AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

D23-9387

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National Safety and Quality Cosmetic Surgery Standards

Public consultation

About the Commission

The Australian Commission on Safety and Quality in Health Care (the Commission) leads and coordinates national improvements in the safety and quality of health care. The Commission works in partnership with the Australian Government, state and territory governments and the private sector to achieve a safe, high-quality and sustainable health system. In doing so, the Commission also works closely with patients, carers, clinicians, managers, policymakers and healthcare organisations.

Key functions of the Commission include:

- Developing national safety and quality standards
- 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 four priority areas:

- Safe delivery of health care
- Partnering with consumers
- Partnering with healthcare professionals
- Quality, value and outcomes.

Introduction

Cosmetic surgery has seen exponential growth in recent years. Demand is consumer driven, and while surgical interventions are employed, the purpose of these interventions are to achieve a change in physical appearance which is more aesthetically pleasing from the perspective of the person undergoing cosmetic surgery. As a result, there are specific safety and quality risks that are unique to the cosmetic surgery sector. Cosmetic surgery that is not delivered to acceptable safety and quality standards can have severe consequences on patient health outcomes.

In September 2022, Australian Health Ministers agreed to a suite of reforms to the cosmetic surgery sector, to ensure that clinicians providing cosmetic surgery are appropriately qualified and work to the highest health and safety standards.

About the Cosmetic Surgery Standards

The Commission is developing the National Safety and Quality Cosmetic Surgery Standards (Cosmetic Surgery Standards) as part of the agreed reforms to address key safety and quality risks that specifically relate to the sector. The Cosmetic Surgery Standards aim to protect the public from harm and improve the quality of cosmetic surgery delivered.

The Cosmetic Surgery Standards are person-centred and describe the processes and structures that are needed to deliver safe and high-quality clinical care. They comprise of seven individual standards:

Standard	Description
Clinical Governance	The set of relationships and responsibilities established by a service provider to measure and ensure good clinical outcomes. It ensures the community and service provider can be confident that systems are in place to deliver safe and high-quality care, and continuously improve services.
Partnering with Consumers	The systems and strategies to create a person-centred service provider in which patients and consumers are fully informed of the risks and costs of services, and are provided information in a way they can understand to support shared decision making.
The Clinical Governance Standard and the Partnering with Consumers Standard set the overarching requirements, or clinical governance framework, for the effective implementation of all other standards.	
Preventing and Controlling Infections	The systems and strategies to prevent infection, effectively manage infections, prevent and contain antimicrobial resistance and promote appropriate prescribing and use of antimicrobials as part of antimicrobial stewardship.
Medication Safety	The systems and strategies to ensure clinicians are competent to safely prescribe, dispense, administer and monitor medicines, and patients understand their individual medicine needs and risks.
Comprehensive Care	The integrated screening, assessment and risk identification processes for developing an individualised care plan, to prevent and minimise the risks of harm in identified areas.
Communicating for Safety	The systems and strategies for effective communication between patients, carers, families and clinicians across the service provider.
Recognising and Responding to Acute Deterioration	The systems and processes to respond effectively to patients when their physical, mental or cognitive condition deteriorates.

Each standard contains:

- A description of the standard
- Consumer outcome statements
- Statement of intent
- Criteria that describe the key areas covered by the standard
- Explanatory notes on the context of the standard
- Item headings for groups of actions in each criterion
- Actions, describing what is required to meet the standard.

The Cosmetic Surgery Standards are designed to mitigate risk relating to the delivery of clinical care within service providers where cosmetic surgery is performed. Some actions may also be relevant to legal, jurisdictional and business obligations. At all times, a service provider must adhere to regulatory requirements as prescribed in relevant Commonwealth, state and territory legislation, such as licensing or work health and safety obligations.

Where will the Cosmetic Surgery Standards apply?

The Cosmetic Surgery Standards have been developed for implementation in service providers, also referred to as facilities where cosmetic surgery is performed. The Standards provide a framework for the implementation of safety and quality processes and systems and accreditation is the quality assurance mechanism used to test whether these systems are in place. Independent assessment against the standards and the awarding of accreditation status provides confidence to the community that service providers where cosmetic surgery is performed have the safety and quality systems and processes in place to meet expected patient safety and quality standards of care.

The Commission is working with state and territory jurisdictions to develop a National Licensing Framework for Cosmetic Surgery to ensure that all cosmetic surgical procedures are conducted in appropriately licensed facilities. It is intended that accreditation to the Cosmetic Surgery Standards will form part of this licensing framework.

The Cosmetic Surgery Standards are aligned in structure and intent to the National Safety and Quality Health Service (NSQHS) Standards (second edition), which are implemented in all Australian hospitals and day procedure services. Once the Cosmetic Surgery Standards are finalised, the Commission will map the two sets of standards. Where a service provider is required to meet the NSQHS Standards, they will continue to be required to comply with the NSQHS Standards, plus a small number of additional actions. In this way, service providers will be considered to comply with both sets of standards.

Have your say

The Cosmetic Surgery Standards are being developed through broad consultation with consumers, clinicians, service providers, professional and peak bodies, regulators, and other representatives of the sector.

The Commission is seeking your feedback on the draft Cosmetic Surgery Standards in this document. Public consultation starts on **1 May 2023** and ends **26 May 2023.** You are invited to provide feedback on any, or all, of the content relating to individual actions in the Cosmetic Surgery Standards.

The Commission welcomes feedback on any, or all, of the following areas:

1. **Introduction:** What further information is required to support your understanding of the context of the Cosmetic Surgery Standards and how they are to be applied?
2. **Language:** How could we improve the language and terminology used to make it easier to understand and more appropriate and applicable to cosmetic surgery service providers?
3. **Appropriateness**: Are there key safety and quality issues for cosmetic surgery service providers that are not addressed by the actions?
4. **Clarification:** Does any of the content require further clarification or rewording? Please provide any suggestions for these changes.
5. **Gaps and duplication:** Are there any gaps in the content and how should this be addressed? Is there any unnecessarily duplicated content that could be removed?
6. **Other feedback:** Please provide any other feedback relevant to the standards or their implementation.

When providing feedback, please reference the specific section, item and/or action and page number.

You can submit your feedback via our online survey, by participating in an online forum, or by sending it via email to cosmeticsurgery@safetyandquality.gov.au. There is no word limit for your responses.

For further information on how to have your say, please visit:
www.safetyandquality.gov.au/standards/cosmetic-surgery-project

Terminology

The following terminology has been adopted for clarity of purpose within the Cosmetic Surgery Standards. A glossary is included at the end of document explaining words and phrases which may be unfamiliar.

'Cosmetic Surgery'

Cosmetic surgery employs invasive surgical procedures, such as physical removal or readjustment of organs or tissues to revise or change the appearance, colour texture, structure or position of normal bodily features and often involving cutting beneath the skin, with the dominant purpose of achieving what the patient perceives to be a more desirable appearance. It is not used to prevent, diagnose or treat medical diseases or conditions.

Cosmetic surgery does not encompass:

- Non-surgical cosmetic procedures such as cosmetic injectables, thread lifts and cryolipolysis (fat freezing)
- Mole removal
- Reconstructive surgery
- Gender affirmation surgery
- Surgery that has a medical justification even if it leads to improvements in appearance.

