Australian Commission on **Safety and Quality** in Health Care

NSQHS Standards

National Safety and Quality Health Service Standards

Third edition – initial draft

July 2026

safetyandquality.gov.au

The Australian Commission on Safety and Quality in Health Care pays respect to the Gadigal people as the Traditional Custodians of Country where the Commission's office is located. We extend that respect to all Aboriginal and Torres Strait Islander peoples, and their deep time connections to land, water and sky.

We recognise that knowledge about healthy Country, community and culture has been developed by Aboriginal and Torres Strait Islander peoples over tens of thousands of years and has been shared for generations. We are committed to partnering with and learning from Aboriginal and Torres Strait Islander peoples through the work that we do.

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Background

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 to achieve better care, everywhere.

The Commission achieves its objectives by setting national standards for health care, providing evidence-informed guidance for health professionals, helping patients understand what they should expect from their care and publishing information about the safety and quality of the Australian healthcare system.

The Commission's Strategic Plan 2025-30 focuses on:

- **high-quality care in an evolving environment** – so that high-quality health care is delivered consistently, reliably and equitably for all Australians
- **strong outcome focused clinical governance** – so that clinical governance, integrated standards and accreditation drive better patient outcomes
- **empowered patients, families, carers and communities** – so that health care is designed and delivered with patients and communities
- **an improvement-driven workforce culture** – because better health care is everyone's responsibility, every day.[1]

National Safety and Quality Standards are central to building an environment and culture where everyone in a health service works together with patients, families, carers and consumers to deliver high-quality care. The Commission develops and maintains the National Safety and Quality Health Service (NSQHS) Standards to support Australian health services to manage risk, reduce preventable harm and continuously improve care. The NSQHS Standards incorporate up-to-date evidence-based practices, emerging evidence and contemporary approaches to clinical governance.

The NSQHS Standards are developed in collaboration with:

- patients, families, carers, consumers, and the community
- Aboriginal and Torres Strait Islander peoples
- medical, midwifery, nursing, pharmacy, allied health and non-clinical workforces
- clinical experts and technical committees
- the public and private health sectors
- the Australian Government and state and territory health authorities.

Introduction

The vision for the third edition of the NSQHS Standards is high-quality care for all Australians, supported by nationally consistent and effective systems operating across the continuum of care.

The third edition of the NSQHS Standards recognises the realities of modern practice in the Australian health system and supports health services to adapt and evolve while ensuring care is consistently high-quality and improving over time.

Modern practice involves increasing demand, complexity and morbidity, new models of care and an increase in the role and reach of digital technology. That is why the third edition of the NSQHS Standards focuses beyond the minimum safety requirements for health care delivery so that health services can develop their systems and enable a healthy workforce culture, culturally safe and responsive health care and continuous learning across the health service.

If implemented well, the NSQHS Standards support multidisciplinary care teams to manage risk, use data for improvement and partner with patients, their family and carers at every step of the care continuum.

They are the standards of care that should be applied consistently in health services every day.

Purpose

The third edition of the NSQHS Standards:

- respond to recognised and emerging system pressures, including workforce sustainability, increase in the reach of digital technologies, the importance of equity of outcomes and continuing system integration
- reflect a maturing focus from specifying clinical processes to prioritising how patients experience care, measuring outcomes of care and acting on this information to improve care when required
- move away from a sole focus on complying with accreditation requirements towards building the culture of the whole organisation to support the consistent delivery of high-quality care.

Overview of the Standards

The third edition of the NSQHS Standards streamlines the previous eight standards into a set of three standards to better support an integrated whole-of-system approach to health care across Australia.

The Standards strengthen the link between clinical governance, workforce capability and patient outcomes within a health service and are designed to work together as a single, integrated system for safety and quality.

High-quality care, cultural safety and equity are embedded across the Standards as critical and essential elements to the implementation of the NSQHS Standards into practice.

This requires consistent, organisation-wide application, recognising that **everyone has a role to play in delivering high-quality care**.

Clinical Governance Standard

This Standard outlines the responsibilities of the board, executive and leaders for ensuring that the health service's clinical governance system supports the delivery of high-quality care.

Clinical governance is central to providing the best possible outcomes for patients. It is the combination of inclusive governance, organisational cultures that are psychologically safe and striving for continuous improvement and innovation, with effective systems and structures that enables everyone in a health service to deliver care that is consistently high quality and improving.

