AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

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National Safety and Quality Primary Healthcare Standards

Public consultation

Contents

About the Commission

The Australian Commission on Safety and Quality in Health Care (the Commission) was established under the *National Health Reform Act 2011* to lead and coordinate key improvements in safety and quality in health care across Australia. The Commission's key functions include:

- Developing national safety and quality standards
- Developing national safety and quality accreditation schemes for organisations providing healthcare services
- Developing clinical care standards to improve the implementation of evidence-based health care
- Coordinating work in specific areas to improve outcomes for patients
- Providing information, publications and resources about safety and quality.

The Commission works in partnership with patients, carers, clinicians, the Australian, state and territory health systems, the private sector, managers and healthcare organisations to achieve a safe, high-quality and sustainable health system.

The Commission is funded jointly by the Australian Government and by state and territory governments. As a corporate Commonwealth entity and part of the Health portfolio of the Australian Government, the Commission is accountable to the Australian Parliament and the Minister for Health.

Introduction

The National Safety and Quality Primary Healthcare (NSQPH) Standards are being developed by the Australian Commission on Safety and Quality in Health Care (the Commission) through extensive consultation with healthcare providers, professional bodies, Primary Health Networks, consumers and other representatives of the sector. The NSQPH Standards aim to protect the public from harm and improve the quality of care delivered to patients and consumers.

This consultation document has been written to assist those that have an interest in shaping the development of the NSQPH Standards. This may include primary healthcare service providers as well as professional bodies, consumers, government agencies such as Primary Health Networks, and funders and regulators of primary healthcare services. The document explains the aims of the NSQPH Standards, how they have been developed, who should implement them, as well as the accreditation process. You will find an explanation of the aim of each individual standard together with explanatory notes that describe the intent of actions to inform implementation in practice. At the end of document you will find appendices on not-applicable actions and the Clinical Governance Framework, together with a glossary explaining words and phrases which may be unfamiliar.

Have your say

The Commission is seeking your feedback to ensure the NSQPH Standards meets the needs and expectations of the sector and the community.

You are invited to provide feedback on the whole document, or specific sections that are important to you. The Commission welcomes feedback on any or all of the following areas:

- **Introduction:** Does the Introduction aid your understanding of the context of the NSQPH Standards and how they are to be applied? If not, please outline what further information is required to support your understanding.
- **Appropriateness:** Do the actions cover the key safety and quality issues for primary healthcare services? If no, please provide details.
- **Actions:** Do the actions make sense to you? Is it clear how they will be applied in your primary healthcare service?
- **Language:** Is the language and terminology used in the document easy to understand and appropriate for the primary healthcare sector? How could it be improved?
- **Not applicable actions:** Is the summary table of not applicable actions at Appendix 1 clear? What other 'not applicable actions' need to be added for your service? What other primary healthcare services should be included in this table?

The consultation period is open until close of business, **Friday 27 November 2020**. The Commission is inviting feedback via **written submissions** or participation in an **online consultation forum.** For further information on how to have your say, please visit the Commission's website.

Written submissions received may be published on the Commission's website, including the names of individuals and/or organisations. Other personal information, such as email addresses and phone numbers, will be de-identified. If you would like your submission to remain confidential, please advise the Commission.

Purpose of the National Safety and Quality Primary Healthcare Standards

The NSQPH Standards aim to protect the public from harm and improve the quality of care delivered, by addressing key safety and quality issues in primary healthcare services identified by consumers and the sector. The NSQPH Standards focus on areas in which there are:

- A large number of patients involved
- Known gaps between current service provision and best practice outcomes, and
- Improvement strategies that are evidence-based and achievable.

Implementation of the NSQPH Standards will assist primary healthcare services to minimise the risk of harm and improve care for patients.

For a primary healthcare service, accreditation to the NSQPH Standards means that both the service and its patients will know that the expected standards of safety and quality are being met.

What is primary health care?

Primary health care is the first level of contact for individuals, families and communities with the national health system. [1] Primary health care is provided as close as possible to where people live and work, and is the first stage of a continuing health care process.[1] Primary health includes health promotion, prevention, early intervention, treatment of acute conditions, management of chronic conditions and end-of-life care.[2]

What is a primary healthcare service?

In Australia, primary health care is delivered across different settings by a wide range of primary healthcare providers.[3]

Primary healthcare providers include registered health practitioners such as Aboriginal and Torres Strait Islander Health Workers, dentists, general practitioners, nurses and midwives, optometrists, pharmacists, physiotherapists, podiatrists and psychologists, and self-regulated practitioners such as audiologists, dietitians and exercise physiologists.[3-5]\

Primary healthcare services are delivered across a wide range of settings that vary in size and structure. They can include traditional 'bricks and mortar' establishments such dental practices and community health services, as well as gyms, a person's home, residential aged care facilities or telehealth services using video-conferencing technology. In remote locations, primary healthcare providers may offer services via fly-in/fly-out health clinics.[6]

While some primary healthcare services are operated by sole traders, others may involve multiple primary healthcare providers, as well as owners, managers, administrative staff and a governing body. In many primary healthcare services, individuals serve dual or multiple roles. For example, an individual may hold management-related responsibilities as well as practising as a primary healthcare provider.

About the National Safety and Quality Primary Healthcare Standards

The NSQPH Standards describe the level of care to be delivered by primary healthcare services to minimise patient harm.

The NSQPH Standards include terms such as 'clinical governance'. This describes a systematic approach to maintaining and improving the quality of patient care within a clinical setting, health program or health setting. **Appendix 2** explains this concept in more detail.

The NSQPH Standards describe the key areas, or criteria, covered by each individual standard and the 'actions' that explain the systems and processes a primary healthcare service must have in place to meet that criterion. Actions related to a particular theme are grouped together under the term 'Item'. The Standards also include explanatory notes that provide further information about the intent of actions and how they may apply in practice.

The NSQPH Standards are comprised of three individual standards:

- **Clinical Governance Standard**, which describes frameworks or systems that primary healthcare services require to support the delivery of safe and high-quality care
- **Partnering with Consumers Standard**, which describes strategies to ensure primary healthcare services deliver person-centred care by partnering with patients in the delivery of care and incorporating the views and experiences of patients and consumers into the design of services
- **Clinical Safety Standard,** which considers specific high-risk areas of care commonly encountered in primary health care.

The Clinical Governance Standard and the Partnering with Consumers Standard set the overarching requirements, or clinical governance framework, for the effective implementation of the third Clinical Safety Standard.

Each standard contains:

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

The NSQPH Standards address healthcare-related safety and quality matters. However, some actions may also be relevant to a healthcare service's legal, jurisdictional and business obligations. At all times, a primary healthcare service must adhere to regulatory requirements as prescribed in relevant Commonwealth, state and territory legislation, such as Work Health Safety obligations.

Who should implement the National Safety and Quality Primary Healthcare Standards?

Implementing the NSQPH Standards is voluntary. However, the NSQPH Standards have been designed to facilitate significant benefits for both the primary healthcare services as well as patients and consumers. The Commission strongly encourages primary healthcare services in Australia to implement them.

The NSQPH Standards may be particularly useful for primary healthcare services where safety and quality standards do not currently exist or where primary healthcare services are ineligible to be assessed against relevant profession-specific standards. Regardless of the setting, the NSQPH Standards provide all primary healthcare services with access to a consistent national framework for improving safety and quality.

Not all actions in the NSQPH Standards will apply in all primary healthcare services. For example, actions relating to medication safety would not be applicable in a service that does not prescribe, supply and/or administer medicines. For further direction and information see **Appendix 1: Not-applicable actions**.

Implementing the National Safety and Quality Primary Healthcare Standards

The NSQPH Standards provides a framework to support primary healthcare services implement a continuous cycle of patient safety and quality improvement activities. This will help to ensure services have in place the safety and quality systems that minimise the risk of harm and improve care for patients.

A suite of resources will be available to support the implementation of the NSQPH Standards by providing practical guidance and assistance. These will be available on the Commission's website www.safetyandquality.gov.au.

The main steps in the implementation of the NSQPH Standards are as follows:

Step 1: Getting to know the NSQPH Standards

Primary healthcare services should familiarise themselves with the actions of the NSQPH Standards and how they will be applied, including identifying actions that do not need to be implemented in specific circumstances. Refer to **Appendix 1: Not-applicable actions** for further detail.

Step 2: Working through individual actions of NSQPH Standards

Implementation of the NSQPH Standards is self-paced. How the NSQPH Standards are implemented will vary depending on the size and context of the primary healthcare service, as well as the types of services delivered.

For each applicable action within the NSQPH Standards, a primary healthcare service should consider how its current way of working, policies, training and involvement of patients and consumers demonstrates the achievement of a specific action in practice. The primary healthcare service should at the same time identify the documents, processes and/or records that can be provided as evidence that each applicable action within the NSQPH Standards is met.

Where gaps are identified, a primary healthcare service should consider the changes needed to meet the requirements of the specific action. Documentation from these quality improvement activities becomes evidence of changes being introduced.

The Commission will develop resources such as an electronic workbook and self-assessment checklist to support primary healthcare services implement the NSQPH Standards. The resources will be available via the Commission's website www.safetyandquality.gov.au.

Primary healthcare services will also be able to contact the Commission's **Safety and Quality Advice Centre** via email accrediation@safetyandquality.gov.au or telephone for enquiries and information regarding the implementation of the NSQPH Standards.

Additional supports may also be available from local government agencies, for example Primary Health Networks, member-based professional organisations and consumer advocacy groups.

Step 3: Continuous quality improvement activities

Once the NSQPH Standards have been implemented, a primary healthcare service should make sure it continues to use the processes and systems developed when delivering patient care. This will help the service to identify and reduce the risks of harm to patients from the delivery of care, and ensure that the care delivered is appropriate. Primary healthcare services should conduct regular self-assessments of their safety and quality systems and monitor patient care and outcomes to identify areas that would benefit from quality-improvement activities. This includes reviewing ways of working, policies and procedures, incident reports, best practice guidelines and the setting where primary healthcare services are delivered.

