state and require involuntary treatment, clinicians ensure that this treatment is consistent with legislation	New action

	No. actions in version 1	No. actions in version 2
Existing	23	6
New action or new components in an action	Not applicable	5
Total	23	11

Standard BP: Blood product safety

Status

This is an existing standard.

What has changed and why?

- The focus of the actions has changed to the consumer receiving blood and blood products, rather than only the products.
- Inappropriate or unnecessary use of blood products exposes consumers to unnecessary risk. Therefore, a more explicit focus has been put on effectively managing consumers' own blood status.
- Actions have been made more explicit to address identified gaps in practice.
- Duplications within the standard have been removed
- Actions have been modified to more specifically reflect national policy agreements about blood and blood products.

Standard BP: Blood product safety

Leaders of a health service organisation describe, implement and monitor systems to ensure the safe, appropriate, efficient and effective care of consumers' own blood, and to ensure that blood product requirements are met. The workforce uses the blood product safety systems.

Intention of this standard

Use evidenced-based strategies to ensure that the management of consumers' own blood and any blood products they receive is safe and appropriate.

Criteria

1. Blood management systems

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

2. Managing blood product availability and safety

Strategies are used to effectively manage blood product availability and safety.

3. Prescribing and clinical use of blood products

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

Blood management systems

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

Item	Action required	Link to v1
BP1 Integrated safety and quality systems	BP1.1 The health service organisation integrates systems for blood and blood product management with the systems in Standard GS: Governance for safety and quality, and Standard PC: Partnering with consumers	New components 7.1.1, 7.1.2
BP2 Quality improvement	BP2.1 The health service organisation and the workforce use the organisation-wide quality improvement system to: <ol style="list-style-type: none"> a. monitor the performance of the blood management systems b. take action to improve the blood management systems and their performance c. report on effectiveness and outcomes 	7.1.3, 7.2.2, 7.4.1, 7.5.2, 7.5.3, 7.6.2, 7.7.2, 7.8.2

Managing blood product availability and safety

Strategies are used to effectively manage blood product availability and safety.

Item	Action required	Link to v1
BP3 Storage, distribution and traceability	BP3.1 The health service organisation has systems: <ol style="list-style-type: none"> 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 track and trace blood products from entry into the organisation to transfusion, discard or transfer 	New components 7.7.1
BP4 Availability	BP4.1 The health service organisation has systems to manage: <ol style="list-style-type: none"> a. the availability of blood products to meet appropriate clinical need and reduce usage b. wastage in times of shortage 	7.8.1

Prescribing and clinical use of blood products

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

Item	Action required	Link to v1
BP5 Identifying risk	BP5.1 Clinicians use systems to identify consumers with increased risk of bleeding, transfusion-related risks or specific transfusion requirements	7.2.1
BP6 Managing consumers' need for blood	BP6.1 Clinicians manage a consumer's need for blood products by: <ol style="list-style-type: none"> identifying consumers at increased risk of bleeding managing consumers in a way that boosts and conserves the consumer's own blood managing the clinical risks to reduce the consumer's need for blood products 	7.1.1
BP7 Documentation	BP7.1 Clinicians document a best-possible transfusion history, decisions relating to blood management and transfusion details in the healthcare record	7.5.1, 7.6.1
BP8 Prescribing and monitoring	BP8.1 Clinicians use systems to prescribe and administer blood and blood products, and monitor consumers in accordance with national guidelines and national criteria	New action
BP9 Adverse event reporting	BP9.1 The health service organisation uses systems for reporting transfusion-related adverse events to the manufacturers and the Therapeutic Goods Administration, in accordance with their requirements	7.6.3
	BP9.2 The health service organisation participates in haemovigilance activities in accordance with the national framework	7.3.3

	No. actions in version 1	No. actions in version 2
Existing	23	7
New action or new components in an action	Not applicable	3
Total	23	10

Roles for safety and quality in health care

This section outlines the role for each group of participants in ensuring the safe and effective delivery of healthcare services in a health service organisation.

Consumers play an important role in the safe delivery of health care. As partners with health service organisations and their healthcare providers, consumers are involved in making decisions for service planning, developing models of care, measuring service and evaluating systems of care. They also participate in making decisions about their own health care; for this, they need to know and exercise their healthcare rights, and be engaged in their health care and decisions about their treatment. Consumers need to access information about options and agreed treatment plans. Health care can be improved when consumers share – with clinicians – issues that may affect their compliance with treatment plans.

