

# Risk screening and assessment

## Introduction

A key focus of the Comprehensive Care Standard of the National Safety and Quality Health Service (NSQHS) Standards is on minimising patient harm by ensuring clinical risks are identified early and managed appropriately.

This fact sheet outlines how risk screening and assessment should be applied in practice by health services and why this practice is essential to delivering safe, high-quality, person-centred care. Risk screening and assessment are tailored to an individual patient, and clinicians use their professional judgement to interpret and act on the results. The use of validated screening and assessment tools helps inform the plan for care, prompt timely interventions, and support safer, more targeted patient care.

## Definitions

### **Risk screening - “Is the patient at potential risk?”**

Risk screening is a systematic process used to identify whether a patient may be at risk of harm. Its purpose is to determine whether further assessment or early intervention is required. It is commonly completed on admission, transfer of care, or when a patient’s condition changes. Risk screening is typically quick, standardised, repeatable and clearly flags risk.

### **Risk assessment - “What is the risk, why is it present, and what needs to be done?”**

Risk assessment is a clinical process used to explore, understand, and evaluate identified risks in detail to inform clinical decision-making, prioritise care needs, and reduce the likelihood of harm. It integrates clinical assessment, clinical judgement, patient input, and relevant history to inform the plan for care. Typically risk assessment is detailed, enables prioritisation of interventions, is person-centred and action focused.

## Why effective screening and assessment matters

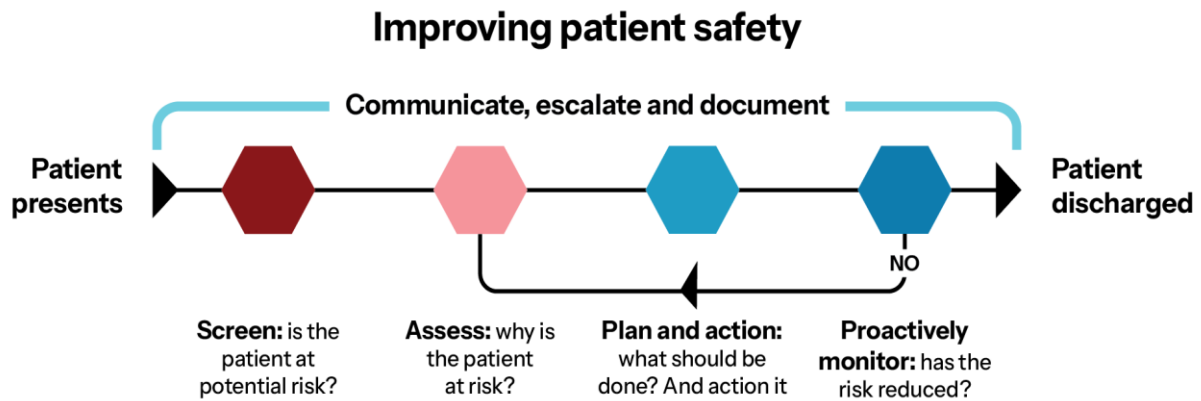
The consistent use of validated risk-screening and assessment processes ensure early recognition of potential harm. However, identifying risk alone is not enough. In line with [NSQHS Standards Action 5.10](#), health services and clinicians are required to move beyond risk identification and implement evidence-based interventions with ongoing review to ensure that risks are managed effectively and harm is prevented.

## Why effective monitoring and communication matters

Monitoring and communication are essential for identifying changes in a patient’s condition or risks in a timely manner. Ongoing monitoring ensures that care remains aligned with the

patient's clinical needs, while clear communication ensures all members of the multidisciplinary team understand the plan for care, required actions and progress.

**Figure 1 The practice of undergoing risk screening, assessment, mitigation and monitoring**



**Screening without action is low-value care**

## What good practice looks like

### Health Services

- Ensure organisational policies, procedures, and processes support effective risk screening and assessment to enable care planning that is tailored to each patient's individual risks and care context.
- Within contexts of care where risks are well understood, mitigation strategies are prioritised and incorporated into routine practice.

### Clinicians

- Identify and respond to clinical risks by undertaking clinical assessment and applying professional judgement to develop and implement an appropriate, individualised care plan and ensure that the plans are enacted.
- Rescreen and reassess care requirements based on changes in the patient's condition and care needs.

### Accrediting agencies

- Evaluate the outcome of risk screening and assessment to ensure that the appropriate plan for care is in place and actioned for the specific context of care.
- Recognise variation in tools and ensure assessments are appropriate for different healthcare settings (acute, aged care, maternity, mental health, community).

### For more information

Please visit: <https://www.safetyandquality.gov.au/national-standards/nsqhs-standards/comprehensive-care-standard>

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