'Patient' or 'consumer'

'Patient' refers to a person or group considering or receiving cosmetic surgery and the term 'consumer' refers to a person who has used or may use a cosmetic surgery service provider, or a consumer representative or advocate. The term 'patient' encompasses all other relevant terms that may be used in cosmetic surgery such as 'client'.

'Clinician'

'Clinician' describes registered health practitioners who are involved in the provision of cosmetic surgery. Clinicians may also be referred to as healthcare professionals, healthcare providers or practitioners, or a profession-specific description, for example 'doctor', 'surgeon', 'nurse', or 'psychologist'.

'Workforce'

'Workforce' refers to all people working in a service provider, including clinicians and any other (medical or non-clinical) employed, credentialled or contracted, locum, agency, trainee, student, volunteer or peer workers.

'Service provider'

'Service provider', also referred to as a facility, describes the physical setting where cosmetic surgery is performed. The organisation may vary in size and complexity. These range from single owner-operator day-only services, where a single clinician is also responsible for administrative and management of the operation of the organisation, to complex organisations comprising many clinicians who may not be directly employed, a supporting workforce, management and overarching governing body.

Where 'service provider' is used in the actions, this refers to those responsible for leading and governing the services and setting where cosmetic surgery is performed.

How actions in the Cosmetic Surgery Standards are implemented by a service provider will depend on its size, organisational complexity and relevant members of the workforce.

‘Systems’

The Cosmetic Surgery Standards rely on service providers establishing safety and quality systems. A system includes the resources, policies, processes and procedures which are organised, integrated, regulated and administered to accomplish a stated goal. Safety and quality systems will vary depending on the size of the service provider and the risks associated with cosmetic surgery being delivered.

Draft National Safety and Quality Cosmetic Surgery Standards

Clinical Governance Standard

Service providers 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.

Consumer outcome

I am confident the service provider is well run and that I will receive safe, high-quality clinical care.

Intention of this standard

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

Explanatory notes

Clinical governance

Clinical governance is the set of relationships and responsibilities established by a service provider between regulators and funders, managers, owners and governing bodies (where relevant), clinicians, healthcare providers, the workforce, patients, consumers and other stakeholders to ensure optimal clinical outcomes (see **Figure 1**).[1] It ensures that:

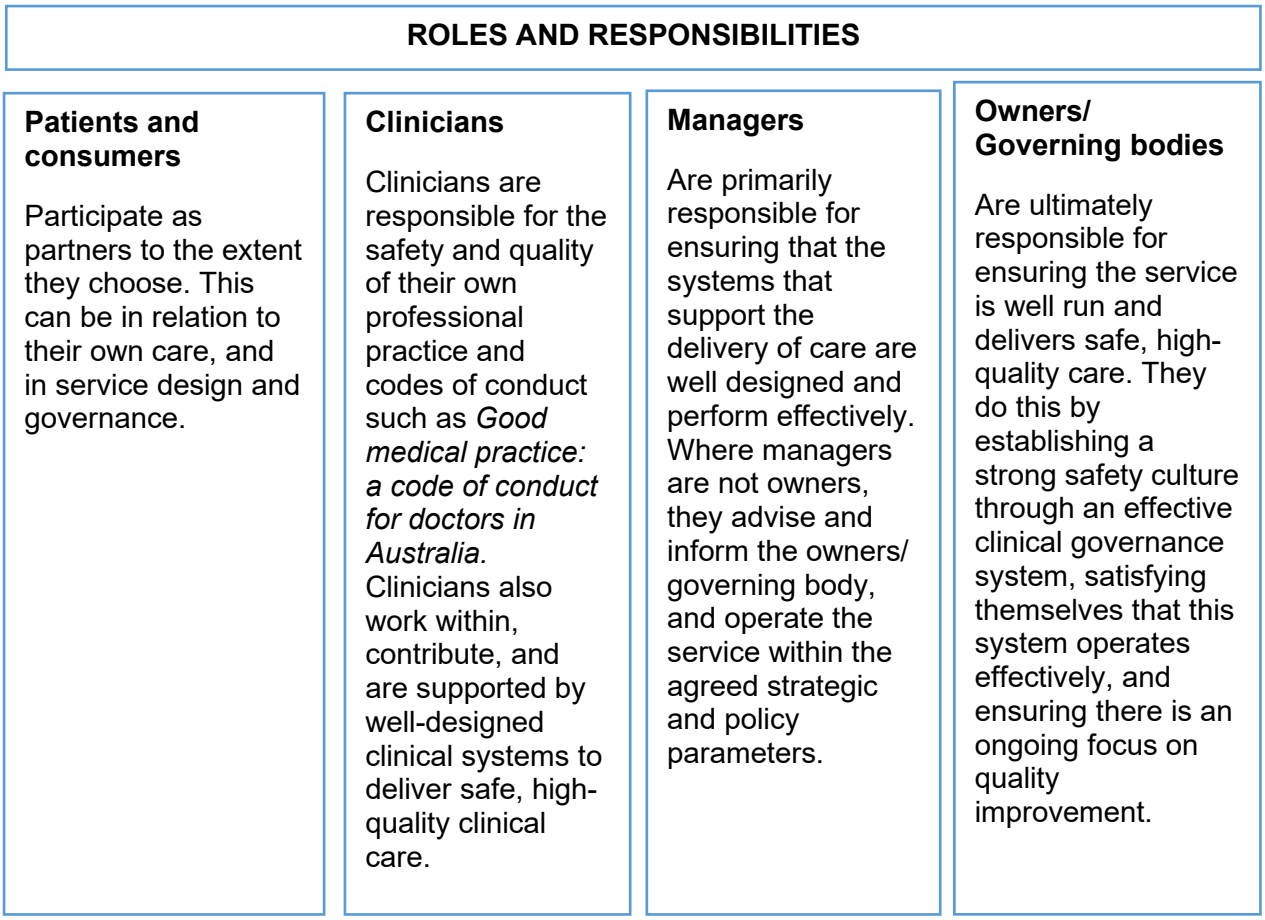
- The community can be confident there are systems in place to deliver safe and high-quality care
- There is a commitment to continuously improve services
- Everyone is accountable to patients and the community for ensuring the delivery of safe, effective and high-quality care. This includes service providers, clinicians, other members of the workforce and managers, owners and governing bodies (where they exist). Depending on the size of the service provider, multiple roles may be carried out by the same individual.[1]

Clinical governance framework

A service provider's clinical governance framework describes the safety and quality systems and processes that need to be in place to ensure the delivery of safe, high-quality care. The existence of a robust clinical governance framework provides assurances to patients and the community of safe care as well as driving improvements in cosmetic surgery.

The Clinical Governance Standard together with the Partnering with Consumers Standard when fully implemented, form a comprehensive clinical governance framework. This provides a foundation to support the implementation of the remaining standards, which address areas of high-risk to patients that are commonly encountered in cosmetic surgery.

Figure 1: Roles and responsibilities for clinical governance



Governance, leadership and culture

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

Consumer outcome: The service provider is high quality and continuously makes improvements.