Clinicians provide health care to consumers. They are essential in delivering safe and high-quality health care. The system can be improved when clinicians actively participate in organisational processes, safety systems and improvement initiatives, and are trained in the roles and services for which they are accountable. Clinicians can make healthcare systems safer and more effective if they:

- understand their broad responsibility for safety and quality in health care
- follow safety and quality procedures
- supervise and educate other members of the workforce
- participate in the review of performance procedures individually, or as part of a team.

When clinicians form partnerships with consumers, not only can a consumer's experience of care be improved, but the design and planning of organisational processes, safety systems, quality initiatives and training can be more effective.

Other members of the workforce who are not clinicians are also important to the delivery of quality health care. By actively participating in organisational processes – such as the development and implementation of safety systems, improvement initiatives and related training – they can identify and address limitations of safety systems. A key role for this group is to notify clinicians when concerns exist about a consumer.

Managers of health service organisations implement and maintain systems, materials, education and training that ensure that clinicians deliver safe, effective and reliable health care. They support the establishment of partnerships with consumers when designing, implementing and maintaining systems. Their key role is managing performance and facilitating compliance across the organisation and within individual areas of responsibility for the governance of safety and quality systems. They are leaders who can model behaviours that optimise safe and high-quality care. Safer systems can be achieved when managers of health service organisations consider safety and quality implications in their decision-making processes.

The role of **health service executives and owners** is to plan and review integrated governance systems that promote consumer safety and quality of health care, and to clearly articulate organisational and individual accountability for safety and quality throughout the organisation. Explicit support for the role of consumers in safety, models of care, program design and review of the organisation's performance is key to the establishment of effective partnerships with consumers by health service managers and the clinical workforce.

Roles for safety and quality in health care

The **highest level of governance** will vary widely across health service organisations. It may be a board, an organisation's owner, a partnership or a body. The role of the highest level of governance is ultimately to be responsible for the safety and quality of the organisation. It provides the strategic direction on safety and quality matters, and leadership on the safety culture of the organisation. It also monitors performance of the organisation. The highest level of governance is also key to setting the organisation's approach to partnering with consumers.

Glossary

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

acute suffering: rapid-onset physical, psychological or cognitive symptoms that are causing distress to the consumer.

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 consumer's behalf and should be prepared from the consumer's perspective to guide decisions about care.(9)

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.(7)

adverse drug reaction: a drug response 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.(10)

adverse event: an incident that results in harm to a consumer.

antimicrobial: a chemical substance that inhibits or destroys bacteria, viruses or fungi, including yeasts or moulds.(11)

antimicrobial resistance: a property of organisms, including bacteria, viruses, fungi and parasites, that confers the capacity to grow or survive in the presence of antimicrobial levels that would normally suppress growth or kill susceptible organisms.(12)

antimicrobial stewardship: a program implemented in a health service organisation to reduce the risks associated with increasing microbial resistance and to extend the effectiveness of antimicrobial treatments. Antimicrobial stewardship may incorporate a broad range of strategies, including the monitoring and review of antimicrobial use.(11)

approved identifiers: items of information accepted for use in identification, including name (family and given names), date of birth, sex, address, medical 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 are not to be used.

aseptic technique: a technique that aims to prevent microorganisms on hands, surfaces and equipment from being introduced to susceptible sites. Therefore, unlike sterile techniques, aseptic techniques can be achieved in typical ward and home settings.(13)

assessment: a clinician's evaluation of the disease or condition based on the consumer's subjective report of the symptoms and course of the illness or condition, and the clinician's objective findings, including data obtained through laboratory tests, physical examination, medical history, and information reported by family members and other members of the healthcare team. (14)

Australian Charter of Healthcare Rights: specifies the key rights of consumers when seeking or receiving healthcare services. It was endorsed by health ministers in 2008.(2)

Australian Open Disclosure Framework: endorsed by health ministers in 2013. It provides a framework for health service organisations and clinicians to communicate openly with consumers when health care does not go to plan.(1)

best-possible medication history: a list of all the medicines a consumer is using at presentation (including all prescribed, over-the-counter and complementary medicines), obtained by interviewing the consumer (and/or their carer) and confirmed, where appropriate, by using a number of different sources of information.(15)

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

blood management: a process that improves outcomes for the consumer by improving their medical and surgical management in ways that boost and conserve their own blood.

blood products: blood products include fresh blood products such as red blood cells and platelets, fresh frozen plasma, cryoprecipitate and cryodepleted plasma, plasma-derived blood products, and recombinant blood products.