Effective clinical governance means that boards, executives, clinical leaders and the workforce are clearly accountable to patients and the community for providing high-quality care - care that is person-centred, safe, effective, accessible and integrated, provided in a way that is equitable, efficient and sustainable.

Engagement and partnerships with patients, families, carers, consumers and community are also critical to achieving high-quality care and better patient outcomes.

This Standard creates the conditions for high-quality care carrying through the foundations from the National Model for Clinical Governance[2].

Person-Centred Practice Standard

This Standard outlines the systems that support clinicians to provide high-quality care so that patients receive care that is person-centred, safe, effective, accessible and integrated.

Person-centred practice is a model for providing health services that focus on the provision of person-centred care. It is achieved through building effective collaborative relationships between clinicians who facilitate evidence-informed shared decision-making with patients and consumers.

Person-centred practice is a core safety and quality capability in clinical systems, communication processes, teamwork and shared decision-making. It supports health services in providing individualised and culturally safe care and being adaptive towards the people they support. It also includes supporting staff with leadership modelling, reflective practice and training to demonstrate everyday person-centred practice.

This Standard emphasises the importance of effective communication and collaboration within the multidisciplinary care team and with patients, their family and carers to tailor care to the needs of the individual and improve outcomes.

Safe Clinical Systems Standard

This Standard outlines the priority systems, policies and processes that keep people safe while receiving care or working in a health service, prevent avoidable harm and support the sustainable delivery of high-quality care.

Safe clinical systems are critical to ensuring the consistent application and use of evidence-informed practice to minimise risk of harm. This Standard includes infection prevention and control, medication safety, blood management, patient identification and digital systems.

This Standard aims to make safe care the default.

The Clinical Governance Standard establishes the requirements and conditions for high-quality care by setting the organisation's culture, systems and structures. These requirements are carried through to the Person-Centred Practice Standard and Safe Clinical Systems Standard reflecting what needs to be in place to support the workforce and health service to provide high-quality care.

Consistent, organisation-wide application of the NSQHS Standards recognises that **everyone has a role to play in delivering high-quality care.**

Structure of the NSQHS Standards (third edition)

Each of the standards contains:

- a description of the standard
- the intent of the standard
- a list of the key areas covered by the standard
- a description of the key area
- purpose statements which describe key elements of the standard

- detailed requirements setting out what should be implemented to help achieve the stated purpose.

Implementation of the NSQHS Standards

The NSQHS Standards are designed to be clear, scalable and able to be applied consistently in different health service contexts. By addressing all relevant requirements within each standard, a health service will ensure it is effectively implementing the NSQHS Standards.

Implementation and assessment of the NSQHS Standards should be proportionate to the size, scope, complexity, clinical risk profile, service model and digital maturity of the individual health service.

Assessment to the NSQHS Standards focuses on the effectiveness of systems in the health service to support high-quality care, rather than requiring uniform implementation models across all services.

Within the Standards, it is important to identify the links between different requirements, as similar implementation strategies may apply to multiple requirements. Identifying links will help reduce the duplication of effort in implementing the separate standards and ensure that safety and quality systems are integrated within the health service.

Application of the NSQHS Standards

As health system regulators, state and territory health departments and authorities determine which of the National Safety and Quality Standards apply to a health service.

Currently, all public and private hospitals and day hospitals in Australia need to be assessed against the NSQHS Standards. Accreditation may also be required as part of funding or contract arrangements. Check local arrangements to understand individual health service requirements.

Core elements underpinning the Standards

The third edition signals a shift in the structure and emphasis of the NSQHS Standards to support the delivery of high-quality care across Australia, which includes an emphasis on providing culturally safe and equitable care.