Item	Action
Governance, leadership and culture	1.01 The service provider: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures these are communicated effectively to the workforce d. Establishes and maintains a clinical governance framework and uses the processes within the framework to drive improvements in safety and quality e. Clearly defines the safety and quality roles, responsibilities and accountabilities for those governing the service provider, management, clinicians and the workforce f. Monitors the action taken as a result of clinical incidents g. Reviews and monitors its progress on safety and quality performance h. Establishes and maintains systems for integrating care with other service providers involved in a patient's care
	1.02 The service provider considers the safety and quality of health care for patients in its business decision-making
	1.03 The service provider establishes and maintains systems to adapt clinical practices to reduce and mitigate its contribution to emissions
	1.04 The service provider has processes to assure itself that clinicians conducting cosmetic surgery: a. Comply with Medical Board of Australia and jurisdictional requirements for the assessment of patients for suitability for the planned surgery b. Allow sufficient time for informed consent processes to occur c. Ensure advertising of cosmetic surgery that they commission or are referenced in complies with legislation, national codes and guidelines

Item	Action
Clinical leadership	1.05 Clinical leaders support clinicians and others in the workforce to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Function within the clinical governance framework to improve the safety and quality of cosmetic surgery for patients

Patient safety and quality systems

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

Consumer outcome: I know the care I receive is well organised and my feedback will be heard and dealt with.

Item	Action
Policies and Procedures	1.06 The service provider uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements
Measurement and quality improvement	1.07 The service provider supports clinicians to contribute complete and accurate clinical data to clinical quality registries specified by the Medical Board of Australia relevant to clinicians' scope of clinical practice
	1.08 The service provider: a. Uses reports from clinical quality registries, its administrative, clinical and performance data to identify priorities for safety and quality improvement b. Acts on, reviews and monitors identified priorities for safety and quality improvement c. Measures changes in safety and quality indicators and outcomes d. Provides timely information on safety and quality improvement and performance to the governing body, the workforce and patients
Risk management	1.09 The service provider: a. Supports the workforce to identify, mitigate, report and manage safety and quality risks b. Routinely documents and monitors safety and quality risks c. Plans for, and manages, service provision during internal and external emergencies and disasters, including cyber security risks and threats
Incident management and open disclosure	1.10 The service provider has an incident management system that: a. Supports the workforce to communicate concerns, recognise and report incidents b. Supports patients to communicate concerns or report incidents c. Involves the workforce in the review of incidents d. Provides timely feedback on the analysis of incidents to the workforce and patients who have communicated concerns or incidents

Item	Action
	e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Is regularly reviewed and improved to support the effectiveness of care
	1.11 The service provider uses the Australian Open Disclosure Framework[2] when a patient is harmed from the provision of cosmetic surgery
Feedback and complaints management	1.12 The service provider: a. Has processes to regularly seek feedback from patients about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Reviews and reports on feedback to improve safety and quality systems
	1.13 The service provider: a. Supports 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 d. Provides patients with the contact details of relevant healthcare complaints authorities when there are unresolved complaints
Healthcare records	1.14 The service provider has a system for maintaining a record of care that: a. Makes the record available to clinicians at the point of care b. Requires the workforce to maintain accurate and complete records c. Complies with security and privacy regulations d. Supports systematic audit of clinical information e. Integrates multiple information systems, where they are used
	1.15 The service provider has processes to: a. Collect patient information prior to admission b. Ensure patients that are admitted comply with the service provider's admission policies
	1.16 The service provider uses a digital clinical information system that: a. Enables clinical information to be integrated into nationally agreed electronic health records

Item	Action
	b. Supports interoperability by the use of national healthcare unique identifier and standard national terminology
	1.17 Where the service provider is adding clinical information into the nationally agreed electronic health records, they implement processes for the workforce to access information in compliance with legislative requirements

Clinical performance and effectiveness

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

Consumer outcome: I get the services that I need from people who are qualified to provide my care.

Item	Action
Safety and quality training	1.18 The service provider: a. Provides its workforce with orientation and training 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 the workforce completes mandatory safety and quality training
Evaluating performance	1.19 The service provider has effective and reliable processes to: a. Regularly review the performance of its workforce b. Monitor performance to ensure clinicians are adhering to professional standards, codes and guidelines c. Identify needs for training and development of safety and quality d. Makes mandatory notifications about clinicians as required by legislation and jurisdictional requirements
Credentialing and scope of clinical practice	1.20 The service provider has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation b. Monitor performance to ensure that clinician's function within their designated scope of clinical practice c. Review data from safety and quality incidents, feedback and complaints received d. Use information from safety and quality incidents, feedback and complaints to review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered
	1.21 The service provider has credentialling processes to verify the qualifications and experience of clinicians providing cosmetic surgery to ensure only medical practitioners with appropriate qualifications, skills and training recognised by national legislation: a. Conduct cosmetic surgery b. Assist with the provision of anaesthetics for cosmetic surgery

Item	Action
Safety and quality roles and responsibilities	1.22 The service provider has processes to support its workforce to understand the clinical governance framework and fulfill their assigned safety and quality roles and responsibilities
Evidence-based care	1.23 The service provider has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care
Variation in clinical care and patient outcomes	1.24 The service provider supports its clinicians to: a. Monitor and review data on variation in patient outcomes and clinical care provided against best practice care b. Explore reasons for variation from best practice c. Use information on unwarranted clinical variation to improve clinical care and patient outcomes

Safe environment for the delivery of care

The environment in which cosmetic surgery is delivered enables safe and high-quality care for patients.

Consumer outcome: I feel safe and comfortable accessing care.

Item	Action
Safe environment	1.25 The service provider maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are safe and fit for purpose
	1.26 The service provider admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so

Partnering with Consumers Standard

Service providers develop, implement, and maintain systems to partner with consumers in their own care.

Consumer outcome

I am a partner in my own care and my opinion is valued in designing and delivering 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.

Explanatory notes

Partnering with consumers

Delivering care that is based on partnerships provides many benefits for patients, consumers, clinicians, service providers and the system.

Effective partnerships exist when people are treated with dignity and respect, information is shared with them, and participation and collaboration in care processes are encouraged and supported to the extent that people choose.[3] Effective partnerships, a positive experience for service users, high-quality care and improved safety are all linked.[4-6]

At the **individual level**, partnerships relate to the interaction between clinicians and patients when care is provided. This involves providing care that is respectful; sharing information in an ongoing way; working with patients, carers and families to make decisions and plan care; and supporting and encouraging patients to actively participate in their own care.[4]

At the **service provider level,** partnerships relate to the relationship with consumers that values and incorporates their views into the planning, design, delivery, monitoring and evaluation of cosmetic surgery.[4]

The processes involved with these partnerships will vary according to the type and size of cosmetic surgery being delivered.

Clinical governance framework

A service provider's clinical governance framework describes the safety and quality systems and processes that need to be in place to ensure the delivery of safe, high-quality care. The existence of a robust clinical governance framework provides assurances to patients and the community of safe care as well as driving improvements in cosmetic surgery.

Service providers implementing the Partnering with Consumers Standard together with the Clinical Governance Standard will establish a clinical governance framework. This will provide a foundation to support the implementation of all standards, which considers high-risk areas commonly encountered by cosmetic surgery.