care plan: an integrated and individualised plan of care that includes medical, nursing, allied health and other information necessary for providing comprehensive care to the consumer.

carers: people who provide care (either paid or unpaid) and support to family members or friends who have a disability, mental illness, chronic condition, terminal illness or general frailty. Carers include parents and guardians caring for children.(17)

challenging behaviour: any behaviour with the potential to physically or psychologically harm the person showing the behaviour, another person or property. It can range from verbal abuse to threats or acts of physical violence.(16)

Clinical Care Standards: standards endorsed by health ministers and developed by the Commission that identify and define the care people should expect to be offered or receive for specific conditions.

clinical communication: an exchange of information that occurs between treating clinicians. Communication can be formal (when a message conforms to a predetermined structure – for example, in a healthcare record or stored electronic data) or informal (when the structure of the message is determined solely by the relevant parties – for example, a face-to-face or telephone conversation).(18)

clinical governance: a system in which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. This is achieved by creating an environment in which there is transparent responsibility and accountability for maintaining standards, and by allowing excellence in clinical care to flourish.(19)

clinical handover: the transfer of professional responsibility and accountability for some or all aspects of care for a consumer, or group of consumers, to another person or professional group on a temporary or permanent basis.(20)

clinical information system: a computerised healthcare record and management system, 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 (e.g. prescribing of medications, reviewing laboratory results, administering intravenous fluids) specified for each clinical and administrative user. Clinical information systems enable computerised data entry and data retrieval by healthcare professionals.(21)

clinician: a healthcare provider, trained as a health practitioner, 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 not specified here. They may include nurses, 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 judgment. Dementia and delirium are common forms of cognitive impairment seen in hospitalised older consumers.(14)

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

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

consumer: a person who uses, or may potentially use, health services. Depending on the nature of the health service organisation, this person may be referred to as a patient, a client, a consumer, a customer or some other term. Consumers also include families, carers, friends and other support people, as well as representatives of consumer groups.(22)

consumer-based visitation: a flexible visiting environment in which the consumer (or their next of kin) establishes visiting parameters that best suit the individual circumstances of that consumer. Consumer-based visitation recognises that family and carer involvement improves healthcare delivery.

consumer-centred care: an approach to the planning, delivery and evaluation of health care that is founded in mutually beneficial partnerships among clinicians and consumers.(23)

consumer e-health record: an electronic application through which individuals can access, manage and share their health information, and that of others for whom they are authorised, in a private, secure and confidential environment.(24)

contemporaneously (documenting information): the recording of information in the healthcare record as soon as possible after the event that is being documented. Each entry should include the date and time of the entry, the author's signature and legibly printed name, and the author's designated role.(25)

contractor: a person or firm that undertakes a contract to provide materials or labour to perform a service or do a job.(26)

credentialing: the formal process used by a health service organisation to verify the qualifications, experience, professional standing and other relevant professional attributes of

health practitioners, so that they can form a view about their competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments.(27)

critical information: information that has a substantial impact on a person's care or treatment. This includes information with a negative or positive impact on a person's care, information that is material to the person and critical to their care, and information that may require the clinician to reassess the person's care plan.

decision support tools: tools that can help clinicians and consumers to draw on available evidence when making clinical decisions. The tools take a number of formats. Some are explicitly designed to facilitate shared decision making (e.g. decision aids). Others provide some of the information needed for some components of the shared decision-making process (e.g. risk calculators, evidence summaries), or provide ways of initiating and structuring conversations about health decisions (e.g. communication frameworks, question prompt lists). See also *shared decision making*.(28)

definitive management: the treatment plan for a disease or disorder that has been chosen as the best one for the consumer after all other choices have been considered.(29)

delirium: an acute disturbance of consciousness, attention, cognition and perception that tends to fluctuate during the course of the day.(30) 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).(31)

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, religious orientation and languages spoken.

emergency assistance: clinical advice or assistance provided when a consumer's condition has deteriorated acutely. This assistance is provided as part of the rapid response system, and is additional to the care provided by the attending medical officer or team.(7)

end of life: the period when a consumer 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 consumers with chronic or malignant disease, or very brief in the case of consumers who suffer acute and unexpected illnesses or events, such as sepsis, stroke or trauma.(32)

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

e-referral: The exchange of significant consumer information from one treating healthcare provider to another via a national system of creating, storing and sharing referral reports.(33)

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 consumers at all times.(7)

event summary: a record of key health information about significant healthcare events that are relevant to the ongoing care of an individual – for example, to indicate a clinical intervention or improvement in a condition, or to show that a treatment has been started or completed. An event summary may contain information on:

- allergies and adverse reactions
- medicines
- diagnoses
- interventions
- immunisations
- diagnostic investigations.(34)

fall: an event that results in a person coming to rest inadvertently on the ground or floor, or another lower level.(35)

goals of care: clinical and other goals for a consumer'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 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.

guidelines: clinical practice guidelines are systematically developed statements to assist practitioner and consumer decisions about appropriate health care for specific circumstances.(36)

haemovigilance: a set of surveillance procedures covering the entire transfusion chain, from the donation and processing of blood and its components, to their provision and transfusion to consumers, to their follow-up. It includes monitoring, reporting, investigation and analysis of adverse events related to donation, processing and transfusion of blood, as well as development and implementation of recommendations to prevent the occurrence or recurrence of adverse events.(37)

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.(1)

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.(4)

health literacy: the Commission separates health literacy into two components – individual health literacy and the health literacy environment.

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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 health system and affect the ways in which consumers access, understand, appraise and apply health-related information and services.(38)

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

highest level of governance: the board, chief executive officer, organisation owner, partnership and/or other higher-level body of governance (individual or group of individuals) within a health service organisation who are responsible for strategic and operational decisions on safety and quality of an organisation.

high-risk medicines: medicines that have a high risk of causing serious injury or death to a consumer if they are misused. Examples of high-risk medicines are anticoagulants, insulin, opioids, chemotherapy medicines, concentrated electrolytes, IV digoxin, and neuromuscular blocking agents.(39)

incident: an event or circumstance that resulted, or could have resulted, in unintended and/or unnecessary harm to a consumer and/or a complaint, loss or damage.

infection: the invasion and reproduction of pathogenic (disease-causing) organisms inside the body. This may cause tissue injury and disease.(11)

infection control or infection control measures: actions to prevent the spread of pathogens between people in a healthcare setting. Examples of infection control measures are targeted surveillance of healthcare-associated infections, infectious disease monitoring, hand hygiene and use of personal protective equipment.(11)

informed consent: a process of communication between a consumer and their medical officer that results in the consumer's authorisation or agreement to undergo a specific medical intervention.(40) This communication should ensure that the consumer has an understanding of all the available options and the expected outcomes, such as the success rates and side effects for each option.(41)

injury: damage to tissues caused by an agent or circumstance.(42)

invasive 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.(36) Jurisdictional requirements encompass a number of types of documents from state and territory governments, including regulations, guidelines, policies, directives and circulars. Terms used for each document may vary by state and territory.

medication: the use of medicine for therapy or diagnosis, its interaction with the consumer and its effect.

medication management system: the system used to manage the provision of medicines to consumers. This system includes manufacturing, compounding, procuring, dispensing, prescribing, storing, administering, distributing and monitoring the effects of medicines. It also includes the rules, guidelines, decision-making and support tools, policies and procedures that are in place to direct the use of medicines. The system is specific to a healthcare setting.

medication reconciliation: a formal process of obtaining and verifying a complete and accurate list of each consumer's current medicines, and matching the medicines the consumer should be prescribed to those they are actually prescribed. Any discrepancies are discussed with the prescriber, and reasons for changes to therapy are documented. When care is transferred (e.g. between wards, hospitals or home), a current and accurate list of medicines, including reasons for change, is provided to the person taking over the consumer's care.

medication review: a critical review of a consumer's medication management undertaken by clinicians. The review includes all prescribed, over-the-counter and complementary medicines, and is used to optimise therapy and minimise medication-related problems.(43)

medicine: a chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental welfare of people. Prescription, non-prescription and complementary medicines are included, irrespective of how they are administered.(44)

medicines list: a complete list of all medicines, with sufficient information to fully identify all products (prescription and non-prescription medicines, including over-the-counter and complementary medicines), prepared by the clinician. Key components include the name of the medicine, the form of the dose, the strength and directions for use.(6)

mental illness: a health problem that significantly affects how a person feels, thinks, behaves and interacts with other people. It is diagnosed according to standardised criteria.(45)

minimum dataset: the minimum set of information and content that must be contained and transferred in a particular type of clinical handover.(46) Many minimum datasets are possible; the type will depend on the context and reason for the handover.(47)

multidisciplinary team: A team including professionals from a range of disciplines who work together to deliver comprehensive care that addresses as many of the consumer's health and other needs as possible. The professionals in the team may function under one organisational umbrella or may be from a range of organisations brought together as a unique team. As a consumer's condition changes over time, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient.(48) Multidisciplinary care includes interdisciplinary care. **Discipline:** a branch of knowledge within the health system.(49)

national standard secure messaging: a set of specifications developed collaboratively by the e-health community, including the National E-Health Transition Authority, Standards Australia, desktop software vendors and secure messaging service