Assurance to the community – the accreditation (assessment) process

Accreditation is a program in which trained external reviewers assess a primary healthcare service's implementation of the NSQPH Standards. Assessment involves assessors seeking evidence of implementation against the actions in the NSQPH Standards. Assessment against the NSQPH Standards and the awarding of accreditation status provides assurance to the community that a primary healthcare service has the safety and quality systems and processes in place to meet expected patient safety and quality standards of care. Primary healthcare services will be able to become accredited to the NSQPH Standards under the Australian Primary Healthcare Safety and Quality Accreditation (APHSQA) Scheme, which will provide for the national coordination of accreditation processes.

Alignment with other standards

The structure and format of the NSQPH Standards is consistent with the second edition of the Commission's National Safety and Quality Health Service (NSQHS) Standards, to which all hospitals and day procedure services in Australia must be accredited[7]. Both sets of standards highlights the importance of clinical governance (Clinical Governance Standard) and consumer partnerships (Partnering with Consumers Standard) in effective, safe and good quality care wherever care is delivered.

Primary healthcare services may already be complying with a range of quality improvement standards such as the National Disability Insurance Scheme Practice Standards, the Aged Care Quality Standards and National Standards for Mental Health Services. The NSQPH Standards are at the core of safety and quality service delivery in primary health care and where possible, the Commission will work with relevant organisations to investigate potential mechanisms to reduce the administrative burden associated with accreditation to multiple sets of standards.

A number of profession-specific standards exist and some primary healthcare services, such as general practices and community pharmacies, already have accreditation programs in place.[8, 9] Accreditation in these programs may be a requirement to access government funding such as the Practice Incentive Program (PIP), the Workforce Incentive Program (WIP) and certain Community Pharmacy Programs.[10-12] Commonwealth, state or territory governments or funders of primary healthcare services may require the implementation of the NSQPH Standards for funding or contractual requirements.

While there will be overlap with profession-specific standards, the NSQPH Standards aim to provide a consistent national framework for safety and quality improvement activities across the primary healthcare sector, with a focus on embedding clinical governance frameworks and consumer-centred care.

Terminology used in the National Safety and Quality Primary Healthcare Standards

'Patient', 'client', 'person' or 'consumer'

The NSQPH Standards uses the term 'patient' to refer to a person or group receiving primary healthcare services and the term 'consumer' to refer to a person who has used or may use a primary healthcare service, or a consumer representative or advocate. The term 'patient' encompasses all other relevant terms that may be used in primary health care including 'client', 'person', and 'people with lived experience of specific areas of ill health'.

'Primary healthcare provider', 'health practitioner', 'healthcare provider' or 'clinician'

The NSQPH Standards uses the term 'primary healthcare provider' to describe trained individuals who are involved in the provision of health care in a primary healthcare setting. Primary healthcare providers may also be referred to as health practitioners, healthcare providers, clinicians or by a profession-specific description, for example dentist or physiotherapist.

'Healthcare' vs. 'health care'

Throughout this document, the Commission has used the words 'health care' when referring to a noun (for example, 'the state of health care in Australia') and 'healthcare' when referring to an adjective (for example, the 'healthcare system' or 'primary healthcare services').

'Systems'

The NSQPH Standards rely on primary healthcare services establishing safety and quality systems. A system includes the resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish a stated goal.

Safety and quality systems will vary depending on the size of the primary healthcare service and the risks associated with the services being delivered.

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National Safety and Quality Primary Healthcare Standards

1. Clinical Governance Standard

Primary healthcare services have a responsibility to the community for continuous improvement of the safety and quality of their services, and ensuring they are person centred, safe and effective.

Intention of this standard

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

Criteria

Governance, leadership and culture

The primary healthcare service sets up and uses clinical governance systems to improve the safety and quality of health care for patients.

Patient safety and quality systems

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

Clinical performance and effectiveness

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

Safe environment for the delivery of care

The environment in which services are delivered enables safe and high-quality health care for patients.

Governance, leadership and culture

The primary healthcare service sets up and uses clinical governance systems to improve the safety and quality of health care for patients.

Item	Action	*Explanatory notes*
Governance, leadership and culture	1.01 The primary healthcare service: a. Has culture of safety and quality improvement b. Partners with patients, carers and consumers c. Set priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce d. Establishes and maintains a clinical governance framework e. Ensures that roles and responsibilities for safety and quality are clearly defined and to ensure accountability in the service f. Monitors and reviews the safety and quality performance of the service g. Considers the safety and quality of health care for patients in its business decision-making h. Establishes and maintains systems for integrating care with other service providers	*Clinical governance is the set of relationships and responsibilities established by a primary healthcare service between regulators and funders, owners and managers, primary healthcare providers, patients, consumers and other stakeholders to ensure good clinical outcomes.* *For further information on what a clinical governance framework is, refer to* ***Appendix 2****.* *These processes should be used to drive improvements in safety and quality.* *Systems for integrating care may be as simple as structured referral processes, agreed mechanisms for communication or involvement in multidisciplinary teams and shared care arrangements.*

Patient safety and quality systems

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

Item	Action	*Explanatory notes*
Policies and procedures	1.02 The primary healthcare service uses a risk management approach to: a. Establish and maintain policies, procedures and protocols b. Monitor and improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements in relation to safety and quality	*Policies and procedures form part of a service's clinical governance framework. Refer to* ***Appendix 2*** *for further information.* *This action refers to safety and quality policies and procedures that are:* • *Adapted to the specific service needs and risks* • *Based on evidence and best practice*

Item	Action	*Explanatory notes*
		• *Updated with changes to the evidence or service delivery* *A risk management approach ensures policies cover all key risks to minimise and control probability and impact of harm to patients.*
Measurement and quality improvement	1.03 The primary healthcare service uses a range of data to: a. Identify priorities for safety and quality improvement b. Implement and monitor safety and quality improvement activities c. Measure changes in safety and quality outcomes d. Provide timely information on safety and quality performance to its workforce and patients	*Data may include clinical data, feedback from patients, and details of complaints, adverse events and near misses.* *Where available, it could also include benchmark data against similar services.*
Risk management system	1.04 The primary healthcare service: a. Supports the workforce to identify, mitigate and manage safety and quality risks b. Documents and routinely monitors safety and quality risks c. Plans for, and manages internal and external emergencies, pandemics and disasters	*Risks will be different for different services but may include failures in the storage of temperature-sensitive medicines; lack of privacy controls to protect patient healthcare records; loss of key utilities, e.g. electricity or access to technology such as electronic medical records.*
Incident management and open disclosure	1.05 The primary healthcare service has an incident management system that: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce in the review of incidents d. Provides timely feedback on the analysis of incidents to the workforce and patients, carers and families who have communicated concerns or incidents e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system	*An incidents management system may be a paper-based log or a comprehensive electronic system of adverse events and near misses that is regularly reviewed. It relies on a culture of reporting and review, so individuals and services can learn from previous adverse events and change their processes and systems to reduce the risk of them happening again.*

Item	Action	*Explanatory notes*
	g. Regularly reviews and acts to improve the effectiveness of the incident management	
	1.06 The primary healthcare service uses the Australian Open Disclosure Framework when a patient is harmed through the delivery of care.	*Primary healthcare providers should use the Open Disclosure Framework whenever patients are harmed. 'Open disclosure' describes the process of the service provider having an open discussion with the patient, carers and the patient's family about adverse events that resulted in harm to the patient while receiving health care. Further information on open disclosure, including applicability for sole practitioners and small practices is available on the Commission's website.*
Feedback and complaints management	1.07 The primary healthcare service: a. Seeks feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback on their understanding and use of the safety and quality system c. Uses feedback to improve safety and quality	*Feedback provides important opportunities to identify and drive improvements in the way care is delivered*
	1.08 The primary healthcare service: a. Provides opportunities for its patients to report complaints b. Has processes to address complaints in a timely way c. Uses information from the analysis of complaints to improve safety and quality	*Complaints to a primary healthcare service are one form of feedback that can highlight risks in service provision.*
Diversity and high-risk groups	1.09 The primary healthcare service: a. Identifies the diversity of patients using its service, including those who are at a higher risk of harm b. Uses this information to minimise risks in the planning and delivery of care	*Understanding the diversity of the people accessing care enables a service to better plan and provide for their service needs, including use of relevant care pathways. It also enables the identification of patients who may be at a higher risk of harm. Risks can be associated with English as a second language, age, ethnicity, being of Aboriginal*

Item	Action	*Explanatory notes*
		and/or Torres Strait Islander origin and having other health-related conditions.
Healthcare records	1.10 The primary healthcare service has a healthcare record system that: a. Makes the healthcare record available to primary healthcare providers at the point of care b. Supports primary healthcare providers to maintain accurate and complete healthcare records c. Complies with privacy and security regulations d. Supports audits of healthcare records e. Facilitates a patient's access to their healthcare record	*Healthcare records must be accurate and up to date. Patients have a right to access their health information, during or following an episode of care. It is important that patients let their healthcare provider know if any information is incorrect, incomplete or out of date.* *Linked to action 3.24*
	1.11 The primary healthcare service has processes to: a. Receive and review reports b. Action reports c. Communicate to the patient information from reports and action taken d. Document reports in the patient's healthcare record	*Reports from other healthcare providers, such as patient referrals or pathology results, must be reviewed, acted upon, communicated to the patient and documented.*
	1.12 The primary healthcare service using My Health Record has processes to: a. Use national healthcare identifiers b. Use standard national terminologies	*This action applies to primary healthcare services with primary healthcare providers authorised to view and add patient health information to a patient's My Health Record.*
	1.13 The primary healthcare service providing clinical information into the My Health Record system has processes to: a. Comply with legislative requirements b. Ensure the accuracy and completeness of information uploaded	*This action applies to primary healthcare services using conformant clinical software containing an authenticated digital certificate to access the My Health Record system.*