Australian Charter of Healthcare Rights

The Australian Charter of Healthcare Rights (the Charter) (**Figure 2**) describes the rights that consumers, or someone they care for, can expect when receiving care. In doing so, the service provider ensures the seven healthcare rights described in the Charter are upheld in the planning and delivery of care.

Figure 2: The Australian Charter of Healthcare Rights[7]

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 care.

Consumer outcome: I am supported to be a partner in my own care.

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

Partnering with patients in their own care

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

Consumer outcome: I can choose how I partner in my care.

Item	Action
Healthcare rights	2.03 The service provider: a. Uses the Australian Charter of Healthcare Rights[7] b. Has processes to support the workforce apply the principles of the Australian Charter of Healthcare Rights in the planning and delivery of cosmetic surgery c. Makes the Australian Charter of Healthcare Rights easily accessible for the workforce and patients
Informed consent	2.04 The service provider ensures that its informed consent processes comply with legislation and best practice
	2.05 The service provider has processes to provide patients with informed financial consent relating to cosmetic surgery prior to admission
	2.06 The service provider has processes to assure itself that clinicians conducting cosmetic surgery have provided patients: a. Information about the cosmetic surgery including expected outcomes, risks relevant to the patient and possible complications b. Information on all financial costs relating to the cosmetic surgery c. Information on any possible future costs including management of complications
	2.07 The service provider has processes to ensure informed consent is given by a legally eligible decision-maker for patients under the legal age of consent
Shared decisions and planning care	2.08 The service provider has processes for clinicians to partner with patients to plan, communicate, set and review goals, make decisions and document their preferences for cosmetic surgery
	2.09 The service provider supports the workforce to partner with patients, so that patients can be actively involved in their own care

Health literacy

Service providers communicate with consumers in a way that supports effective partnerships.

Consumer outcome: I am given the information I need, in a way I can understand, to support me in making decisions about my care.

Item	Action
Accessing service information	2.10 The service provider makes information available to consumers on: a. Service location(s) and access details b. Medical practitioners conducting cosmetic surgery in the facility c. Estimated costs associated with cosmetic surgery performed in the facility d. Where estimated costs of services not directly charged by the service provider can be obtained e. Where to access post-operative health care when the service provider is closed, and in an emergency f. Mechanisms for providing feedback and contact details for the appropriate healthcare complaints authority
Communication that supports effective partnerships	2.11 The service provider supports clinicians to communicate with patients, about cosmetic surgery to ensure: a. Information is provided in a way that meets the needs of patients, and is easy to understand and use b. The clinical needs of patients are addressed while they are accessing cosmetic surgery c. On discharge, patients are provided with verbal and written information about their ongoing care and what to do if emergency assistance is required
Advertising	2.12 The service provider conducts regular audits of advertising of cosmetic surgery it commissions or is referenced in to ensure that advertising is not: a. False, misleading or deceptive, or likely to be misleading, or deceptive b. Offer a gift, discount or other inducement c. Use testimonials or purported testimonials about the surgery d. Create unreasonable expectation of beneficial treatment e. Directly or indirectly encourage the indiscriminate use of cosmetic surgery

Partnering with consumers in service design

Consumers are partners in the planning, design, delivery, monitoring and evaluation of cosmetic surgery.

Consumer outcome: My opinion matters in the development, delivery and review of cosmetic surgery.

Item	Action
Partnerships in the planning, design, monitoring and evaluation of cosmetic surgery	2.13 The service provider partners with the workforce and patients to seek and incorporate their views and experiences into the planning, design, monitoring and evaluation of cosmetic surgery

Preventing and Controlling Infections Standard

Evidence-based processes are used to prevent and control infections, antimicrobials are appropriately used and prescribed, and the service is clean and hygienic.

Consumer outcome

My risk of getting or spreading infection is assessed and minimised.

Intention of this standard

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

Explanatory notes

Each year, many infections are associated with the provision of clinical care and affect a large number of patients and, in some cases, consumers and members of the workforce.[8] These infections:

- Cause considerable harm and may increase risk of morbidity, and death
- Increase the use of health care
- Place greater demands on the workforce.

Infection prevention and control within clinical settings aims to minimise the risk of transmission of infections and the development of resistant organisms. One way this is minimised is through antimicrobial stewardship.

Antimicrobial stewardship is the ongoing effort by a service provider to optimise antimicrobial use among patients to improve patient outcomes, ensure cost-effective therapy and reduce adverse sequelae of antimicrobial use (including antimicrobial resistance). An antimicrobial stewardship program involves strategies and interventions that aim to reduce unnecessary antimicrobial use and promote the use of agents that are less likely to select for resistant microorganisms. This is done in line with treatment guidelines and with consideration of local susceptibility patterns.[9]

The Preventing and Controlling Infections Standard requires service providers to use evidence-based systems to reduce the risk of infection using the hierarchy of controls in conjunction with infection prevention and control systems. The hierarchy of controls is a model used in work health and safety management to control hazards that ranks controls from most to least reliable. If it is not reasonably practical to eliminate risks, then risks must be minimised, as far as is reasonably practicable, by using one or a combination of substitution, isolation, or engineering controls, followed by administrative controls and personal protective equipment.[10]

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

Systems are in place to support and promote prevention and control of infections, and improve antimicrobial stewardship.

Consumer outcome: The service is clean and hygienic.

Item	Action
Integrating clinical governance	3.01 The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for infection prevention and control b. Identifying and managing risks associated with infections c. Implementing policies and procedures for antimicrobial stewardship d. Identifying and managing antimicrobial stewardship risks
	3.02 The service provider: a. Identifies and manages risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems b. Identifies requirements for, and provides the workforce with, access to training to prevent and control infections c. Has processes to ensure the workforce has the capacity, skills and access to equipment to implement systems to prevent and control infections d. Has resources and processes to promote effective antimicrobial stewardship e. Identifies requirements for, and provides access to, training to support the workforce to conduct antimicrobial stewardship activities f. Has processes to ensure the workforce has the capacity and skills to implement antimicrobial stewardship g. Plans for public health and pandemic risks
Applying quality improvement systems	3.03 The service provider applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of infection prevention and control systems b. Implementing strategies to improve infection prevention and control systems c. Reporting to the workforce, patients and other relevant groups on the performance of infection prevention and control systems

Item	Action
	d. Monitoring the effectiveness of the antimicrobial stewardship program e. Implementing strategies to improve antimicrobial stewardship outcomes f. Reporting to the workforce, patients and other relevant groups on antimicrobial stewardship outcomes g. Supporting and monitoring the safe and sustainable use of infection prevention and control resources
Surveillance	3.04 The service provider has a surveillance strategy for infections, infection risk, and antimicrobial use and prescribing that: a. Incorporates national and jurisdictional information in a timely manner b. Collects data on healthcare-associated and other infections relevant to the size and scope of the organisation c. Monitors, assesses and uses surveillance data, where available, to reduce the risks associated with infections d. Reports surveillance data on infections to the workforce, patients and other relevant groups e. Collects data on the volume and appropriateness of antimicrobial use relevant to the size and scope of the organisation f. Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing g. Monitors responsiveness to risks identified through surveillance h. Reports surveillance data on the volume and appropriateness of antimicrobial use to the workforce, patients and other relevant groups

Infection prevention and control systems

Evidence-based processes are used to prevent and control infections. Patients presenting with, or with risk factors for, infection or colonisation with an organism of local, national or global significance are identified promptly, and receive the necessary management and treatment. The service provider implements systems for the safe and appropriate prescribing and use of antimicrobials as part of an antimicrobial stewardship program.