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providers. This set of specifications defines an approach to e-health communication using widely supported information technology industry standards.(50)

near miss: an incident or potential incident that was averted and did not cause harm, but had the potential to do so.(51)

open disclosure: an open discussion with a consumer about an incident that resulted in harm to the consumer 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.(52)

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.(42)

partnership: a situation that develops when 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 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. Generally, partnerships at all levels are necessary to ensure that the health service organisation is responsive to consumer input and needs, although the nature of the activities for these different types of partnership will depend on the type of health service organisation.

point of care: the time and location where an interaction between a consumer and clinician occurs 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.

population: the people living in a defined geographic region who receive services from a health service organisation.

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.

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

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

quality improvement: the combined and unceasing efforts of everyone – clinicians, consumers and their families, researchers, payers, planners and educators – to make the changes that will lead to better consumer outcomes (health), better system performance (care) and better professional development.(53)

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

responsibility and accountability of care: accountability includes the obligation to report and be answerable for consequences. Responsibility is the acknowledgment that a person has to take action that is appropriate to a consumer's care needs.(54)

restraint: the restriction of an individual's freedom of movement by physical or mechanical means.(55) This may include chemical restraint, in which medication is given primarily to control a person's behaviour rather than to treat a mental illness or physical condition.(56)

reusable device: a medical device that is designated by its manufacturer as suitable for reprocessing and reuse.(57)

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

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

routine (provision of care): a health service organisation routinely provides care to a specified group of consumers when the care is commonplace and the organisation can reasonably expect to provide care to these consumers in its service.

safety culture: a commitment to safety that permeates all levels of an organisation, from the front-line workforce to executive management. Features commonly include acknowledgment of the high-risk, error-prone nature of an organisation's activities; a blame-free environment where 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 address safety concerns.(58)

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.(27)

screening: a process of identifying consumers who are at risk, or already have a disease or injury. Screening requires sufficient knowledge to make a clinical judgment.(59)

seclusion: the confinement of a consumer at any time of the day or night alone in a room or area from which free exit is prevented.(55)

sexual safety: the recognition, maintenance and mutual respect of the physical, psychological, emotional and spiritual boundaries between people.(60)

shared decision making: a consultation process in which a clinician and a consumer jointly participate in making a health decision, having discussed the options and their benefits and harms, and having considered the consumer's values, preferences and circumstances.(28)

standard: agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.(42)

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

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 consumer whose decision-making capacity is impaired. A substitute decision maker may be appointed by the consumer, appointed for (on behalf of) the person, or identified as the default decision maker by legislation, which varies from state to state.(14)

suffering: experiencing anything subjectively unpleasant. This may include pain, malaise, nausea, vomiting, loss, depression, agitation, alarm, fear or grief.(42)

surveillance: an epidemiological practice that involves monitoring the spread of disease to establish progression patterns. the main role of surveillance is to predict, observe and provide a measure for strategies that may minimise the harm caused by outbreak, epidemic and pandemic situations, as well as to increase knowledge of the factors that might contribute to such circumstances.(11)

system: the resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish the objective of the standard. The system:

- brings together risk management, governance, 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 material
- employs a range of incentives and sanctions to influence behaviours and encourage compliance with policy, protocol, regulation and procedures.

training: the development of knowledge and skills.

transitions of care: situations when a consumer's care is transferred between healthcare locations, providers, or levels of care within the same location as the consumer's conditions and care needs change.(61)

treatment-limiting orders: orders, instructions or decisions that involve the reduction, withdrawal or withholding of life-sustaining treatment. These may include 'no cardiopulmonary resuscitation' or 'not for resuscitation'.(7)

unwarranted variation: variation in health care that is unrelated to a consumer's needs or preferences.(62)

workforce: all people working in a health service organisation, including clinicians (see above) and any other employed, contracted, locum, agency, student or volunteer members of the health service organisation who have assigned roles and responsibilities for care of, administration of, support of or involvement with consumers in the health service organisation.

NSQHS version 1 Standard 5: Patient identification and procedure matching

Status

This standard has been removed as a stand-alone standard. In version 2, the core elements of the standard have been included in Standard CS: Communicating for safety.

Why has this standard been removed?