Clinical performance and effectiveness

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

Item	Action	*Explanatory notes*
Safety and quality training	1.14 The primary healthcare service: a. Provides its workforce with an orientation to their safety and quality roles on commencement with the service, when safety and quality responsibilities change and when new services are introduced b. Identifies the training needs of its workforce to meet the requirements of these Standards c. Ensures its workforce completes training to meet its safety and quality training needs	*The primary healthcare service needs to ensure its workforce, including locums and contractors, has the skill and knowledge required to implement the safety and quality systems in the service. An example of training includes understanding the legal, ethical and practical components of informed consent.*
	1.15 The primary healthcare service has strategies and practices to provide culturally safe services to meet the needs of its Aboriginal and Torres Strait Islander patients	*Cultural safety identifies that consumers are safest when healthcare providers have considered power relations, cultural differences and patients' rights.[13] Part of this process requires healthcare providers to examine their own realities, beliefs and attitudes. [13] Refer to the 'cultural safety' definition in glossary for essential features of cultural safety.*
Safety and quality roles and responsibilities	1.16 The primary healthcare service ensures its workforce understands and fulfils their assigned safety and quality roles and responsibilities	*Irrespective of the size, all members of the workforce, including locums and contractors, need to know and understand their responsibilities for safety and quality if they are to fulfil their role effectively.*
Evaluating performance	1.17 The primary healthcare service has processes to: a. Regularly evaluate performance of its workforce b. Identify safety and quality training needs	*There are many ways to evaluate performance, which will be dependent on the structure and size of the primary healthcare service. Examples include continuing professional development and self-reflection, peer evaluation or formalised performance management processes. Outcomes of performance evaluations provide*

Item	Action	*Explanatory notes*
		opportunities to plan for skills and knowledge development.
Scope of clinical practice	1.18 The primary healthcare service has processes to: a. Define the scope of clinical practice for primary healthcare providers, considering the skills required to perform their role b. Regularly evaluates primary healthcare providers' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of primary healthcare providers periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered	*Primary healthcare providers practising within their designated scope of clinical practice will reduce the risk of harm to patients by ensuring care is provided by a competent provider in an ethical manner. Where applicable, this includes maintaining current registration with the relevant national health practitioner regulation board or maintaining accreditation with the relevant self-regulation body.*
	1.19 The primary healthcare service has processes to ensure that primary healthcare providers have the qualifications and skills required to perform their role	*This may include confirming registration status, where available; checking for recency of practice, providing oversight or testing competencies on commencement with a primary healthcare service.*
Evidence-based care	1.20 The primary healthcare service provides its workforce with ready access to best practice guidelines and decision support tools relevant to their clinical practice	*The use and monitoring of evidence-based clinical guidelines, decision support tools and standards supports effective care.*
Variation in care delivered and health outcomes	1.21 The primary healthcare service: a. Monitors and reviews care delivered against best practice guidelines to identify variation b. Explores reasons for variation of care from best practice c. Uses information on unwarranted variation from best practice to deliver appropriate care	*Services delivered to patients should be consistent with best practice. Identifying services associated with the highest preventable risk to patients or highest activity and monitoring and reviewing how these services deviate from best practice may help identify opportunities to deliver appropriate care, and in turn improve patient outcomes.* *Some Clinical Care Standards may be applicable in the primary healthcare setting.*

Item	Action	*Explanatory notes*
		Primary healthcare services should also consider whether care delivered utilises programs and services that aim to address the specific needs of Aboriginal and Torres Strait Islander patients.

Safe environment for the delivery of care

The environment in which services are delivered enables safe and high-quality health care for patients.

Item	Action	*Explanatory notes*
Safe environment	1.22 The primary healthcare service maximises safety and quality of care: a. Through the design of the environment b. By ensuring infrastructure, devices and equipment being used are maintained and are fit for purpose c. By ensuring patients' privacy when care is provided	*The primary healthcare service environment, such as the physical space and the information and communications technology used, need to be fit for purpose and maintained in good working order to ensure patient safety and maximise the quality of care delivered.* *Primary healthcare services that do not have a fixed place of practice will need to ensure there are strategies in place to comply with standards when they are delivering care, whatever the settings.*
	1.23 The primary healthcare service provides easy patient access to its facilities	*This may include providing easy patient access for people with a disability, facilitating access to services via telehealth and signposting*
	1.24 The primary healthcare service demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people	*Providing a welcoming environment for Aboriginal and Torres Strait Islander people can improve their willingness to participate in care, their experience of care and ultimately their outcomes of care.*

2. Partnering with Consumers Standard

Primary healthcare services develop, implement and maintain systems to partner with consumers in their own care.

Intention of this standard

The Partnering with Consumers Standard recognises the importance of working with consumers in the planning and delivery of their own care and providing clear communication to minimise risks of harm. This standard, together with the Clinical Governance Standard, form a comprehensive clinical governance framework.

Criteria

Clinical governance and quality improvement systems to support partnering with consumers

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

Partnering with patients in their own care

Partnering with patients underpins the delivery of care. Patients are partners in their own care to the extent that they choose.

Health literacy

Primary healthcare services communicate with consumers in a way that supports effective partnerships.

Partnering with consumers in service design

Consumers are partners in the planning, design, monitoring and evaluation of services.

Clinical Governance and quality and quality improvement systems to support partnering with consumers

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

Item	Action	*Explanatory notes*
Integrating clinical governance	2.01 Primary healthcare providers use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers	*The safety and quality systems set up are used to support the primary healthcare service to partner with consumers.*
Applying quality improvement systems	2.02 The primary healthcare service applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers	*The primary healthcare service assesses how well it well it is partnering with consumers and takes action to improve.*

Partnering with patients in their own care

Partnering with patients underpins the delivery of care. Patients are partners in their own care to the extent that they choose.

Item	Action	*Explanatory notes*
Healthcare rights and informed consent	2.03 The primary healthcare service: a. Uses a Charter of Rights consistent with the Australian Charter of Healthcare Rights b. Make the Charter of Rights easily accessible for patients, carers, families and consumers c. Ensures its informed consent processes comply with legislation and best practice	*The Australian Charter of Healthcare Rights describes the rights of patients in accessing care. These rights are essential to ensuring that safety and quality care is provided to all people, in all healthcare settings. This includes informed consent.* *Services will be expected to display the Australian Charter of Healthcare Rights in healthcare settings or provide access for their patients to the charter.*
	2.04 The primary healthcare service has processes to identify: a. The capacity of a patient to make decisions about their own care	*According to the legislation of every Australian jurisdiction, all adults are presumed to have the capacity to make decisions about their care. A policy on identifying*

Item	Action	*Explanatory notes*
	b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves	*substitute decision-makers is required for patients whose decision-making capacity is limited or fluctuates. Substitute decision-makers are involved in decisions about a patient's care.*
Sharing decisions and planning care	2.05 The primary healthcare service has processes for primary healthcare providers to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care	*Shared decision making is a process in which the primary healthcare provider and patient jointly participate in making a health decision, having discussed the options, and their benefits and harms, and having considered the patient's values, preferences and circumstances.[14] Where possible, supported decision making enables a patient to remain involved. Substitute decision-making should be used as a last resort for the shortest possible time, and reviewed regularly.[14] It should not be a substitute to appropriate support for the patient making decisions about their own care.*
	2.06 The primary healthcare service supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care	

Health literacy

Primary healthcare services communicate with consumers in a way that supports effective partnerships.

Item	Action	*Explanatory notes*
Communication that supports effective partnerships	2.07 The primary healthcare provider communicates with patients, their carers and/or family about health and health care in a way that: a. Is tailored to the patient's needs and preferences b. Is easily understood c. Addresses the need for ongoing care	*When tailoring information, consider the diversity of people who use the service and, where relevant, the cultural diversity of the local community.* *Some primary healthcare providers may be eligible to access Translating and Interpreting Service (TIS National).* *Linked to action 1.09 and 1.16*
Accessing primary healthcare service information	2.08 The primary healthcare service provides information to the public about: a. The services available	*Providing information on access will help consumers decide when, how and whether to use the service.*

Item	Action	*Explanatory notes*
	b. The opening hours and how to access care c. The likely service costs d. Alternative care when the service is closed, or in an emergency e. Service location(s) and access details	*Access details can refer to physical access or remote access where telehealth is used.* *Where the same service is provided from multiple sites, access details for each site should be provided.* *Where services are provided in a patient's home, access details are not required.*

Partnering with consumers in service design

Consumers are partners in the planning, design, monitoring and evaluation of services.

Item	Action	*Explanatory notes*
Partnerships in the planning, design, monitoring and evaluation of services	2.09 The primary healthcare service works in partnership with consumers to incorporate their views and experiences into the planning, design, monitoring and evaluation of services	*Different types of partnerships with patients and consumers exist within the healthcare system. Effective partnerships, a positive experience for patients, and high-quality health care and improved safety are linked.*[15-17] *Examples include seeking feedback from patients and consumers, such as the views of local Aboriginal and Torres Strait Islander communities, when redesigning the physical environment, considering implementing a new service, or changing an existing service. Patients' accounts of their experience of care may be used in the review of services.* *Linked to action 1.07.*

3. Clinical Safety Standard

Primary healthcare services implement systems and processes to maximise safe, good-quality care and minimise clinical safety risks.

Intention of this standard

This standard aims to ensure clinical safety risks commonly encountered in primary health care are addressed and mitigated. The clinical safety risks in this standard include:

- Preventing and controlling healthcare-associated infection
- Medication safety
- Comprehensive care
- Communicating for safety (maintaining continuity of care).