Consumer outcome: My risk of getting or spreading an infection is assessed and minimised.

Item	Action
Standard and transmission-based precautions	3.05 The service provider has processes to apply standard and transmission-based precautions that are fit for the setting and consistent with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare,* and jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws.
	3.06 The service provider has: a. Collaborative and consultative processes for the assessment and communication of infection risks to patients and the workforce b. Infection prevention and control systems, in conjunction with the hierarchy of controls, in place to reduce transmission of infections so far as is reasonably practicable c. Processes for the use, training, testing and fitting of personal protective equipment by the workforce d. Processes to monitor and respond to changes in scientific and technical knowledge about infections, relevant national or jurisdictional guidance, policy and legislation e. Processes to audit compliance with standard and transmission-based precautions f. Processes to assess competence of the workforce in appropriate use of standard and transmission-based precautions g. Processes to improve compliance with standard and transmission-based precautions h. Processes for appropriate storage and management of waste
	3.07 The workforce applies standard precautions and transmission-based precautions whenever required, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care

Item	Action
	b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs and patient placement to prevent and manage infection risks d. The risks to the wellbeing of patients in isolation e. Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems; workflow design; service provider design; surface finishes f. Precautions required when a patient is moved within the service provider or between external services g. The need for additional environmental cleaning or disinfection processes and resources h. The type of procedure being performed i. Equipment required for routine care
	3.08 The service provider has processes to: a. Review data on and respond to infections in the community that may impact patients and the workforce b. Communicate details of a patient's infectious status during an episode of care, and at transitions of care c. Provide relevant information to a patient about their infectious status, infection risks and the nature and duration of precautions to minimise the spread of infection
Hand hygiene	3.09 The service provider has a hand hygiene program that is incorporated in its overarching infection prevention and control program as part of standard precautions and: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, patients and other relevant groups d. Uses the results of audits to improve hand hygiene compliance
Aseptic technique	3.10 The service provider has processes for aseptic technique that: a. Identify the procedures in which aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique

Item	Action
Invasive medical devices	3.11 The service provider 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
Clean and safe environment	3.12 The service provider has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare and jurisdictional requirements – to: a. Respond to environmental risks, including novel infections b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy e. Use the results of audits to improve environmental cleaning processes and compliance with policy
	3.13 The service provider has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Clinical and non-clinical areas, and workplace amenity areas c. Maintenance, repair and upgrade of equipment, furnishings and fittings d. Handling, transporting and storing linen e. Novel infections, and risks identified as part of a public health response or pandemic planning
Workforce screening and immunisation	3.14 The service provider has a risk-based workforce vaccine-preventable diseases screening and immunisation policy and program that: a. Is consistent with the current edition of the Australian Immunisation Handbook b. Is consistent with jurisdictional requirements for vaccine preventable diseases c. Addresses specific risks to the workforce, consumers and patients
Infections in the workforce	3.15 The service provider has risk-based processes for preventing and managing infections in the workforce that: a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the

Item	Action
	Australian Guidelines for the Prevention and Control of Infection in Healthcare b. Align with state and territory public health requirements for workforce screening and exclusion periods c. Manage risks to the workforce, patients and ongoing service providers, including for novel infections d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual e. Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and service providers f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection g. Provide for outbreak monitoring, investigation and management h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection
Reprocessing of reusable medical devices	3.16 When reusable equipment and devices are used, the service provider has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure c. Processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections
Antimicrobial stewardship	3.17 The service provider has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that is informed by current evidence-based Australian therapeutic guidelines and resources, and includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard[11]

Item	Action
	e. Acts on the results of antimicrobial use and appropriateness audits to promote continuous quality improvement
	3.18 The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy and guidance • areas of action for antimicrobial resistance • areas of action to improve appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing • the service provider's performance over time for use and appropriateness of use of antimicrobials

Medication Safety Standard

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

Consumer outcome

My risks from adverse events involving medicines are assessed and minimised. I am supported to understand and make decisions about my medicines.

Intention of this standard

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

Explanatory notes

Medicines are the most common treatment used in clinical care. Although appropriate use of medicines contributes to significant improvements in health, medicines can also be associated with harm.[12] Because they are so commonly used, medicines are associated with a higher incidence of errors and adverse events when compared with other clinical interventions. Some of these adverse events are costly, and up to 50% are potentially avoidable.[13] Errors affect both clinical outcomes for consumers and healthcare costs.[14] Standardising and systemising processes can improve medication safety by preventing medication incidents.

Clinical governance and quality improvement to support medication management

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

Consumer outcome: My risks from adverse events involving medicines are assessed and minimised.

Item	Action
Integrating clinical governance	4.01 Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management
Applying quality improvement systems	4.02 The service provider applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management
Medicines scope of clinical practice	4.03 The service provider has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians

Documentation of patient information

The service provider records and makes available the best possible medication history, including information relating to medicine allergies and adverse events involving medicines when commencing an episode of care.

Consumer outcome: My medication history is recorded and referred to during my care.

Item	Action
Medication reconciliation	4.04 Clinicians take a best possible medication history as part of the assessment of a patient's suitability for cosmetic surgery and is reconfirmed as early as possible in the provision of cosmetic surgery
	4.05 Clinicians review a patient's current medication orders against their best possible medication history and the documented plan for cosmetic surgery, and reconcile any discrepancies on presentation and at transitions of care
Adverse events involving medicines	4.06 The service provider has processes for documenting a patient's history of medicine allergies and adverse events involving medicines and medical devices in the record for cosmetic surgery on presentation
	4.07 The service provider has processes for documenting adverse events involving medicines and medical devices experienced by patients during an episode of care in the healthcare record and in the service provider's incident reporting system
	4.08 The service provider has processes for reporting adverse events involving medicines and medical devices experienced by patients to: a. The patient's referring general practitioner b. Therapeutic Goods Administration, in accordance with its requirements

Continuity of medication management

The service provider reviews a patient's medicines, and information is provided to them about their medicine needs and risks. A medicines list is provided to the patient and the receiving clinician when handing over care.

Consumer outcome: I have received a medicines list and am supported to understand and make decisions about my medicines.

Item	Action
Information for patients	4.09 The service provider has processes to support clinicians to provide patients with information about their individual medicines needs and risks
Provision of a medicines list	4.10 The service provider has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes

Medication management processes

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

Consumer outcome: The medicines I need are available and safely administered when I need them.

Item	Action
Information and decision support tools for medicines	4.11 The service provider ensures that information and decision support tools for medicines are available to clinicians
Safe and secure storage and distribution of medicines	4.12 The service provider complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines
High-risk medicines	4.13 The service provider: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, supply and administer high-risk medicines safely

Comprehensive Care Standard

Comprehensive care is the coordinated delivery of the total clinical care required with regard for a patient's preferences. It may be a discrete episode of care or part of an ongoing comprehensive care plan.