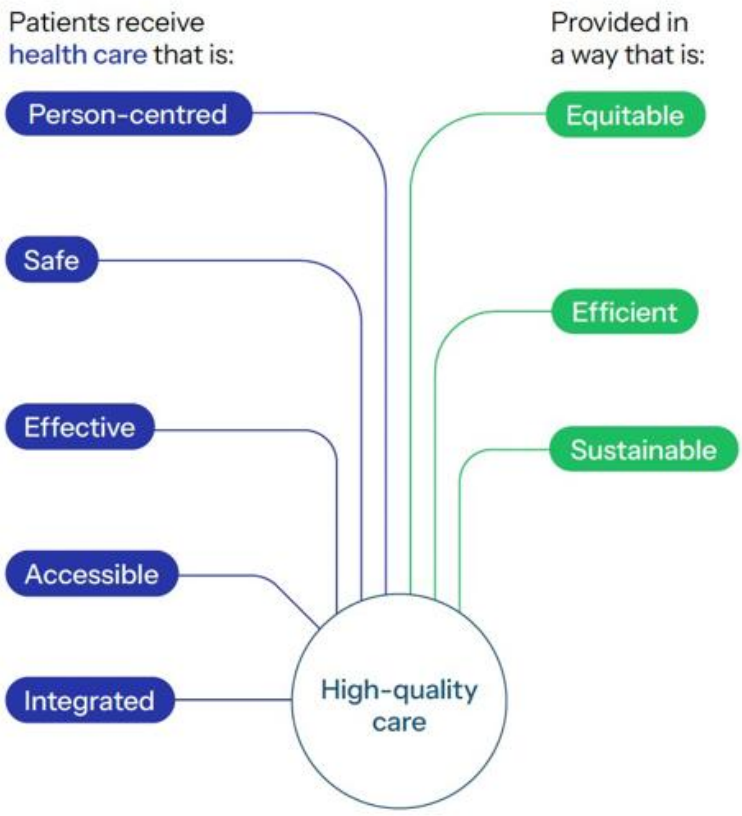
High-quality care

High-quality care is person-centred, safe, effective, accessible and integrated, provided in a way that is equitable, efficient and sustainable.

Cultural safety, as determined by Aboriginal and Torres Strait Islander peoples, is necessary for high-quality care. Cultural safety must be embedded in each domain of high-quality care to improve health outcomes for Aboriginal and Torres Strait Islander peoples[3]. A definition of cultural safety and its role in health care is discussed in the next section.

High-quality care consists of multiple interconnected domains, as shown in **Figure 1**. Each domain focuses on an important aspect of health care needed to achieve high-quality care. Together, the domains describe how care should be delivered to achieve the best outcomes for individuals and populations.[2]

Figure 1: Domains of high-quality care



Under the National Health Reform Agreement (NHRA), all Australian governments have agreed to establish a new health system performance framework, which contemporises and replaces the Australian Health Performance Framework. This requires a broader common definition of high-quality care to provide a shared policy framework to support governments, health system leaders and regulators in strengthening safety and quality across the Australian health system.

Cultural safety

Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families, carers and communities. In health care, culturally safe practise is the ongoing critical reflection of knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive health care, free of bias, discrimination and racism. Culturally safe practices for Aboriginal and Torres Strait Islander peoples include:

- acknowledging colonisation and systemic racism, and the social, cultural, behavioural and economic factors which impact individual and community health

- acknowledging and addressing individual racism, discrimination, biases, assumptions, stereotypes and prejudices and providing care that is holistic, free of bias, discrimination and racism
- recognising the importance of self-determined decision-making, partnership and collaboration in health care which is driven by the individual, family and community
- fostering a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander peoples and colleagues.[4]

The requirements for improving cultural safety and equity throughout the NSQHS Standards focus on embedding cultural safety in health care and addressing inequity at multiple levels.

In the NSQHS Standards, cultural safety is applied in relation to Aboriginal and Torres Strait Islander peoples in recognition of their status as the First Peoples of Australia and the ongoing need to address the impacts of racism and inequity in healthcare. It is important to also acknowledge the need to ensure safe, person-centred and respectful care for people from all cultural and social backgrounds, while maintaining the meaning of cultural safety in the First Nations context.

National policy context

Recent reports have demonstrated that systemic and institutional racism remains across Australian healthcare structures, policies and practices, contributing directly to inequitable access and outcomes. The development of the third edition is also within a broader national policy context, focused on improving health outcomes, system sustainability and consumer trust.

- The Priority reforms under the *National Agreement on Closing the Gap*[5] signed in July 2020, challenge all government organisations to 'embed and practice meaningful cultural safety' and 'deliver services in partnership with Aboriginal and Torres Strait Islander organisations, communities and peoples'.
- The *National Health Reform Agreement (NHRA) Addendum (2026-2031)*[6] states that the health system must recognise and embed Aboriginal and Torres Strait Islander holistic health and wellbeing, the cultural and social determinants of health and a life course approach. Schedule B: Better Outcomes for Aboriginal and Torres Strait Islander peoples reinforces that health equity is a core responsibility of the entire health system.
- The *National Aboriginal and Torres Strait Islander Health Plan 2021-2031* calls for systemic action to eliminate racism across the health system and to ensure that mainstream health services provide care that is culturally safe, as determined by Aboriginal and Torres Strait Islander peoples and communities.