The core of NSQHS Standard 5: Patient identification and procedure matching was Action 5.1.1, which required use of an organisation-wide system for identifying consumers and correctly matching them to their care. This is the set of policies, procedures and protocols that is designed to ensure the consistent and correct identification of a consumer at any point during an admission or course of treatment. All of the other actions within the standard linked back to Action 5.1.1; linked to other parts of the NSQHS Standards, such as clinical handover or incident reporting; or reflected the quality improvement cycle that was built into all the NSQHS Standards.

As discussed elsewhere, the use of multiple actions to support quality improvement within each standard has been removed in version 2. When these actions and the links to other standards were removed, all that remained was Action 5.1.1. Rather than having this as a stand-alone standard, it has been incorporated into Standard CS: Communicating for safety. This reflects the importance of identification as a fundamental part of safe communication.

Identification of individual patients

At least three approved patient identifiers are used when providing care, therapy or services.

Item	Action required	Link to v2
5.1 Developing, implementing and regularly reviewing the effectiveness of a patient identification system including the associated policies, procedures and/or protocols that: <ul style="list-style-type: none"> • define approved patient identifiers • require at least three approved patient identifiers on registration or admission • require at least three approved patient identifiers when care, therapy or other services are provided • require at least three approved patient identifiers whenever clinical handover, patient transfer or discharge documentation is generated 	5.1.1 Use of an organisation-wide patient identification system is regularly monitored	CS2.1
	5.1.2 Action is taken to improve compliance with the patient identification matching system	GS8.1
5.2 Implementing a robust organisation-wide system of reporting, investigation and change management to respond to any patient care mismatching events	5.2.1 The system for reporting, investigating and analysis of patient care mismatching events is regularly monitored	CS2.1
	5.2.2 Action is taken to reduce mismatching events	GS9.1
5.3 Ensuring that when a patient identification band is used, it meets the national specifications for patient identification bands	5.3.1 Inpatient bands are used that meet the national specifications for patient identification bands	CS8.1

Process to transfer care

A patient's identify is confirmed using three approved patient identifiers when transferring responsibility for care.

Item	Action required	Link to v2
5.4 Developing, implementing and regularly reviewing the effectiveness of the patient identification and matching system at patient handover, transfer and discharge	5.4.1 A patient identification and matching system is implemented and regularly reviewed as part of structured clinical handover, transfer and discharge processes	CS8.1

Processes to match patients and their care

Health service organisations have explicit processes to correctly match patients with their intended care.

Item	Action required	Link to v2
5.5 Developing and implementing a documented process to match patients to their intended procedure, treatment or investigation and implementing the consistent national guidelines for patient procedure matching protocol or other relevant protocols	5.5.1 A documented process to match patients and their intended treatment is in use	CS8.1
	5.5.2 The process to match patients to any intended procedure, treatment or investigation is regularly monitored	GS8.1
	5.5.3 Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation	GS8.1

NSQHS version 1 Standard 8: Preventing and managing pressure injuries

Status

This standard has been removed as a stand-alone standard. All of the elements have been included in Standard GS: Governance for safety and quality, Standard PC: Partnering with consumers, Standard CC: Comprehensive care, and Standard RH: Reducing harm.

Why has this standard been removed?

Items 8.1, 8.2 and 8.3 referred to policies, procedures, protocols, risk management and quality improvement, which have been moved to Standard GS, as they have for other standards. Similarly, Actions 8.9.1 and 8.10.1, on communicating with patients and carers, have been moved to Standard PC: Partnering with consumers.

The core of Standard 8 was actions referring to screening, assessment and care planning for pressure injuries (in Items 8.5, 8.6 and 8.7). These steps are now included in Standard CC Comprehensive care, so longer appear in a separate standard about pressure injuries.

The remaining actions from Standard 8 are for an evidence-based wound management system, comprehensive skin inspections, and the provision of appropriate equipment and devices. It is proposed that these actions be included in Standard RH: Reducing harm.

Moving actions to broader standards on safe delivery of quality care, and preventing and managing specific risks of harm reflects feedback received that pressure injury prevention cannot be considered in isolation from other comorbidities, including malnutrition and cognitive impairment, which are included in Standard RH.

Governance and systems for the prevention and management of pressure injuries

Health service organisations have governance structures and systems in place for the prevention and management of pressure injuries.