Consumer outcome

My clinical care is safe, of high-quality and is tailored to meet my needs and preferences.

Intention of this standard

Patients receive comprehensive care that is, coordinated delivery of the total clinical care required with regard for a patient's preferences. This clinical care is planned and delivered in collaboration with the patient. It considers the effect of the patient's health issues on their life and wellbeing, and is clinically appropriate.

Explanatory notes

Safety and quality gaps are often reported as failures to provide adequate care for specific conditions, or in specific situations or settings, or to achieve expected outcomes in certain populations. The actions relating to comprehensive care aim to address the underlying issues related to many adverse events, which often include failures to:

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

Clinical governance and quality improvement to support comprehensive care

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

Consumer outcome: The service provider delivers safe, high-quality and comprehensive care.

Item	Action
Integrating clinical governance	5.01 Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care
Applying quality improvement systems	5.02 The service provider applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care
Designing systems to deliver comprehensive care	5.03 The service provider has systems for comprehensive care that: a. Provide care to patients in the setting that best meets their clinical needs b. Ensure timely referral of patients with specialist healthcare needs to relevant services c. Identify, at all times, the clinician with overall accountability for a patient's care
Collaboration and teamwork	5.04 The service provider has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team
	5.05 Clinicians work collaboratively to plan and deliver comprehensive care
	5.06 The service provider facilitates reporting to a patient's relevant healthcare providers

Planning and delivering comprehensive care

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

Consumer outcome: My care is delivered in partnership with me and is tailored to meet my needs and preferences.

Item	Action
Suitability for cosmetic surgery	5.07 The service provider has processes to assure itself that clinicians conducting cosmetic surgery assess a patient's suitability for the cosmetic surgery and is informed by: a. A patient's general health, including psychological health and other medical conditions that may impact suitability for cosmetic surgery b. Where available, information from a patient's referring medical practitioner c. The patient's goals d. Outcomes of independent psychological assessments when further assessment is undertaken
Screening and assessment	5.08 The service provider has processes relevant to the patient accessing cosmetic surgery for integrated and timely screening and assessment
Planning and delivering comprehensive care	5.09 The service provider has processes to assure itself that clinicians conducting cosmetic surgery: a. Develop and agree a plan for the cosmetic surgery with the patient b. Deliver cosmetic surgery in accordance with the agreed plan for cosmetic surgery c. Provide post-operative instructions to the patient, including when to seek emergency assistance d. Schedule follow-up health care when required

Communicating for Safety Standard

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

Consumer outcome

My service providers communicate with each other about my care, so I receive the clinical care I need.

Intention of this standard

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

Explanatory notes

Communication is a key safety and quality issue in clinical care. The actions relating to communicating for safety recognises the importance of effective communication and its role in supporting continuous, coordinated and safe patient care.

Communication is inherent to patient care, and informal communication will occur throughout clinical care delivery. It is not intended these actions will apply to all communications within a service. Rather, the intention is to ensure that systems and processes are in place at key times when effective communication is critical to patient safety, for example, during transitions of care.

Clinical governance and quality improvement to support effective communication

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

Consumer outcome: People involved in my care are able to communicate with each other about my care.

Item	Action
Integrating clinical governance	6.01 Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication
Applying quality improvement systems	6.02 The service provider applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes
Organisational processes to support effective communication	6.03 The service provider has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within a service provider, between multidisciplinary teams, between clinicians or between service providers; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes

Correct identification and procedure matching

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

Consumer outcome: My service provider is able to identify who I am, so I receive the clinical care I need.

Item	Action
Correct identification and procedure matching	6.04 The service provider: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and cosmetic surgery is provided; and when clinical handover, transfer or discharge documentation is generated
	6.05 The service provider specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care

Communication at clinical handover

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

Consumer outcome: When a new clinician is involved in my care, they have been provided with sufficient information about my care.

Item	Action
Clinical handover	6.06 The service provider, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of the patient c. Clinicians who are to be involved in the clinical handover
	6.07 Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of information, responsibility and accountability for care

Communication of critical information

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

Consumer outcome: My service provider is able to escalate care when required and in a timely way.

Item	Action
Communicating critical information	6.08 Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, to patients and clinicians who make decisions about ongoing healthcare
	6.09 The service provider ensures there are communication processes for patients, to directly communicate critical information and risks about care to clinicians

Documentation of information

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

Consumer outcome: My healthcare record is updated with essential information in a timely way.

Item	Action
Documentation of information	6.10 The service provider has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan

Recognising and Responding to Acute Deterioration Standard

Service providers have systems in place to recognise and respond to serious deterioration in patients and escalate clinical care appropriately.

Consumer outcome

If my health deteriorates, I know I will receive the clinical care I need in a timely way.

Intention of this standard

To ensure that a person's acute deterioration is recognised promptly and appropriate action is taken.

Explanatory notes

Serious adverse events are often preceded by observable physiological and clinical abnormalities.[15] Other serious events such as suicide or aggression are also often preceded by observed or reported changes in a person's behaviour or mood that can indicate a deterioration in mental state. Early identification of deterioration may improve outcomes and lessen the intervention required to stabilise patients whose condition deteriorates.[16]

The National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration, has been endorsed by Australian Health Ministers as the national approach for recognising and responding to clinical deterioration in acute care facilities in Australia. It provides a consistent national model to support clinical, organisational and strategic efforts to improve recognition and response systems.

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

Clinical governance and quality improvement to support recognition and response systems

Organisation-wide systems are used to support and promote detection and recognition of acute deterioration, and the response to patients whose condition acutely deteriorates.

Consumer outcome: The service provider is able to recognise and respond in a timely way if my health deteriorates.

Item	Action
Integrating clinical governance	7.01 Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration
Applying quality improvement systems	7.02 The service provider applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems

Detecting and recognising acute deterioration, and escalating care

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

Consumer outcome: If my health deteriorates, it will be noticed and I will receive the clinical care I need.

Item	Action
Recognising acute deterioration	7.03 The service provider has processes to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient
	7.04 The service provider has processes to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state
Escalating care	7.06 The service provider supports the workforce to: a. Use protocols that specify criteria for escalating care and to call for emergency assistance b. Use agreed collaborative pathways with appropriate partner services to address deterioration in a timely way c. Notify a patient's other care providers, family and carers when their care is escalated
	7.07 The service provider has processes for patients, carers or families to directly escalate care

Responding to acute deterioration

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

Consumer outcome: If my health deteriorates, timely clinical care that meets my needs will be provided.

Item	Action
Responding to deterioration	7.08 The service provider has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration
	7.09 The service provider has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support
	7.10 The service provider has processes for rapid referral to services that can provide definitive management of acute physical deterioration
	7.11 The service provider has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated

Glossary

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

advanced life support: the preservation or restoration of life by the establishment and/or maintenance of airway, breathing and circulation using invasive techniques such as defibrillation, advanced airway management, intravenous access and drug therapy.[17]

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**

adverse events involving medicines: 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.[18] An **allergy** is a type of **adverse event involving medicines**.

Adverse event involving medicines include issues with medicines such as:

- Underuse
- Overuse
- Use of inappropriate medicines (including therapeutic duplication)
- Adverse event involving medicines, including interactions (medicine–medicine, medicine–disease, medicine–nutrient, medicine–laboratory test)
- Noncompliance.