Criteria

Preventing and controlling healthcare-associated infection

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

Medication safety

Systems are in place to support the safe, appropriate and effective use of medicines, reduce the risks associated with medication incidents and improve the safety and quality of medicine use.

Comprehensive care

Comprehensive care is the coordinated delivery of the total health care required or requested by a patient, which may be a discrete episode of care or part of an ongoing comprehensive care plan. This care is planned and delivered in collaboration with the patient and aligns with their expressed goals of care and healthcare needs. It considers the effect of the patient's health issues on their life and wellbeing, and is clinically appropriate.

Communicating for safety

Communicating for safety aims to ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for patients.

Preventing and controlling healthcare-associated infections

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

Item	Action	*Explanatory notes*
Standard and transmission-based precautions	3.01 The primary healthcare service has processes to apply standard and transmission-based precautions that are consistent with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare,* and jurisdictional requirements	*In all healthcare settings there is a risk of infection. Processes for preventing and controlling infections include ensuring training on how, and when to apply the various elements of standard and transmission-based precautions relevant to the primary healthcare setting.* *Primary healthcare services must identify and mitigate all infection and prevention control risks. Actions 3.02 – 3.10 address risks common to primary healthcare services that are known to require specific attention.*
Hand hygiene	3.02 The primary healthcare service has a hand hygiene processes that: a. Is consistent with the National Hand Hygiene Initiative, and jurisdictional requirements b. Supports the workforce and consumers to practise hand hygiene	*Effective hand hygiene is an evidence-based, infection prevention strategy. It involves the availability of alcohol-based hand sanitiser, hand-washing facilities, education, auditing hand hygiene compliance and addressing non-compliance.*
Respiratory hygiene, cough etiquette and physical distancing	3.03 The primary healthcare service supports the workforce and consumers to practise respiratory hygiene, cough etiquette and physical distancing	*Infections that are spread by droplet and airborne modes can be effectively managed with respiratory hygiene and cough etiquette practices, and physical distancing.*
Aseptic technique	3.04 The primary healthcare service has processes for aseptic technique that: a. Identify procedures where aseptic technique applies b. Assess the competence of the workforce to perform aseptic technique c. Provides access to training to address gaps in competency	*This action only applies where aseptic technique is used in the provision of care. Aseptic technique is a set of practices aimed at minimising contamination and is particularly used to protect the patient from infection during procedures.*[18] *Examples of where aseptic*

Item	Action	*Explanatory notes*
	d. Monitor compliance with the service's policies on aseptic technique	*technique applies include wound management and certain procedures performed by podiatrists and dentists.*
Invasive medical devices	3.05 The primary healthcare service has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*	*This action only applies where invasive medical devices are used in the provision of care.*
Clean environment	3.06 The primary healthcare service has processes to maintain a clean and hygienic environment - in line with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare,* and jurisdictional requirements – that: a. Respond to environmental risks b. Requires cleaning and disinfection in line with recommended cleaning frequencies c. Include training in and appropriate use of specialised personal protective equipment for the workforce	*Environmental and infection risks are minimised when the environment is clean and well-maintained.*
	3.07 The primary health service has processes to evaluate and minimise the infection risks associated with: a. New and existing equipment, devices and products used in the primary healthcare service b. Maintaining, repairing and upgrading buildings, equipment, furnishings and fittings c. Handling, transporting and storage of linen	
Workforce immunisation	3.08 The primary healthcare service has a risk-based work immunisation process that: a. Is consistent with the current edition of the *Australian Immunisation Handbook* b. Is consistent with jurisdictional requirements for vaccine-preventable diseases	*This action protects the workforce from vaccine-preventable infections. This action requires a documented process for any members of the workforce that refuse vaccination. This is in order to reduce the risks to patients who may be vulnerable to infections.*

Item	Action	*Explanatory notes*
	c. Addresses service specific risks to the workforce and patients	
Reprocessing of reusable medical devices	3.09 Where reusable equipment, instruments and devices are used, the primary healthcare service has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A tracking or traceability system in place that identifies patients who have a procedure using sterile reusable critical medical instruments, equipment and devices	*This action would only be applicable to some primary healthcare services e.g. dentists or podiatrists* *Critical items include any objects that enter sterile tissue or the vascular system, while semi-critical items come into contact with mucous membranes or non-intact skin.[19] Non-critical items come into contact with intact skin but not mucous membranes.[19] For further information, refer to the Australian Guidelines for the Prevention and Control of Infection in Healthcare* *All reusable critical equipment, instruments and devices and some semi-critical equipment, instruments and devices must be sterilised, either at the premises or by an off-site provider.*
Managing workforce, patients and visitors with acute infections	3.10 The primary healthcare service has a risk-based process for managing members of the workforce with acute transmissible infections that: a. Is consistent with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare* b. Aligns with jurisdictional requirements for affected workers in relation to screening and exclusion periods c. Addresses risks to the workforce, patients and visitors d. Promotes non-attendance at work when an acute transmissible infection is suspected e. Considers workforce capacity	*This action aims to minimise the risks of transmission of acute infections via workers, patients and visitors as well as disruptions to health service delivery where primary healthcare providers are unable practise due to suspected acute transmissible infections. Processes should be risk-based and applicable in response to outbreaks and pandemics. In some instances, physical distancing and screening of staff and visitors may be appropriate.*

Item	Action	*Explanatory notes*
Antimicrobial stewardship	3.11 The primary healthcare service that prescribes, supplies and/or administers antimicrobials: a. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing b. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard c. Reviews compliance of antimicrobial prescribing against current local or Australian therapeutic guidelines d. Identifies areas of improvement and takes action to increase the appropriateness of antimicrobial usage e. Has a mechanism to educate consumers about the risks, benefits and alternatives to antimicrobials for their condition	*Inappropriate and overuse of antimicrobials contributes to the emergence of resistant bacteria and causes patient harm. Patients with antimicrobial-resistant infections are more likely to experience ineffective treatment, recurrent infection, delayed recovery or even death.*[20] *Antimicrobial stewardship is a collective set of strategies to improve the appropriateness and minimise the adverse effects of antibiotic use.*[21]

Medication safety

Systems are in place to support the safe, appropriate and effective use of medicines, reduce the risks associated with medication incidents and improve the safety and quality of medicine use.

Item	Action	*Explanatory notes*
Documentation, provision and access to medicines-related information	3.12 A primary healthcare service that prescribes, supplies and/or administers medicines has processes to ensure primary healthcare providers work within their scope of clinical practice to: a. Take a best possible medication history on presentation or as early as possible in the episode of care b. Partner with patients in the management of their medicines c. Support patients to maintain a current and accurate medicines list d. Encourage patients to share their medicines list with other healthcare providers involved in their care and/or does so on a patient's behalf with their consent	*All primary healthcare providers must understand a patient's medication history relevant to the care provided.* *Primary healthcare providers partner with patients in medication management by actively involving patients in their own care, meeting the patient's information needs and sharing decision-making.*

Item	Action	*Explanatory notes*
	e. Use information on a patient's medication history to minimise risks in the planning and delivery of care	
	3.13 The primary healthcare service has processes to ensure primary healthcare providers work within their scope of clinical practice to: a. Provide information on medicines tailored to the patient's needs and risks b. Take action when a primary healthcare provider or patient identifies a suspected medicines-related problem c. Report suspected adverse drug reactions to the Therapeutic Goods Administration	*Information on medicines should include a rationale for medication use, explain the risk to the patient of both taking and not taking the medication, instructions for effective administration and the expected outcome of use, and action to take if expected outcomes do not occur.*
Safe and secure storage and supply of medicines	3.14 A primary healthcare service that stores, supplies and/or administers medicines complies with manufacturer's instructions, legislative and jurisdictional requirements for the: a. Safe and secure storage of medicines, including high-risk medicines b. Storage of temperature-sensitive medicines and vaccines and cold chain management c. Supply of medicines d. Disposal of unused, unwanted or expired medicines	*Applicable to primary healthcare services such as dental practices and optometrists.* *The safe supply of medicines is linked to action 3.12.*
High-risk medicines	3.15 The primary healthcare service that prescribes, stores, supplies and/or administers medicines has processes to: a. Identify high-risk medicines within the service b. Safely store, prescribe, supply, administer and dispose of high-risk medicines	*High-risk medicines have an increased risk of causing significant patient harm or death if they are misused or used in error.*[22]

Comprehensive care

Comprehensive care is the coordinated delivery of the total health care required or requested by a patient, which may be a discrete episode of care or part of an ongoing comprehensive care plan. This care is planned and delivered in collaboration with the patient and aligns with their expressed goals of care and healthcare needs. It considers the effect of the patient's health issues on their life and wellbeing, and is clinically appropriate.