Item	Action required	Link to v2
8.1 Developing and implementing policies, procedures and/or protocols that are based on current best practice guidelines	8.1.1 Policies, procedures and/or protocols are in use that are consistent with best practice guidelines and incorporate screening and assessment tools	GS4.1 RH1.1
	8.1.2 The use of policies, procedures and/or protocols are regularly monitored	GS4.1 RH1.1
8.2 Using a risk-assessment framework and reporting systems to identify, investigate and take action to reduce the frequency and severity of pressure injuries	8.2.1 An organisation-wide system for reporting pressure injuries is in use	GS5.2 GS9.1
	8.2.2 Administrative and clinical data are used to regularly monitor and investigate the frequency and severity of pressure injuries	GS5.2 GS9.1
	8.2.3 Information on pressure injuries is regularly reported to the highest level of governance in the health service organisation	GS9.1
	8.2.4 Action is taken to reduce the frequency and severity of pressure injuries	GS9.1
8.3 Undertaking quality improvement activities to address safety risks and monitor the systems that prevent and manage pressure injuries	8.3.1 Quality improvement activities are undertaken to prevent pressure injuries and/or improve the management of pressure injuries	RH2.1
8.4 Providing or facilitating access to equipment and devices to implement effective prevention strategies and best practice management plans	8.4.1 Equipment and devices are available to effectively implement prevention strategies for patients at risk and plans for the management of patients with pressure injuries	RH3.3

Preventing pressure injuries

Patients are screened on presentation and pressure injury prevention strategies are implemented when clinically indicated.

Item	Action required	Link to v2
8.5 Identifying risk factors for pressure injuries using an agreed screening tool for all presenting patients within timeframes set by best practice guidelines	8.5.1 An agreed tool to screen for pressure injury risk is used by the clinical workforce to identify patients at risk of a pressure injury	CC5.3
	8.5.2 The use of the screening tool is monitored to identify the proportion of at-risk patients that are screened for pressure injuries on presentation	CC2.1
	8.5.3 Action is taken to maximise the proportion of patients who are screened for pressure injury on presentation	CC5.3 RH2.1
8.6 Conducting a comprehensive skin inspection in timeframes set by best practice guidelines on patients with a high risk of developing pressure injuries at presentation, regularly as clinically indicated during a patient's admission, and before discharge	8.6.1 Comprehensive skin inspections are undertaken and documented in the patient clinical record for patients at risk of pressure injuries	CC5.5 RH3.2
	8.6.2 Patient clinical records, transfer and discharge documentation are periodically audited to identify at-risk patients with documented skin assessments	RH2.1
	8.6.3 Action is taken to increase the proportion of skin assessments documented on patients at risk of pressure injuries	RH2.1
8.7 Implementing and monitoring pressure injury prevention plans and reviewing when clinically indicated	8.7.1 Prevention plans for all patients at risk of a pressure injury are consistent with best practice guidelines and are documented in the patient clinical record	CC2.5 CC6.1 RH3.2
	8.7.2 The effectiveness and appropriateness of pressure injury prevention plans are regularly reviewed	CC2.1
	8.7.3 Patient clinical records are monitored to determine the proportion of at-risk patients that have an implemented pressure injury prevention plan	CC2.1
	8.7.4 Action is taken to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan	CC2.1

Managing pressure injuries

Patients who have pressure injuries are managed according to best practice guidelines.

Item	Action required	Link to v2
8.8 Implementing best practice management and ongoing monitoring as clinically indicated	8.8.1 An evidence-based wound management system is in place within the health service organisation	RH3.1
	8.8.2 Management plans for patients with pressure injuries are consistent with best practice and documented in the patient clinical record	CC6.1 CC7.2
	8.8.3 Patient clinical records are monitored to determine compliance with evidence-based pressure injury management plans	CC2.1
	8.8.4 Action is taken to increase compliance with evidence-based pressure injury management plans	CC8.4

Communicating with patients and carers

Patients and carers are informed of the risks, prevention strategies and management of pressure injuries.

Item	Action required	Link to v2
8.9 Informing patients with a high risk of pressure injury, and their carers, about the risks, prevention strategies and management of pressure injuries	8.9.1 Patient information on prevention and management of pressure injuries is provided to patients and carers in a format that is understood and is meaningful	PC4.3 RH1.1
8.10 Developing a plan of management in partnership with patients and carers	8.10.1 Pressure injury management plans are developed in partnership with patients and carers	PC6.1 RH1.1

NSQHS version 1 Standard 10: Preventing falls and harm from falls

Status

This standard has been removed as a stand-alone standard. Elements of it have been included in Standard CC: Comprehensive care, and Standard RH: Reducing harm.