The Commission's work on cultural safety

The NSQHS Standards (third edition) seeks to embed cultural safety into everyday systems and processes within health services to re-orient healthcare delivery to focus on models, practices and approaches that respect and prioritise First Nations ways of knowing, being and doing. The requirements have been informed by consultation with key Aboriginal and Torres Strait Islander stakeholders and are designed to contribute to the elimination of bias, discrimination and racism and the delivery of better health outcomes for First Nations peoples.

In parallel with the development of the third edition of the NSQHS Standards, the Commission is coordinating a First Nations-led project to analyse evidence on standards for cultural safety (including associated measures and indicators) to inform recommendations for national standards for cultural safety for hospitals. The first stage of this project is currently underway

and is focused on building the evidence and consulting with key stakeholders. The findings from this project and lessons from the co-design processes will be combined with feedback from the public consultation on NSQHS Standards, to help shape the requirements for the next draft of the third edition.

Equity

In Australia, equity is a key priority for health leaders. Equity includes:

- reducing the gap in health outcomes between Aboriginal and Torres Strait Islander peoples and other Australians
- supporting other priority populations
- tackling disparities between health services in metropolitan, regional, rural and remote areas.

Health inequities relate to differences among groups of people whether those groups are defined socially, economically, demographically, geographically or by another dimension of inequality such as age, sex, gender, ethnicity, disability or sexual orientation. Social and cultural factors can contribute to health outcomes in ways that may be complex and interrelated.[7]

A person's participation in health care can be affected by cultural and historical factors including experiences of colonisation, imbalances in power, differences in language, historical or intergenerational trauma, a lack of cultural safety, bias, discrimination and racism.[8]

Equity means that the NSQHS Standards are applied consistently in health services every day across Australia, so every patient receives the right care, every time.

Patient preferences

Person-centred care is one of the domains of high-quality care, which respects the person receiving care, their family and carers, and responds to the person's preferences, needs and values.[2]

It's an approach to the planning, provision and evaluation of health care that is founded on partnership between clinicians, patients, families and communities, where care is tailored to the needs of the person, based on their expressed beliefs, hopes and expectations.[9]

Person-centred practice has a broader lens, shifting the focus from what clinicians do to how organisations enable and sustain such behaviours through practitioner capability, care environments, and organisational culture.

It is a model for providing health services that focuses on the provision of person-centred care. It is achieved through building effective collaborative relationships between clinicians who facilitate evidence-informed shared decision-making with patients and consumers.[9]

In previous editions of the NSQHS Standards, a separate Partnering with Consumers Standard combined with the Clinical Governance Standard to establish the Clinical Governance Framework for the health service. For the third edition, the requirements and expectations for partnering with consumers have been deliberately woven throughout all the Standards. This is further strengthened by the focus on outcomes rather than compliance, ensuring that consumer participation is meaningful and can be measured or demonstrated in achieving quality outcomes.

Where the NSQHS Standards refer to patients, their family and carers, this should be interpreted in accordance with the patient's preferences, wishes and consent. The involvement of family members, carers and support people should be guided by the patient's

choices and occur only where appropriate. Health services, their clinical and non-clinical workforce respect and support patient autonomy, ensuring that decisions about the participation of family members, carers and support people are determined by the patient wherever possible.

The Rationale for Change has been developed to provide further information about the foundational elements underpinning the NSQHS Standards including:

- Strengthening clinical governance
- Cultural safety
- Supporting genuine partnership with consumers
- Digitally enabled care
- Virtual care
- Clinical research.

Clinical Governance Standard

Clinical Governance Standard

High-quality care means that patients receive care that is person-centred, safe, effective, accessible and integrated, in a way that is equitable, efficient and sustainable. Health care must be free from bias, racism and discrimination.

Intention of this Standard

The health service's board, executive and leaders are accountable for ensuring that the organisation's clinical governance system supports the delivery of high-quality care. High-quality care is the shared goal for every member of the health service workforce, whether their role involves direct patient contact or contributes indirectly to patient outcomes.