Item	Action	*Explanatory notes*
Multidisciplinary collaboration	3.16 The primary healthcare service: a. Maximises opportunities for primary healthcare providers to collaborate with other health service providers b. Supports collaboration with other health service providers to develop a coordinated approach to the planning and delivery of care c. Facilitates reporting to a patient's other relevant care providers	*Collaboration includes referral to other healthcare providers, sending reports to a referring healthcare provider and discussions regarding a patient's care to ensure there is a coordinated approach to care provided.*
Health promotion and prevention	3.17 The primary healthcare service has processes to support health promotion, illness prevention and early intervention for its patients, considering the diversity of its patient population and high-risk groups	*A fundamental aim of any health system is to prevent disease and reduce ill health, so that people remain as healthy as possible for as long as possible.* [23] *Health promotion and prevention activities are used to target health challenges such as the prevention of infectious diseases and the increasing prevalence of chronic diseases and include signage or general lifestyle discussions with patients as part of the delivery of care.* *Primary healthcare services should consider the local community, such as Aboriginal and Torres Strait Islander populations, in health promotion and prevention activities.* *Links to actions 1.22 and 2.07*
Planning and delivering comprehensive care	3.18 The primary healthcare service has processes to ensure providers work within their scope of practice to plan and deliver comprehensive care by:	*Planning and delivering of comprehensive care may be a discrete episode of care (e.g. a hearing check) or as part of a comprehensive care plan (e.g.*

Item	Action	*Explanatory notes*
	a. Conducting risk screening and assessment b. Conducting a clinical assessment and diagnosis c. Identifying the patient's goals of care d. Identifying and minimising risks faced by patients from multicultural and diverse background e. Developing and agreeing a plan for care in partnership with the patient f. Delivering comprehensive care g. Reviewing and improving the processes of comprehensive care delivery h. Receiving and documenting in the patient's healthcare record a current advance care plan	*services provided under a mental health care plan or chronic disease management plan).* *Further information on this action can be found in the Commission's Implementing the Comprehensive Care Standard: Essential elements for delivering comprehensive care (August 2018)* [24] *Risk screening undertaken will be specific to the service being provided to patients accessing care and the patient receiving care. Patients from diverse background, who may have English as a second language may require additional support to understand or effectively partner in their own care.* *Not all patients will have an advance care plan. Where they are in place, primary healthcare providers need to be able to accept and action if appropriate.*
	3.19 The primary healthcare service has processes to: a. Routinely ask if a patient is of Aboriginal and/or Torres Strait Islander origin b. Record this information in the patient's healthcare record c. Use this information to optimise the planning and delivery of care	*Aboriginal and Torres Strait Islander peoples generally have poorer health outcomes than other Australians.* [25] *Establishing processes to identify Aboriginal and Torres Strait Islander peoples will assist in delivering high-quality and culturally safe care to all Aboriginal and Torres Strait Islander people, regardless of appearance.* [25] *There are a number of programs/services available that aim to address the specific needs of Aboriginal and Torres Strait Islander people.*
Comprehensive care at the end of life	3.20 The primary healthcare provider has processes to identify patients who are at the end of life that are consistent with the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care* and uses this information to plan and deliver care	*End of life refers to the period when a patient is living with, and impaired by, a fatal condition, even if the trajectory is ambiguous or unknown. This period may be years in the case of patients with chronic or malignant disease, or very brief in the case of patients who suffer*

Item	Action	*Explanatory notes*
		acute and unexpected illness or events, such as sepsis, stroke or trauma. [26] *Refer to the National Consensus Statement: Essential elements for safe and high-quality end-of-life care.* *Linked to action 1.09*
Predicting, preventing and managing aggression and violence	3.21 The primary healthcare service has processes to support collaboration with patients, carers and families to: a. Identify and mitigate situations that may precipitate aggression and violence b. Implement de-escalation strategies	*Carers and family accompanying patients are the primary source of information on likely aggression and violence. For example, patients with dementia can express pain or discomfort by being aggressive. Prior warning of this may better assist a primary healthcare provider when delivering care.*
Predicting, preventing and managing self-harm and suicide	3.22 The primary healthcare service has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed	*Carers and family accompanying patients may be a key source of information on likely self-harm and suicide.* *Safely and effectively responding to patients may include calling an ambulance, referring a patient to a mental health service or referring an patient of Aboriginal or Torres Strait Islander origin to a culturally safe, trauma informed mental health and wellbeing service.*
Recognising acute deterioration or distress and escalating care	3.23 The primary healthcare service has processes to: a. Detect deterioration in a patient's physical, mental or cognitive health b. Escalate care when a patient's physical, mental or cognitive health unexpectedly deteriorates c. Ensure rapid access to services that can deliver emergency care for patients whose physical, cognitive or mental condition acutely deteriorates d. Notify other relevant healthcare providers and family or carers when a patient's care is escalated	*Processes to escalate care may include administering first aid or contacting an ambulance. Notifying other relevant healthcare providers and family or carers will support closing the loop and is linked to action 3.26.* *Other relevant healthcare providers may include their general practitioner.*

Communicating for safety

Communicating for safety aims to ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for patients.

Item	Action	*Explanatory notes*
Processes for effective communication	3.24 The primary healthcare service has effective communication processes and uses patient identifiers to ensure patients are correctly identified	*Ensuring patients can correctly identify themselves will help ensure the correct care is delivered.*
	3.25 The primary healthcare service has processes to: a. correctly match patients to their care b. ensure essential information is documented in a patient's healthcare record	
Communication to support patient referral	3.26 The primary healthcare provider referring patients to other services: a. Uses best practice structured communication processes b. Consider the patient's risks, goals and preferences for care c. Provides information that is current, comprehensive and accurate	*Patient referrals include referrals to another relevant healthcare provider or to another healthcare setting e.g. hospital or aged care setting.* *Patient referral should contain information relevant to the healthcare provider the patient is being referred to.*
Minimising patient 'loss to follow-up'	3.27 The primary healthcare service has effective communication processes to: a. Maximise patient attendance of planned appointments b. Recall patients for follow-up care	*Ensuring patients can be contacted supports closed-loop communication and minimises the risks associated with care that is incomplete.* *Examples of when a patient may need to be recalled include when a significant test result requires further care/follow up or when incorrect healthcare advice has been provided.*
Communication of critical information	3.28 The primary healthcare service uses effective communication processes to communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Relevant healthcare providers involved in the patient's care b. Patients, substitute decision-makers, carers and families, in	

Item	Action		*Explanatory notes*
		accordance with the patient's preferences	
	3.29	The primary healthcare service has communication processes for patients, carers and families to directly communicate critical information and risks about care to their primary healthcare providers	

Appendix 1: Not applicable actions

In some circumstances, actions from the NSQPH Standards may not be applicable to a primary healthcare service. Table 1: Summary of 'not applicable' actions detail the circumstances where primary healthcare services may not need to implement certain actions. These will automatically apply to services of that type.

If there are additional actions the primary healthcare service considers not applicable, an application for these actions to be rated 'not applicable' can be made to the accrediting agency at the time the on-site assessment is confirmed. Supporting evidence must be provided to the accrediting agency and the accrediting agency must make their determination in accordance with the criteria for 'not applicable' actions issued by the Commission. Confirmation that the specified actions are rated 'not applicable', and therefore will not be assessed will occur prior or during the on-site assessment.

In large primary healthcare services, there may be specific service areas where an action does not apply, while remaining applicable elsewhere in the organisation. In these cases, the action will apply for the primary healthcare service but is not required to be assessed for service areas where it is demonstrated as not applicable.

Primary healthcare services not proceeding with accreditation should record their rationale and supporting evidence in their self-assessment process.

Table 1: Summary of 'not applicable' actions

	Action	Audiology services	Chinese medicine	Chiropractic services	Dental services	Dietitian services	Exercise physiology	Occupational therapy	Optometry services	Osteopathy	Physiotherapy	Mental health services	Podiatry services	Speech pathology services	Comment
1. Clinical Governance Standard															
Governance, leadership and culture															
Governance, leadership and culture	1.01														No exclusion
Patient safety and quality systems															
Policies and procedures	1.02														No exclusion
Measurement and quality improvement	1.03														No exclusion
Risk management system	1.04														No exclusion
Incident management and open disclosure	1.05														No exclusion
	1.06														No exclusion
Feedback and complaints management	1.07														No exclusion
	1.08														No exclusion
Diversity and high-risk groups	1.09														No exclusion
Healthcare records	1.10														No exclusion
	1.11														No exclusion
	1.12	*	*	*	*	*	*	*	*	*	*	*	*	*	*Not applicable when evidence is provided that the My Health Record system is not in use.
	1.13	*	*	*	*	*	*	*	*	*	*	*	*	*	*Not applicable when evidence is provided that the My Health Record system is not in use.

	Action	Audiology services	Chinese medicine	Chiropractic services	Dental services	Dietitian services	Exercise physiology	Occupational therapy	Optometry services	Osteopathy	Physiotherapy	Mental health services	Podiatry services	Speech pathology services	Comment
Clinical performance and effectiveness															
Safety and quality training	1.14														No exclusion
	1.15														No exclusion
Safety and quality roles and responsibilities	1.16														No exclusion
Evaluating performance	1.17														No exclusion
Scope of clinical practice	1.18														No exclusion
	1.19														No exclusion
Evidence-based care	1.20														
Variation in service provision and health outcomes	1.21														No exclusion
Safe environment for the delivery of care															
Safe environment	1.22														No exclusion
	1.23														No exclusion
	1.24	*	*	*	*	*	*	*	*	*	*	*	*	*	*Not applicable when evidence is provided that the risk of harm to Aboriginal and Torres Strait Islander patients is the same as for the primary healthcare service's general population
2. Partnering with Consumers															
Clinical governance and quality improvement systems to support partnering with consumers															
Integrating clinical governance	2.01														No exclusion
Applying quality improvement systems	2.02														No exclusion
Partnering with patients in their own care															

	Action	Audiology services	Chinese medicine	Chiropractic services	Dental services	Dietitian services	Exercise physiology	Occupational therapy	Optometry services	Osteopathy	Physiotherapy	Mental health services	Podiatry services	Speech pathology services	Comment
Healthcare rights and informed consent	2.03														No exclusion
	2.04														No exclusion
Sharing decisions and planning care	2.05														No exclusion
	2.06														No exclusion
Health literacy															
Communication that supports effective partnerships	2.07														No exclusion
Accessing primary healthcare service information	2.08														No exclusion
Partnering with consumers in service design															
Partnerships in the planning, design, monitoring and evaluation of services	2.09														No exclusion
3. Clinical Safety Standard															
Preventing and controlling healthcare-associated infection															
Standard and transmission-based precautions	3.01														No exclusion
Hand hygiene	3.02														No exclusion
Respiratory hygiene, cough etiquette and physical distancing	3.03														No exclusion
Aseptic technique	3.04	*		*		*	*	*		*	*	*	*	*	*Not applicable when evidence is provided that procedures where sterility needs to be maintained does not occur.
Invasive medical devices	3.05	*	*	*	*	*	*	*	*	*	*	*	*	*	*Not applicable when evidence is provided that

	Action	Audiology services	Chinese medicine	Chiropractic services	Dental services	Dietitian services	Exercise physiology	Occupational therapy	Optometry services	Osteopathy	Physiotherapy	Mental health services	Podiatry services	Speech pathology services	Comment
															invasive medical devices are not used.
Clean environment	3.06														No exclusion
	3.07														No exclusion
Workforce immunisation	3.08														No exclusion
Reprocessing of reusable medical devices	3.09	*		*		*	*	*	*	*	*	*		*	*Not applicable where evidence is provided that sterile reusable critical medical instruments, equipment and devices are not used.
Managing workforce, patients and visitors with acute infections	3.10														No exclusion
Antimicrobial stewardship	3.11	*		*		*	*	*	* ∞	*	*	*	* ∞	*	*Not applicable where prescribing, supplying and/or administering antimicrobial medicines is not within a primary healthcare provider's scope of clinical practice. ∞ Primary healthcare providers may attain an endorsement of professional registration for scheduled medicines, which enables them to prescribe, supply and/or administer medicines.