Why has this standard been removed?

Many of the actions in Standard 10 are replicated in Standard 8: Preventing and managing pressure injuries. As outlined in the previous section, many of the actions in Standard 10 have been moved to Standard GS: Governance for safety and quality, Standard PC: Partnering with consumers, Standard CC: Comprehensive care, and Standard RH: Reducing harm.

The remaining actions from Standard 10 are for multifactorial falls prevention, discharge planning, and the provision of appropriate equipment and devices. It is proposed that these actions be included in Standard RH.

As with Standard 8, falls prevention is considered an issue that cannot be examined in isolation from other comorbidities, especially cognitive impairment and delirium, which are included in Standard RH.

Governance and systems for the prevention of falls

Health service organisations have governance structures and systems in place to reduce falls and minimise harm from falls.

Item	Action required	Link to v2
10.1 Developing, implementing and reviewing policies, procedures and/or protocols, including the associated tools, that are based on the current national guidelines for preventing falls and harm from falls	10.1.1 Policies, procedures and/or protocols are in use that are consistent with best practice guidelines (where available) and incorporate screening and assessment tools	GS4.1
	10.1.2 The use of policies, procedures and/or protocols is regularly monitored	GS4.1
10.2 Using a robust, organisation-wide system of reporting, investigation and change management to respond to falls incidents	10.2.1 Regular reporting, investigating and monitoring of falls incidents is in place	GS9.1
	10.2.2 Administrative and clinical data are used to monitor and investigate regularly the frequency and severity of falls in the health service organisation	GS9.1
	10.2.3 Information on falls is reported to the highest level of governance in the health service organisation	GS9.1
	10.2.4 Action is taken to reduce the frequency and severity of falls in the health service organisation	GS9.1
10.3 Undertaking quality improvement activities to address safety risks and ensure the effectiveness of the falls prevention system	10.3.1 Quality improvement activities are undertaken to prevent falls and minimise patient harm	CC2.1
10.4 Implementing falls prevention plans and effective management of falls	10.4.1 Equipment and devices are available to implement prevention strategies for patients at risk of falling and management plans to reduce the harm from falls	RH4.2

Screening and assessing risks of falls and harm from falling

Patients on presentation, during admission, and when clinically indicated, are screened for risk of a fall and the potential to be harmed from falls.

Item	Action required	Link to v2
10.5 Using a best practice-based tool to screen patients on presentation, during admission and when clinically indicated for the risk of falls	10.5.1 A best practice screening tool is used by the clinical workforce to identify the risk of falls	CC5.3
	10.5.2 Use of the screening tool is monitored to identify the proportion of at-risk patients that were screened for falls	CC2.1
	10.5.3 Action is taken to increase the proportion of at-risk patients who are screened for falls upon presentation and during admission	CC2.1 RH2.1 RH3.1
10.6 Conducting a comprehensive risk assessment for patients identified at risk of falling in initial screening processes	10.6.1 A best practice assessment tool is used by the clinical workforce to assess patients at risk of falling	CC5.4
	10.6.2 The use of the assessment tool is monitored to identify the proportion of at-risk patients with a completed falls assessment	CC2.1
	10.6.3 Action is taken to increase the proportion of at-risk patients undergoing a comprehensive falls risk assessment	CC2.1

Preventing falls and harm from falling

Prevention strategies are in place for patients at risk of falling.

Item	Action required	Link to v2
10.7 Developing and implementing a multifactorial falls prevention plan to address risks identified in the assessment	10.7.1 Use of best practice multifactorial falls prevention and harm minimisation plans is documented in the patient clinical record	CC5.5 RH4.1
	10.7.2 The effectiveness and appropriateness of the falls prevention and harm minimisation plan are regularly monitored	RH2.1
	10.7.3 Action is taken to reduce falls and minimise harm for at-risk patients	RH2.1
10.8 Patients at risk of falling are referred to appropriate services, where available, as part of the discharge process	10.8.1 Discharge planning includes referral to appropriate services, where available	CC6.1 RH4.3

Communicating with patients and carers

Patients and carers are informed of the identified risks from falls and are engaged in the development of a falls prevention plan.

Item	Action required	Link to v2
10.9 Informing patients and carers about the risk of falls, and falls prevention strategies	10.9.1 Patient information on falls risks and prevention strategies is provided to patients and carers in a format that is understood and meaningful	PC4.3
10.10 Developing falls prevention plans in partnership with patients and carers	10.10.1 Falls prevention plans are developed in partnership with patients and carers	PC6.1

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