Everyone in a health service contributes to leadership, working together to achieve results that could not be achieved working alone

Key areas

Leading systems and organisational culture
Partnering with consumers
Building a healthy workforce culture
Enabling high-quality and integrated clinical practice
Managing and reducing risk
Using data for better care

Leading systems and organisational culture

The board, executive and leaders are accountable for an organisational strategy and culture. They establish, maintain and continually improve organisational systems to achieve high-quality care with better patient outcomes and experiences and an engaged, empowered workforce.

Purpose		Requirements
The board is accountable for **high-quality care**	1.01	The board governs organisational systems that: a. maintain a clinical governance framework aligned to the *National Model for Clinical Governance*[2], which is tailored to the size, scope and complexity of the services provided b. evaluate the organisation's performance against the clinical governance framework c. set the strategic direction and foster a culture that prioritises high-quality care d. identify and eliminate systemic, structural and institutional bias, racism and discrimination e. embed *the* National Agreement on Closing the Gap Priority Reforms[5] into governance systems
The board is accountable for **organisation-wide culture, systems and structures**	1.02	The board governs organisational systems to: a. build partnerships with consumers, including those with lived experience, who reflect the diverse communities it serves, and incorporate their perspectives into strategic planning, priority-setting and decision-making b. align financial, operational and business decision-making with the organisation's strategic direction for high-quality care c. support the workforce to deliver high-quality care and monitor the effectiveness of clinical governance structures and activities d. embed a learning organisation approach to service, system and practice improvement e. use data insights to support decision-making and the delivery of high-quality care
The board, executive and leaders are accountable for creating a **healthy workforce culture**	1.03	The board, executive and leaders have organisational systems to: a. enable a healthy workforce culture where members of the workforce feel safe to escalate concerns b. support the workforce to have leadership roles in establishing and maintaining the safety culture c. uphold a zero-tolerance approach to bias, discrimination and racism, ensuring concerns and reports of risks, incidents adverse events and complaints are investigated and required action is taken

The board, executive and leaders are accountable for **digitally enabled care**	1.04	The board, executive and leaders have organisational systems to: a. ensure oversight of digitally enabled care, privacy and security, health information and digital tools and technologies used for clinical support and decision-making b. ensure the responsible use and maintenance of an information security management system for health information, including compliance with security and privacy jurisdiction requirements c. detect, respond to and report on information security risks and incidents d. integrate digital tools and technologies downtime and cybersecurity planning and preparedness into governance systems e. maximise digital capabilities through the procurement, risk assessment, implementation, use, maintenance and replacement of all digital tools and technologies f. cultivate partnerships with the workforce, consumers and community in the design, implementation and governance of digitally enabled care g. uplift digital health literacy across the workforce with a focus on improving quality of care
The board, executive and leaders are accountable for **working with Aboriginal and Torres Strait Islander leaders to deliver cultural governance and systemic reform**	1.05	The board, executive and leaders work in formal partnership[5] with Aboriginal and Torres Strait Islander leaders to establish accountability for: a. embedding a robust cultural governance framework including actively recruiting and effectively supporting Aboriginal and Torres Strait Islander leadership at all governance levels b. undertaking system and business model reform to mitigate practices that limit Aboriginal and Torres Strait Islander peoples' empowerment, shared decision making, co-design, and high-quality care c. recognising Aboriginal and Torres Strait Islander peoples' ways of knowing, being and doing as valid methodologies and integrating Aboriginal and Torres Strait Islander cultural knowledges as foundational to high-quality care d. implementing evaluation mechanisms, designed and led by Aboriginal and Torres Strait Islander peoples, that demonstrate monitoring and evaluation to ensure systemic change
The board, executive and leaders are accountable for the **environmental sustainability** of health care	1.06	The board, executive and leaders address environmental sustainability and climate resilience with strategies for: a. setting priorities and targets that align with jurisdictional requirements and are developed in partnership with the workforce, consumers and the community b. evaluating the effectiveness of the implemented strategies c. acting to improve progress towards targets

The board, executive and leaders are accountable for **minimising unwarranted variation and low value care**	1.07	The board, executive and leaders work with clinicians, the broader workforce, patients and consumers to: a. identify and reduce care that provides little benefit or disproportionate harms b. minimise waste in the delivery of care c. reduce inequities in the provision of high-quality care d. investigate reported instances of unwarranted clinical variation
The board, executive and leaders are accountable for the quality of health care provided in **clinical research activities**	1.08	The board, executive and leaders have organisational systems to: a. support accountability for the quality of care provided as part of clinical research within the organisation b. integrate clinical research within the clinical governance framework to promote partnerships with consumers, ethical practice, transparency, clinical safety and effectiveness c. assure the quality of care for patients participating in clinical research d. enable clinicians to participate in clinical research, education and teaching

Partnering with consumers

Boards and executives lead systems that build a culture of person-centred care that empowers consumers as partners in governance at every level of the organisation. Organisational clinical governance structures and systems systematically engage consumers in planning, design, review and measurement to improve high-quality care and contribute to better outcomes and experiences for patients, their family and carers.