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.[19] Typical allergens include some medicines, foods and latex.[19, 20] An allergen may be encountered through inhalation, ingestion, injection or skin contact.[19] A medicine allergy is one type of **adverse event involving medicines**.

antimicrobial: chemical substances that inhibit the growth of, or destroy, bacteria, fungi, viruses or parasites. They can be administered therapeutically to humans or animals.[9]

antimicrobial resistance: failure of an antimicrobial to inhibit a microorganism at the antimicrobial concentrations usually achieved over time with standard dosing regimens.[9]

antimicrobial stewardship: an ongoing effort by a service provider to reduce the risks associated with increasing antimicrobial resistance and to extend the effectiveness of antimicrobial treatments. It may incorporate a broad range of strategies, including monitoring, reviewing and promoting appropriate antimicrobial use.[9]

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. Service providers and clinicians are responsible for specifying the approved items for identification and procedure matching. Identifiers such as room or bed number should not be used.

aseptic technique: a set of practices aimed at minimising contamination and is particularly used to protect the patient from infection during procedures.[21]

assessment: a clinician's evaluation of a disease or condition based on the patient's subjective report of the symptoms and course of the illness or condition, and 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 workforce. The assessment is an essential element of a comprehensive care plan.[22]

audit (clinical): a systematic review of clinical care against a predetermined set of criteria.[23]

Australian Charter of Healthcare Rights: specifies the key rights of patients when seeking or receiving clinical care. The second edition was launched in August 2019.[7]

Australian Open Disclosure Framework: endorsed by health ministers in 2013, it provides a framework for service providers and clinicians to communicate openly with patients when clinical care does not go to plan.[2]

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 clinician 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.[24]

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

best-practice guidelines: a set of recommended actions that are developed using the best available evidence. They provide clinicians with evidence-informed recommendations that support clinical practice, and guide clinician and patient decisions about appropriate care in specific clinical practice settings and circumstances.[25]

business decision-making: decision-making regarding service planning and management for a service provider. 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.

care pathway: a complex intervention that supports mutual decision-making and organisation of care processes for a well-defined group of patients during a well-defined period.[26]

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.[27]

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 health care people should expect to be offered or receive for specific conditions.

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

clinical communication process: the method of exchanging information about a person's care. It involves several components, and includes the sender (the person who is communicating the information), the receiver (the person receiving the information), the message (the information that is communicated) and the channel of communication. Various channels of communication can be used, including verbal (face to face, over the phone, videoconference), written and electronic.[28] Sending and receipt of the information can occur at the same time, such as verbal communication between two clinicians, or at different times, such as non-verbal communication during which a clinician documents a patient's goals, assessments and comprehensive care plan in the healthcare record, which is later read by another clinician.

clinical governance: the set of relationships and responsibilities established by a service provider between regulators and funders, owners and managers and governing bodies (where relevant), clinicians, the workforce, patients, consumers and other stakeholders to ensure optimal clinical outcomes.[1] It ensures that:

- The community can be confident there are systems in place to deliver safe care
- There is a commitment to continuously improve services
- Everyone is accountable to patients and the community for ensuring the delivery of safe, effective care. This includes clinicians, other members of the workforce and managers, owners and governing bodies (where they exist).

Depending on the size of the service provider, multiple roles may be carried out by the same individual.

clinical governance framework: describes the processes and structures that are needed to deliver safe and high-quality clinical care.[1] These include:

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

clinical handover: the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.[29]

clinical information system: a computerised healthcare record and management system that is used by clinicians in clinical settings. Clinical information systems are typically organisation-wide, have high levels of security and access, and have roles and rights (for example, prescribing medicines, reviewing laboratory results, administering intravenous fluids) specified for each clinical and administrative user. Clinical information systems enable electronic data entry and data retrieval by clinicians.[30]

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

clinical leaders: clinicians with management or leadership roles in a service provider who can use their position or influence to change behaviour,

practice or performance. Examples are directors of clinical services, heads of units and clinical supervisors.

clinician: registered health practitioners who practise a profession relating to the provision of clinical care. Clinicians may be required maintain profession-specific registration with a national board under the National Registration and Accreditation Scheme.[31] A clinician may also referred to as a health professional, health practitioner, healthcare provider or practitioner or profession-specific description.

cognitive impairment: deficits in one or more of the areas of memory, communication, attention, thinking and judgement. This can be temporary or permanent. It can affect a person's understanding, their ability to carry out tasks or follow instructions, their recognition of people or objects, how they relate to others and how they interpret the environment. Cognitive impairment can be a result of several conditions, such as acquired brain injury, a stroke, intellectual disability, licit or illicit drug use, or medicines.[22]

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.

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

community: the people living in a defined geographic region or from a specific group who receive clinical care from a service provider.

comprehensive care: Clinical 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 by different service providers. For example, a health 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, clinical services, or is a carer for a patient using clinical 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 clinical care.[32]

contemporaneously (documenting information): recording information in the healthcare record as soon as possible after the event that is being documented.[33]

cosmetic surgery: employs invasive surgical procedures, such as physical removal or readjustment of organs or tissues to revise or change the appearance, colour texture, structure or position of normal bodily features and often involving cutting beneath the skin, with the dominant purpose of achieving what the patient perceives to be a more desirable appearance. It is not used to prevent, diagnose or treat medical diseases or conditions.

Cosmetic surgery does not encompass:[34]

- Non-surgical cosmetic procedures such as cosmetic injectables, thread lifts and cryolipolysis (fat freezing)
- Mole removal
- Reconstructive surgery
- Gender affirmation surgery
- Surgery that has a medical justification even if it leads to improvements in appearance.

credentialling: the formal process used by a service provider to verify the qualifications, experience, professional standing, competencies and other relevant professional attributes of clinicians, so that the organisation can form a view about the clinician's competence, performance and professional suitability to provide safe, high-quality care within specific organisational environments.[35]

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.[21]

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

current medicines list: *See* **medicines list**

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

question prompt lists).[36] *See also* **shared decision making**

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

delirium: an acute disturbance of consciousness, attention, cognition and perception that tends to fluctuate during the day. It is a serious condition that can be prevented in 30–40% of cases, and should be treated promptly and appropriately. Delirium can be hyperactive (the person has heightened arousal; or can be restless, agitated and aggressive) or hypoactive (the person is withdrawn, quiet and sleepy).

deterioration *see* **serious deterioration**

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.

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

emergency assistance: clinical advice or assistance provided when a patient's condition has deteriorated severely. This assistance is provided as part of the rapid response system, and is additional to the care provided by the attending clinician or team.[17]

environment: the context or surroundings in which clinical care is delivered. Environment can also include other patients, consumers, visitors and the workforce.

episode of care: a health problem from its first encounter with a clinician through to the completion of the last encounter.[37]

facility: *See* **service provider**

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 service provider 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. Governance structures will be tailored to the size and complexity of an organisation.