	Action	Audiology services	Chinese medicine	Chiropractic services	Dental services	Dietitian services	Exercise physiology	Occupational therapy	Optometry services	Osteopathy	Physiotherapy	Mental health services	Podiatry services	Speech pathology services	Comment
															In these instances, there is **no exemption for this action.**
Medication safety															
Documentation, provision and access to medicines-related information	3.12	*		*		*	*	*	* ∞	*	*	*	* ∞	*	*Not applicable where prescribing, supplying and/or administering medicines is not within a primary healthcare provider's scope of clinical practice. ∞ Primary healthcare providers may attain an endorsement of professional registration for scheduled medicines, which enables them to prescribe, supply and/or administer medicines. In these instances, there is **no exemption for this action.**
	3.13														No exclusion
Safe and secure storage and supply of medicines	3.14	*		*		*	*	*	* ∞	*	*	*	* ∞	*	*Not applicable where prescribing, supplying and/or administering medicines is not within a primary healthcare provider's scope of clinical practice.

	Action	Audiology services	Chinese medicine	Chiropractic services	Dental services	Dietitian services	Exercise physiology	Occupational therapy	Optometry services	Osteopathy	Physiotherapy	Mental health services	Podiatry services	Speech pathology services	Comment
															∞ Primary healthcare providers may attain an endorsement of professional registration for scheduled medicines, which enables them to prescribe, supply and/or administer medicines. In these instances, there is **no exemption for this action.**
High-risk medicines	3.15	*		*		*	*	*	* ∞	*	*	*	* ∞	*	*Not applicable where prescribing, supplying and/or administering medicines is not within a primary healthcare provider's scope of clinical practice. ∞ Primary healthcare providers may attain an endorsement of professional registration for scheduled medicines, which enables them to prescribe, supply and/or administer medicines. In these instances, there is **no exemption for this action.**
Comprehensive care															
Multidisciplinary collaboration	3.16														No exclusion

	Action	Audiology services	Chinese medicine	Chiropractic services	Dental services	Dietitian services	Exercise physiology	Occupational therapy	Optometry services	Osteopathy	Physiotherapy	Mental health services	Podiatry services	Speech pathology services	Comment
Health promotion and prevention	3.17														No exclusion
Planning and delivering comprehensive care	3.18														No exclusion
	3.19														No exclusion
Comprehensive care at the end of life	3.20														No exclusion
Predicting, preventing and managing aggression and violence	3.21														No exclusion
Predicting, preventing and managing self-harm and suicide	3.22														No exclusion
Recognising acute deterioration or distress and escalating care	3.23														No exclusion
Communicating for safety															
Processes to support effective communication	3.24														No exclusion
	3.25														No exclusion
Communication to support patient referral	3.26														No exclusion
Minimising patient 'loss to follow-up'	3.27														No exclusion
Communication of critical information	3.28														No exclusion
	3.29														No exclusion

Appendix 2: Clinical Governance Framework

The information in Appendix 2 has been adapted from the National Model Clinical Governance Framework[27] for primary health care.

What is clinical governance?

Clinical governance is the set of relationships and responsibilities established by a primary healthcare service between regulators and funders, owners and managers, primary healthcare providers, patients, consumers and other stakeholders to ensure good clinical outcomes.

It ensures that:

- The community can be confident there are systems in place to deliver safe and high-quality health care
- There is a commitment to continuously improve services
- Everyone – including primary healthcare providers, other members of the workforce and the managers and owners of the primary healthcare service – is accountable to patients and the community for ensuring the delivery of safe, effective and high-quality care.

What is a clinical governance framework?

A primary healthcare service's clinical governance framework describes the processes and structures that are needed to deliver safe and high-quality care.

The clinical governance framework of a primary healthcare service for services operated by a sole trader will be simpler compared to a large, corporately-run primary healthcare service where clinical governance is an integrated component of corporate governance.

Individual services, in implementing the National Safety and Quality Primary Healthcare (NSQPH) Standards, will develop and implement governance systems that are appropriate for local needs and values, together with complexity of services and the context in which they are provided.

A robust clinical governance system will drive improvements in safety and quality.

Purpose of a clinical governance framework

The delivery of health care is a complex endeavour. The ways in which care is delivered is rapidly changing, as are the expectations of patients and consumers. Primary healthcare services operate alongside many different types of services across primary, secondary and tertiary, sectors. Patients and consumers move between services and sectors, and safety and quality risks exist at all points on their journeys. Safety and quality are a professional and organisational responsibility.

The purpose of having a clinical governance framework is to describe the safety and quality systems and processes that a primary healthcare service relies on when delivering care. This provides assurances to patients and the community that the primary healthcare service is committed to continuously improving safety and quality for patients.

How do I establish a clinical governance framework?

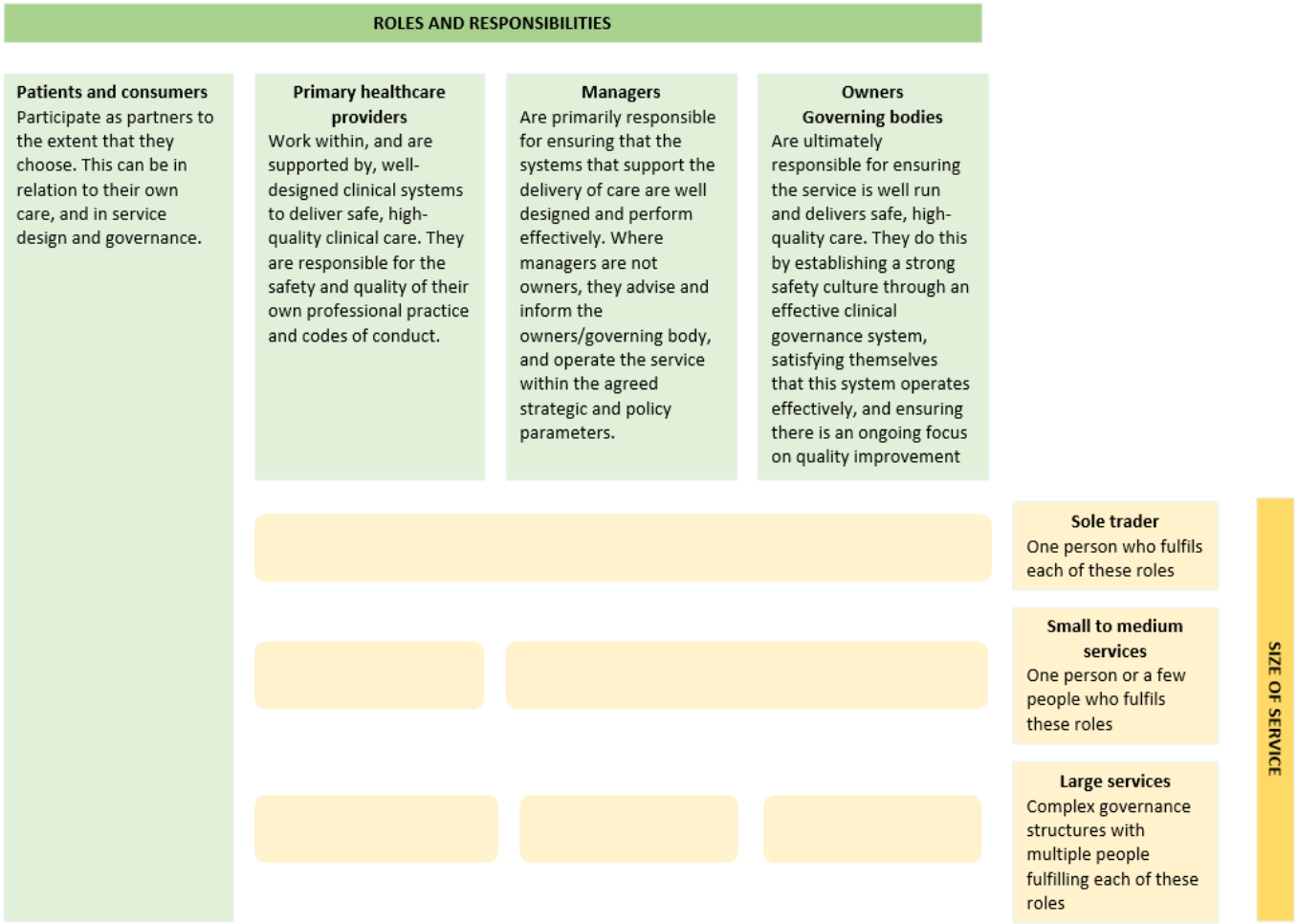
Individual primary healthcare services, in implementing the Clinical Governance Standard and Partnering with Consumers Standard within the NSQPH Standards, will establish a clinical governance framework. These processes and systems in turn support effective implementation of the third Clinical Safety Standard, which considers specific high-risk areas of care commonly encountered in primary health care.