The contribution that consumer leadership, skill and expertise bring to improvement, culture, delivery and evaluation of health services is recognised and valued.

Partnering with consumers in governance systems is key to enabling patient empowerment and active participation in their own care.

Note: The requirements in this key area of the Clinical Governance Standard are key to providing person-centred practice.

Purpose		Requirements
Effective partnerships with consumers build a culture of person-centred care	1.09	The board, executive and leaders have organisational systems to partner with consumers to: a. plan, design (including co-design), measure and review systems, services and models of care to support equitable experiences and outcomes of care b. recruit, train, support and empower consumers in governance roles c. design, develop and review resources that are responsive to patients' needs, culturally safe and free from bias, discrimination and racism d. incorporate the views and experiences of consumers into training and education for the workforce e. measure and review the effectiveness of partnerships with consumers and the engagement of the health service with the community and use this information to improve care f. govern, design and implement clinical research which addresses the health care needs of the community
Patient rights underpin how health care is provided	1.10	The board, executive and leaders have organisational systems to: a. adopt and make available a charter of rights that is consistent with the *Australian Charter of Healthcare Rights*[10] to patients, their family and carers, consumers and the workforce b. educate the workforce on patient rights consistent with the *Australian Charter of Healthcare Rights*[9] and embed these rights in the organisational culture and in the provision of clinical care c. provide equitable access to health care for people with a disability and identify and action the need for reasonable adjustments

Purpose		Requirements
		d. measure patient experiences of how their healthcare rights are respected by the workforce and act to improve care e. embed open disclosure, consistent with the *Australian Open Disclosure Framework*[11], at all levels of the organisation f. monitor and improve the use and effectiveness of open disclosure
Partnerships with Aboriginal and Torres Strait Islander peoples and communities shape health care	1.11	The board, executive and leaders have organisational systems to: a. build respectful and reciprocal partnerships with Aboriginal and Torres Strait Islander peoples, organisations and community-controlled healthcare organisations b. co-design, share power and authority with Aboriginal and Torres Strait Islander peoples and community members to ensure their voices shape planning, design, delivery and evaluation of care c. use Aboriginal and Torres Strait Islander research methodologies, where appropriate, and establish and support mechanisms, developed in partnership with Aboriginal and Torres Strait Islander peoples, to enable their involvement in the planning, delivery and evaluation of clinical research, including the use of flexible and decentralised research delivery models to improve accessibility, participation and equity.
Health care is improved through **patient and consumer feedback**	1.12	The board, executive and leaders have organisational systems for healthcare delivery, including clinical research, to: a. encourage and support patients, their family and carers and consumers to speak up for safety and report when they have concerns b. embed a feedback and complaints system that is easy to access, transparent, culturally safe and free from bias, discrimination and racism c. integrate feedback, complaints and patient reported experience measures with incident management systems and the processes for clinical review and credentialing d. involve patients, their family, carers and consumers, and the workforce in the investigation and resolution of complaints and provide feedback on action taken e. analyse feedback, complaints and patient reported experience measures; use the findings to inform risk management and quality improvement activities; and provide feedback to consumers on the actions taken f. regularly review the effectiveness of the system for feedback and complaints

Building a healthy workforce culture

The workforce across all areas and teams in the organisation is supported, engaged and empowered to speak up about patient safety and quality or to raise concerns about workforce behaviours. There is a healthy workforce culture where people feel respected, valued and responsible for the care provided in their workplace.

Note: This key area applies to the entire workforce, including non-clinical staff and contractors. The next section on 'Enabling high-quality and integrated clinical practice' focuses on the additional clinical responsibilities of multidisciplinary care teams.