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

guidelines: clinical practice guidelines are systematically developed statements to assist clinician and consumer decisions about appropriate clinical care for specific circumstances.[38]

hand hygiene: a general term applying to processes aiming to reduce the number of microorganisms on hands. This includes: application of a waterless antimicrobial agent (e.g. alcohol-based hand rub) to the surface of the hands; and use of soap/solution (plain or antimicrobial) and water (if hands are visibly soiled) followed by patting dry with single-use towels.[21]

healthcare identifiers: are unique numbers assigned and used in health related information to clearly identify the patient, the treating professional and the organisation where clinical care is provided to reduce the potential for errors with clinical information and communication.[39, 40]

healthcare-associated infections: infections that are acquired in service providers (nosocomial infections) or that occur as a result of clinical interventions (iatrogenic infections). Healthcare associated infections may manifest after people leave the service provider.[21]

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.[2]

health practitioner: *see* **clinician**

healthcare provider: *see* **clinician**

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 clinicians in service providers. Healthcare record information must be properly managed and safeguarded from start (record generation) to finish (record destruction) and the entire time in between.[41]

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 clinical 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.[42]

hierarchy of controls: the Preventing and Controlling Infections Standard requires service providers to use evidence-based systems to reduce the risk of infection using the hierarchy of controls in conjunction with infection prevention and control systems. The hierarchy of controls is a model used in work health and safety management to control hazards that ranks controls from most to least reliable. If it is not reasonably practical to eliminate risks, then risks must be minimised, as far as is reasonably practicable, by using one or a combination of substitution, isolation, or engineering controls, followed by administrative controls and personal protective equipment.[10]

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 service providers, 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.[43, 44] 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
- Schedule 8 medicines.

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: an infection occurs when a microorganism enters the body, increases in number and causes a reaction in the body.[44] This may cause tissue injury and disease.[45]

informed consent: a process of communication between a patient and clinician about options for treatment, clinical processes or potential outcomes.[46] This communication results in the patient's authorisation or agreement to undergo a specific intervention or participate in planned care.[46] The communication should ensure that the patient has an understanding of the clinical care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.[47]

informed financial consent: the provision of cost information to patients, including notification of likely out-of-pocket expenses (gaps), by all relevant service providers, preferably in writing, prior to admission or treatment.[48]

injury: damage to tissues caused by an agent or circumstance.[49]

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

invasive surgical procedure: physical removal or readjustment of organs or tissues to revise or change the appearance, colour texture, structure or position of normal bodily features and often involving cutting beneath the skin.[50]

jurisdictional requirements: systematically developed statements from state and territory governments about appropriate clinical care or service delivery for specific circumstances.[38] 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.[51]

mandatory: required by law or mandate in regulation, policy or other directive; compulsory.[52]

medical practitioner: *see* **clinician**

medication management: practices used to manage the provision of medicines. Medication management has also been described as a cycle, pathway or system, which is complex and involves a number of different clinicians. The patient is the central focus. The system includes manufacturing, compounding, procuring, dispensing, prescribing, storing, administering, supplying and monitoring the effects of medicines. It also includes decision-

making, and rules, guidelines, support tools, policies and procedures that are in place to direct the use of medicines.

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

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.[53]

medicines list: a way to keep all the information about medicines a person takes together.[54] 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[55]
- Any medicines that should not be taken by the patient, including those causing allergies and adverse events involving medicines reactions.

Ideally, medicines list also includes the intended use (indication) for each medicine.[56]

mental state: *See* **deterioration in mental state**

minimum information content: the content of information that must be contained and transferred in a particular type of clinical handover. What is included as part of the minimum information content will depend on the context and reason for the handover or communication.[57]

multidisciplinary collaboration: a process where clinicians from different disciplines and/or service providers share clinical information to optimise the delivery of comprehensive care for a patient.[58]

near miss: an incident or potential incident that was averted and did not cause harm but had the potential to do so.[59]

open disclosure: an open discussion with a patient and carer about an incident that resulted in harm to the patient while receiving clinical 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.[2]

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.[49]

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 clinical care processes are encouraged and supported to the extent that patients and consumers choose. Partnerships can exist in different ways in a service provider, 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 service provider 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 service provider.

patient: a person who is receiving clinical care from a service provider. The term 'patient' encompasses all other relevant terms that may be used in cosmetic surgery such as 'client'.

patient identifiers: items of information for use in identification of a patient, including family and given names, date of birth, sex, address, healthcare record number and Individual Healthcare Identifier.

person-centred care: an approach to the planning, delivery and evaluation of clinical care that is founded on mutually beneficial partnerships among clinicians and patients.[60] 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.[4] Also known as patient-centred care or consumer-centred care.

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

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

procedure: the set of instructions to make policies and protocols operational, which are specific to a service provider.

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

process: a series of actions or steps taken to achieve a particular goal.[61]

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

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

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

quality improvement: the combined efforts of the workforce and others – including consumers, patients and their families, researchers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development.[62] 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 Cosmetic Surgery Standards, the interval should be consistent with best practice, risk based, and determined by the subject and nature of the activity.

reports (on patients): Documentation and information relating to a patient's health care e.g. patient records, referrals and scans.

respiratory hygiene and cough etiquette: A combination of measures designed to minimise the transmission of respiratory pathogens via droplet or airborne routes in service providers.[21]

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 service provider.[63]

reusable device: a medical device that is designated by its manufacturer as suitable for reprocessing and reuse.[64]

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.[65]

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

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 a service provider's health and safety management. Positive patient safety cultures have strong leadership that drives and prioritises safety[66] 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.[35]

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.[67]

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.[21]

serious deterioration: physiological, psychological or cognitive changes that may indicate a worsening of the patient's health status.

service context: the particular context in which clinical care is delivered. 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.[68]

service provider: a separately constituted organisation that is responsible for implementing clinical governance, administration and financial management of a service unit or service units providing clinical care to patients. These range from owner-operated day-only services, where a single clinician is also responsible for administrative and management operations of the organisation, to complex organisations comprising of many clinicians who may not be directly employed, a supporting workforce, management and an overarching governing body.

shared decision making: a consultation process in which a clinician and patient jointly participate in making a clinical decision, having discussed the options, and their benefits and harms, and having

considered the patient's values, preferences and circumstances.[36]

standard: agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.[49]

standard national terminologies: a structured vocabulary used in clinical practice to accurately describe the care and treatment of patients. Clinicians 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.[39] 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.[21] Standard precautions include: hand hygiene, use of personal protective equipment (masks, gloves, gowns, protective eyewear) to prevent blood or bodily fluid exposure, routine environmental cleaning aligned to risk, safe use and disposal of sharps, reprocessing of reusable equipment and devices, respiratory hygiene and cough etiquette (including physical distancing), aseptic technique, linen and waste management.[21]

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.[45]

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

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

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

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

training: the development of knowledge and skills.

transitions of care: situations when all or part of a patient's care is transferred between service provider locations, clinicians, or levels of care within the same location, as the patient's conditions and care needs change.[69]

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 and include droplet, contact and airborne precautions or a combination of these precautions based on the route of transmission of infection.[21]

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 clinical processes or outcomes, compared to peers or to a standard such as an evidence-based guideline recommendation.[70]

workforce: all people working in a service provider service, including clinicians and any other (medical or non-clinical) employed, credentialled or contracted, locum, agency, trainee, student, volunteer or peer workers. The workforce can be members of the service provider 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 service provider. *See also* **clinician**

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