In establishing a clinical governance framework, a primary healthcare services will describe five components:

- **Governance, leadership and culture** – how the service sets up and uses clinical governance systems to improve the safety and quality of health care for patients
- **Patient safety and quality improvement systems** – the policies and procedures used to ensure consistent ways of working; how risks are identified and managed; how the needs of the local community are met; how feedback is used to improve services; how healthcare records are securely maintained and used; how incidents, including those where a patient is harmed through the delivery of care, are addressed and learnt from and how priorities for safety and quality improvement are identified and acted upon
- **Clinical performance and effectiveness** – how the service ensures the workforce has the right qualifications, skills and supervision to provide safe, high-quality health care to patients
- **Safe environment for the delivery of care** – how the environment where services are delivered promotes safe and high-quality health care for patients
- **Partnering with consumers** – how the service partners with consumers in their own care; how it communicates with consumers in a way that supports effective partnerships; how it works with consumers to incorporate their views and experiences into the planning, design, monitoring and evaluation of services.

Roles and responsibilities for clinical governance

Within a well governed primary healthcare service, everyone, including primary healthcare providers, other members of the workforce, managers and owners/governing bodies are accountable for their contribution to the safety and quality of care delivered. The broad roles of each are outlined below. Depending on the size of the service, multiple roles may be carried out by the same individual.



In addition to these roles, regulators (for example state and territory health departments) and funders provide regulatory parameters in which primary healthcare services are delivered. Implementation of a primary healthcare service's clinical governance system involves contributions by individuals at all levels of the organisation.

Glossary

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

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

adverse drug reaction: a response to a medicine that is noxious and unintended, and occurs at doses normally used or tested in humans for the prophylaxis, diagnosis or therapy of disease, or for the modification of physiological function.[28] An allergy is a type of adverse drug reaction.

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

alert: warning of a potential risk to a patient.

allergy: occurs when a person's immune system reacts to allergens in the environment that are harmless for most people.[29] Typical allergens include some medicines, foods and latex.[29, 30] An allergen may be encountered through inhalation, ingestion, injection or skin contact.[29] A medicine allergy is one type of adverse drug reaction.

antimicrobial: a chemical substance that inhibits or destroys bacteria, viruses or fungi, and can be safely administered to humans and animals.[31]

antimicrobial resistance: failure of an antimicrobial to inhibit a microorganism at the antimicrobial concentrations usually achieved over time with standard dosing regimens.[31]

antimicrobial stewardship: an ongoing effort by a health service organisation (including primary healthcare services) to reduce the risks associated with increasing antimicrobial resistance and to extend the effectiveness of antimicrobial treatments. It may incorporate several strategies, including monitoring and review of antimicrobial use.[31]

appropriate care: patients are receiving the right care, and the right amount of care according to their needs and preferences, at the right time. The care offered should also be based on the best available evidence.[32]

approved identifiers: items of information accepted for use in identification, including family and given names, date of birth, sex, address, healthcare record number and Individual Healthcare Identifier. Health service organisations and healthcare providers are responsible for specifying the approved items for identification

aseptic technique: a set of practices aimed at minimising contamination and is particularly used to protect the patient from infection during procedures.[18]

assessment: a healthcare provider's evaluation of a disease or condition based on the patient's subjective report of the symptoms and course of the illness or condition, and their objective findings. These findings include data obtained through laboratory tests, physical examination and medical history; and information reported by carers, family members and other members of the healthcare team. The assessment is an essential element of a comprehensive care plan.[33]

audit (clinical): a systematic review of clinical care against a predetermined set of criteria.[34]

Australian Charter of Healthcare Rights: specifies the key rights of patients when seeking or receiving healthcare services. The second edition was launched in August 2019.[35]

Australian Open Disclosure Framework: endorsed by health ministers in 2013, it provides a framework for health service organisations and clinicians to communicate openly with patients when health care does not go to plan.[36]

best possible medication history: a list of all the medicines a patient is using at presentation. The list includes the name, dose, route and frequency of the medicine, and is documented on a specific form or in a specific place. All prescribed, over-the-counter and complementary medicines should be included. This history is obtained by a healthcare provider working within their scope of clinical practice who interviews the patient (and/or their carer) and is confirmed, where appropriate, by using other sources of medicines information.[37]

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

best-practice guidelines: a set of recommended actions that are developed using the best available evidence.

They provide healthcare providers with evidence-informed recommendations that support clinical practice, and guide healthcare provider and patient decisions about appropriate health care in specific clinical practice settings and circumstances.[38]

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

carer: a person who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail or aged. An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are paid, a volunteer for an organisation, or caring as part of a training or education program.[39]

care pathway: a complex intervention for the mutual decision-making and organisation of care processes for a well-defined group of patients during a well-defined period.[40]

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

clinical governance: the set of relationships and responsibilities established by a primary healthcare service between regulators and funders, owners and managers, primary healthcare providers, patients, consumers and other stakeholders to ensure good clinical outcomes.[27]

It ensures that:

- The community can be confident there are systems in place to deliver safe and high-quality health care
- There is a commitment to continuously improve services
- Everyone – including primary healthcare providers, other members of the workforce and managers/owners of the primary healthcare service – is accountable to patients and the community for ensuring the delivery of safe, effective and high-quality care.

clinical governance framework: describes the processes and structures that are needed to deliver safe and high-quality care.[27] These include:

- Governance, leadership and culture
- Patient safety and quality improvement systems
- Clinical performance and effectiveness
- Safe environment for the delivery of care
- Partnering with consumers.

clinical practice: the assessment, diagnosis, treatment and health care delivered to a patient.

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

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

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

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

consumer: a person who has used, or may potentially use, health services, or is a carer for a patient using health services.

consumer advocate: *see* consumer representative

consumer representative: a consumer who has taken up a specific role to provide advice on behalf of consumers, with the overall aim of improving healthcare.[41]

cough etiquette: *see respiratory hygiene and cough etiquette*

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

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

cultural safety: identifies that consumers are safest when healthcare providers have considered power relations, cultural differences and patients' rights. [13]Essential features of cultural safety are:

- An understanding of one's culture
- An acknowledgement of difference, and requirement that healthcare providers are actively mindful and respectful of difference(s)
- Informed by the theory of power relations; any attempt to depoliticise cultural safety is to miss the point
- An appreciation of the historical context of colonisation, the practices of racism at individual and institutional levels, and their impact on Aboriginal and Torres Strait Islander people's living and wellbeing, both in the present and past
- That its presence or absence is determined by the experience of the recipient of care and not defined by the healthcare provider.

decision support tools: tools that can help healthcare providers and consumers to draw on available evidence when making clinical decisions. The tools have a number of formats. Some are explicitly designed to enable shared decision making (for example, decision aids). Others provide some of the information needed for some components of the shared decision-making process (for example, risk calculators, evidence summaries), or provide ways of initiating and structuring conversations about health decisions (for example, communication frameworks, question prompt lists).[42] See also shared decision making

de-escalation strategies: psychosocial techniques that aim to reduce violent or disruptive behaviour. They are intended to reduce or eliminate the risk of violence during the escalation phase, using verbal and non-verbal communication skills. De-escalation is about establishing rapport to gain the patient's trust, minimising restriction to protect their self-esteem, appearing externally calm and self-aware in the face of aggressive behaviour, and intuitively identifying creative and flexible interventions that will reduce the need for aggression.[43]

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

diversity: The varying social, economic and geographic circumstances of consumers who use, or may use, the services of a health service organisation, as well as their cultural backgrounds, disability status, religions, beliefs and practices, languages spoken, sexual orientation, gender identity and gender expression, and sex characteristics.

end of life: the period when a patient is living with, and impaired by, a fatal condition, even if the trajectory is ambiguous or unknown. This period may be years in the case of patients with chronic or malignant disease, or very brief in the case of patients who suffer acute and unexpected illnesses or events, such as sepsis, stroke or trauma.[44]

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

episode of care: a health problem from its first encounter with a healthcare provider through to the completion of the last encounter.[45]

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

governance: the set of relationships and responsibilities established by a health service organisation such as a primary healthcare service between its management,

workforce and stakeholders (including patients and consumers). 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 NSQPH Standards, governance includes both corporate and clinical governance.

guidelines: clinical practice guidelines are systematically developed statements to assist healthcare providers and consumer decisions about appropriate health care for specific circumstances.[46]

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

healthcare identifiers: are unique numbers assigned and used in health related information to clearly identify the patient, the treating professional and the organisation where healthcare is provided to reduce the potential for errors with healthcare related information and communication.[47, 48] In Australia, the Healthcare Identifiers (HI) Service is a national system for uniquely identifying, healthcare providers, healthcare organisations and individuals receiving healthcare.[47] These include:

- Individual Healthcare Identifier (IHI) – identifies a patient (individual) receiving healthcare. An IHI uniquely identifies individuals who receive healthcare, including Australian citizens, permanent residents and visitors to Australia
- Healthcare Provider Identifier – Individual (HPI-I) – identifies an individual healthcare provider who provides healthcare, such as general practitioners, allied health professionals, specialists, nurses, dentists and pharmacists, among others
- Healthcare Provider Identifier – Organisation (HPI-O) – identifies the healthcare provider organisation where healthcare is provided, such as hospitals, medical practices, pathology or radiology laboratories and pharmacies.[47]

Healthcare providers (*see* definition) must be registered with the HI Service and assigned healthcare identifiers to access a patient's My Health Record (*see* definition).[49]

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.[36]

health service organisation: a separately constituted health service that is responsible for implementing clinical governance, administration and financial management of a service unit or service units providing health care to patients. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community and primary health care settings, practices and clinicians' rooms.