Purpose		Requirements
The is a culture where the **workforce is supported, engaged and empowered** to provide high-quality care	1.13	The executive and leaders have organisational systems to: a. attract, recruit and retain a diverse workforce that reflects the community served and community needs b. foster psychological safety and support the workforce to speak up about concerns and report risks, near misses, adverse events and complaints c. respond to workforce concerns transparently; use these insights to reduce risks and improve the quality of care and monitor the effectiveness of actions taken d. provide tailored education and training programs that enable all members of the workforce to support and be accountable for high-quality care e. respond to risks to patient care arising from workforce gaps or pressures f. measure and monitor workforce culture, including psychosocial safety and cultural safety, with validated surveys and use the findings to improve workforce wellbeing
The **workforce understands their responsibilities** for high-quality care	1.14	The executive and leaders have organisational systems in place to: a. educate the workforce about the health service's clinical governance framework and their shared responsibilities for providing or supporting high-quality care b. communicate responsibilities for providing or supporting high-quality care to each member of the workforce at orientation, when their roles and responsibilities change, and when planning and implementing new models of care c. enable the workforce to escalate concerns about deterioration in a patient's condition d. review and discuss performance with the workforce routinely and when there are concerns about performance or behaviour and act to improve performance

Purpose		Requirements
		e. provide practical support and training to the workforce to select and integrate digital tools and technologies into their practice and evaluate their effects
Teams are supported to be high-functioning	1.15	The executive and leaders have organisational systems to: a. build and sustain diverse and inclusive teams with a clearly defined shared purpose, roles and responsibilities b. sustain a culture that focuses teams on person-centred care c. support effective leadership, mentorship and coaching to build capabilities and enable effective communication, conflict management and teamwork d. monitor team performance and continuous improvement activities
The health service is **culturally safe for the Aboriginal and Torres Strait Islander workforce**	1.16	The executive and leaders have organisational systems in place to: a. enable the Aboriginal and Torres Strait Islander workforce to actively lead and meaningfully influence leadership decisions at all levels of the organisation b. effectively support strategies to enable the Aboriginal and Torres Strait Islander workforce's wellbeing c. eliminate bias, discrimination and racism in workforce recruitment and training programs, including in orientation, supervision and performance review

Enabling high-quality and integrated clinical practice

Clinicians are appropriately skilled, capable and supported to deliver high-quality care, and participate in the organisation's clinical governance systems. The organisation has robust systems to embed evidence-informed practice into clinical practice and models of care and to assess and review clinical performance and patient outcomes across the continuum of care.

Purpose		Requirements
Clinicians are supported, trained and developed to perform at their full capability to provide high-quality care	1.17	The executive and leaders have organisational systems to: a. orient clinicians, including agency staff, locums and staff rotating from other sites to new workplaces b. tailor education and training programs to enable clinicians to provide, supervise and be accountable for high-quality care c. provide clinicians in training with supervision from qualified and experienced clinicians with the capacity to supervise d. provide clinicians with access to escalation pathways for senior clinician support and after-hours advice e. provide team-based training to develop and sustain high-functioning multidisciplinary care teams f. align the skills, capability and experience of clinicians with patients' care requirements g. conduct regular performance reviews and monitor and manage clinicians' professional performance and fulfilment of professional development requirements, including participation in morbidity and mortality review meetings and other clinical review processes h. support clinicians to improve models of care by integrating digital tools and technologies with clear criteria for use, defined workflows and routine evaluation of clinical effectiveness, safety, equity and workforce impact
Clinicians actively contribute to clinical governance activities	1.18	The executive and leaders have organisational systems to: a. involve clinicians from different clinical groups in clinical governance roles b. report to the board on clinical perspectives of the quality of care c. support clinicians to implement and evaluate new interventional procedures and clinical practice innovations, including those supported by digital tools and technologies d. support clinical leaders to use endorsed evidence-informed criteria to identify events and complex cases that trigger a multidisciplinary review of clinical decision-making and care provided