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

health practitioner: *see* healthcare provider

healthcare provider: an individual who practises a profession relating to the provision of health care. Healthcare providers may be required maintain profession-specific registration with a national board under National Registration and Accreditation Scheme or be self-regulated.[50] A healthcare provider may also referred to as a health practitioner. *See also* clinician and primary healthcare provider

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

healthcare record system: a healthcare record and management system (that may be paper-based or electronic) that is used by healthcare providers in healthcare settings. Healthcare record information must be properly managed and safeguarded from start (record generation) to finish (record destruction) and the entire time in between.[51]

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

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

The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the healthcare system, which affect the ways in which consumers access, understand, appraise and apply health-related information and services.[52]

higher risk (patients at higher risk of harm):
a patient with multiple factors or a few specific factors that result in their being more vulnerable to harm from

health care or the healthcare system. Risk factors may include having chronic clinical conditions; having language barriers; being of Aboriginal or Torres Strait Islander background; having low health literacy; being homeless; or being of diverse gender identities and experiences, bodies, relationships and sexualities (currently referred to as lesbian, gay, bisexual, transgender and intersex, or LGBTI).

high-risk medicines: medicines that have an increased risk of causing significant patient harm or death if they are misused or used in error. High-risk medicines may vary between hospitals and other healthcare settings, depending on the types of medicines used and patients treated. Errors with these medicines are not necessarily more common than with other medicines. Because they have a low margin of safety, the consequences of errors with high-risk medicines can be more devastating.[22, 53] At a minimum, the following classes of high-risk medicines should be considered:

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

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

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

infection: the invasion and reproduction of pathogenic (disease-causing) organisms inside the body. This may cause tissue injury and disease.[54]

information communications technology: Diverse set of technological tools and resources used to transmit, store, create, share or exchange information. These technological tools and resources include computers, the Internet, live broadcasting technologies, recorded broadcasting technologies and telephony.[55]

informed consent: a process of communication between a patient and healthcare provider about options for treatment, care processes or potential outcomes.[56] This communication results in the patient's authorisation or agreement to undergo a specific intervention or participate in planned care.[56] The communication should ensure that the patient has an understanding of the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.[57]

injury: damage to tissues caused by an agent or circumstance.[58]

jurisdictional requirements: systematically developed statements from state and territory governments about appropriate healthcare or service delivery for specific circumstances.[46] Jurisdictional requirements encompass a number of types of documents from state and territory governments, including legislation, regulations, guidelines, policies, directives and circulars. Terms used for each document may vary by state and territory.

leadership: having a vision of what can be achieved, and then communicating this to others and evolving strategies for realising the vision. Leaders motivate people, and can negotiate for resources and other support to achieve goals.[59]

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

mandatory: required by law or mandate in regulation, policy or other directive; compulsory.[60]

medicine: a chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental wellbeing of people. These include prescription, non-prescription, investigational, clinical trial and complementary medicines, irrespective of how they are administered.[61]

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

- Underuse
- Overuse
- Use of inappropriate medicines (including therapeutic duplication)
- Adverse drug reactions, including interactions (medicine–medicine, medicine–disease, medicine–nutrient, medicine–laboratory test)
- Noncompliance.[62, 63]

medicines list: a way to keep all the information about medicines a person takes together.[64]A medicines list contains, at a minimum:

- All medicines a patient is taking, including over-the-counter, complementary,

prescription and non-prescription medicines; for each medicine, the medicine name, form, strength and directions for use must be included[65]
- Any medicines that should not be taken by the patient, including those causing allergies and adverse drug reactions

Ideally, a medicines list also includes the intended use (indication) for each medicine.[66]

multidisciplinary collaboration: a process where healthcare providers from different disciplines share clinical information to optimise the delivery of comprehensive care for a patient.[67]

My Health Record: the secure online summary of a consumer's health information, managed by the System Operator of the national My Health Record system (the Australian Digital Health Agency). Healthcare providers are able to share health clinical documents to a consumer's My Health Record, according to the consumer's access controls. These may include information on medical history and treatments, diagnoses, medicines and allergies.[68]

near miss: an incident or potential incident that was averted and did not cause harm, but had the potential to do so.[69]

open disclosure: an open discussion with a patient and carer about an incident that resulted in harm to the patient while receiving health care. The criteria of open disclosure are an expression of regret, and a factual explanation of what happened, the potential consequences, and the steps taken to manage the event and prevent recurrence.[70]

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.[58]

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

patient: a person who is receiving care in a health service organisation such as a primary healthcare service.

person-centred care: an approach to the planning, delivery and evaluation of health care that is founded on mutually beneficial partnerships among clinicians and patients.[71] Person-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of person-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care.[15] Also known as patient-centred care or consumer-centred care.

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

policy: a set of principles that reflect the organisation's mission and direction.

primary health care: the first level of contact for individuals, families and communities with the national health system. Primary health care is provided as close as possible to where people live and work, and is the first stage of a continuing health care process.[1] It covers health promotion, prevention, early intervention, treatment of acute conditions, management of chronic conditions and end-of-life care.[2]

primary healthcare provider: a healthcare provider (*see* definition) that delivers care in a primary healthcare service.

primary healthcare service: a primary healthcare provider or organisation that delivers **primary health care** (*see definition)*.

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

process: a series of actions or steps taken to achieve a particular goal.[72]

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

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

quality improvement: the combined efforts of the workforce and others – including consumers, patients and their families, researchers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development.[73] Quality improvement activities may be undertaken in sequence, intermittently or continually.

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

respiratory hygiene and cough etiquette: A combination of measures designed to minimise the transmission of respiratory pathogens via droplet or airborne routes in healthcare settings.[19]

responsibility and accountability for care: accountability includes the obligation to report and be answerable for consequences. Responsibility is the acknowledgement that a person has to take action that is appropriate to a patient's care needs and the health service organisation.[74]

reusable device: a medical device that is designated by its manufacturer as suitable for reprocessing and reuse.[75]

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

risk assessment: assessment, analysis and management of risks. It involves recognising which events may lead to harm in the future, and minimising their likelihood and consequences.[76]

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

safety culture: a product of individual and group values, attitudes, perceptions, competencies and patterns of behaviour that determine the commitment to, and the style and proficiency of an organisation's health and safety management. Positive patient safety cultures have strong leadership that drives and prioritises safety as well as:

- Shared perceptions of the importance of safety
- Constructive communication
- Mutual trust
- A workforce that is engaged and always aware that things can go wrong
- Acknowledgement at all levels that mistakes occur
- Ability to recognise, respond to, give feedback about, and learn from, adverse advents.

scope of clinical practice: the extent of an individual healthcare provider's approved clinical practice, based on the individual's skills, knowledge, professional registration (where applicable), performance and professional suitability, and the needs and service capability of the organisation.74

screening: a process of identifying patients who are at risk, or already have a disease or injury. Screening requires enough knowledge to make a clinical judgement.[77]

self-harm: includes self-poisoning, overdoses and minor injury, as well as potentially dangerous and life-threatening forms of injury. Self-harm is a behaviour and not an illness. People self-harm to cope with distress or to communicate that they are distressed.[78]

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

service context: the particular context in which care is delivered. Health service delivery occurs in many different ways, and the service context will depend on the organisation's function, size and organisation of care regarding service delivery mode, location and workforce.[79]

shared decision making: a consultation process in which a healthcare provider and a patient jointly participate in making a health decision, having discussed the options, and their benefits and harms, and having considered the patient's values, preferences and circumstances.[42]

standard: agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.[58]

standard national terminologies: a structured vocabulary used in clinical practice to accurately describe the care and treatment of patients. Healthcare providers around the world use specialised vocabulary to describe diseases, operations, clinical procedures, findings, treatments and medicines. In Australia, terminologies include SNOMED CT-AU and Australian Medicines Terminology.[80] Standard national terminologies are also referred to as clinical terminologies.

standard precautions: work practices that provide a first-line approach to infection prevention and control, and are used for the care and treatment of all patients.[75]

substitute decision-maker: a person appointed or identified by law to make health, medical, residential and other personal (but not financial or legal) decisions on behalf of a patient whose decision-making capacity is impaired. A substitute decision-maker may be appointed by the patient, appointed for (on behalf of) the person, or identified as the default decision-maker by legislation, which varies by state and territory.[33]

supported decision making: enables a person with cognitive impairment to remain involved in decisions about their health care rather than having their decision-making capacity removed.[14]

surveillance: an epidemiological practice that involves monitoring the spread of disease to establish progression patterns. The main roles of surveillance are to predict and observe spread; to provide a measure for

strategies that may minimise the harm caused by outbreak, epidemic and pandemic situations; and to increase knowledge of the factors that might contribute to such circumstances.[54]

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

- Brings together risk management, governance, and operational processes and procedures, including education, training and orientation
- Deploys an active implementation plan; feedback mechanisms include agreed protocols and guidelines, decision support tools and other resource materials
- Uses several incentives and sanctions to influence behaviour and encourage compliance with policy, protocol, regulation and procedures.

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

telehealth: the use information and communications technologies (ICTs) to deliver health services and transmit health information over both long and short distances. [81]

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

traceability: the ability to trace the history, application or location of reusable medical devices. Some professional groups may refer to traceability as tracking.[75]

tracking: *see* traceability

training: the development of knowledge and skills.

transitions of care: situations when all or part of a patient's care is transferred between healthcare locations, providers, or levels of care within the same location, as the patient's conditions and care needs change.[82]

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

unwarranted variation: where variation is not due to difference in patients' clinical needs or preferences. Unwarranted variation represents an opportunity for improvement.

variation: a difference in healthcare processes or outcomes, compared to peers or to a standard such as an evidence based guideline recommendation.[32]

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

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