Purpose		Requirements
Clinicians are supported to undertake **quality improvement activities**	1.19	The executive and leaders have organisational systems to: a. assist clinicians and multidisciplinary care teams to conduct quality improvement activities b. engage all members of multidisciplinary care teams in quality improvement activities c. consider evidence of engagement in quality improvement activities as part of credentialing and recredentialing requirements
Systems for **credentialling and defining scope of practice** protect patient safety	1.20	The executive and leaders have fair and transparent systems for credentialing and defining scope of practice to: a. verify whether clinicians have the qualifications, expertise and professional standing to fulfil the performance requirements of their role and facility-specific scope of practice b. monitor and manage clinicians' adherence to their facility-specific scope of practice c. review credentials and facility-specific scope of practice regularly, when new services, procedures or technologies are introduced and when there are concerns about clinical performance or workplace behaviours d. use information from performance reviews when reviewing credentials and facility-specific scope of practice e. monitor and improve the effectiveness of the credentialing process
Clinicians use **evidence-informed guidance and resources** to support clinical judgement and provide high-quality care	1.21	The executive and leaders have organisational systems to: a. provide clinicians with access to Clinical Care Standards, evidence-informed guidelines, care pathways and decision support tools b. support clinicians to use the evidence-informed tools to provide high-quality care and in shared decision making with patients c. provide clinicians with timely, tailored information about the quality and outcomes of care their multidisciplinary care team provides d. support clinicians to participate in clinical and peer review, clinical research and quality improvement activities
Clinical Care Standards are effectively used for quality improvement	1.22	The executive and leaders have organisational systems to: a. assess the relevance of Clinical Care Standards according to local service quality improvement priorities, clinical risks and data insights on clinical variation b. implement Clinical Care Standards that are relevant to service quality improvement needs and address organisational clinical risks, unwarranted variation, or other data insights indicating a need for quality improvement, or are required for implementation by a relevant authority

Purpose		Requirements
		c. collect, monitor and act on indicator data for relevant Clinical Care Standards
Health care is coordinated and connected across the health service and with other providers and settings	1.23	The executive and leaders have organisational systems to: a. collaborate with consumers and clinicians to design and improve integrated models of care within the health service and across the continuum of care, including with care providers in other settings b. coordinate patient care across providers and settings, including sharing information at transitions of care

Managing and reducing risk

The organisation has a systematic, transparent and strategic approach to risk that safeguards high-quality care and informs planning and resource allocation across all parts of the organisation.

Information from a variety of sources is used to prioritise risks to patient safety and quality of care, as well as risks to workforce culture and safety. The effectiveness of actions taken to reduce risk is monitored and reported.

Purpose		Requirements
There is a **strategic and systematic approach to manage risks** across the organisation	1.24	The board, executive and leaders have organisational systems to: a. align the risk management strategy with priorities for high-quality care and address key factors and emerging risks that may impact its delivery b. provide robust oversight, identification and management of quality of care risks across all clinical, business and research functions, including digital tools and technologies c. combine information from incidents, risk reports, feedback, complaints and other data sources to inform risk assessments, mitigate risks, monitor trends and guide improvement activities d. use governance structures to enable effective and transparent communication and reporting on risk and risk management across the organisation e. regularly assess the effectiveness of risk identification and management including review of priority areas of risk f. provide workforce education and training programs that identify, assess and manage risks g. use information from the risk management system to improve patient care, workflows, service design and policy
Effective risk management supports high-quality care	1.25	The board, executive and leaders have organisational systems to: a. identify populations at risk of poorer health outcomes and act to improve care to those populations b. identify and manage high-risk activities and common causes of harm c. recognise, monitor and report bias, discrimination and racism as a clinical and organisational risk and act to improve anti-racist practices and cultural safety.
The **incident management system** draws together findings from across the organisation to develop effective responses	1.26	The executive and leaders have organisational systems to: a. maintain an incident management system with clear clinical governance roles and responsibilities b. transparently and promptly investigate and report all incidents, contributing factors and patient safety system failures, including those related to digitally enabled care and the use of digital tools and technologies

Purpose		Requirements
		c. use data to identify trends, recurring themes and systemic risks and act to make improvements and monitor effectiveness d. engage patients, their family and carers, consumers and the workforce to review incidents, actions taken to reduce harm and contribute to safety system improvements e. regularly review and improve the effectiveness of the incident management system
Health care provision is resilient and sustained during **service disruptions and emergencies**	1.27	The executive and leaders have organisational systems to: a. oversee, review and improve emergency preparedness and response frameworks for maintaining healthcare delivery and services during disruptions, internal and external emergencies and disasters b. incorporate climate-related risks, supply chain disruptions, digital downtime, utility outages, cyberattacks, outbreaks and pandemics into emergency preparedness and business continuity planning

Using data for better care

The board, executive, leaders, clinicians and managers have the information to determine whether they are providing high-quality care to patients and whether improvement efforts are effective.

Data are governed, analysed and used in a safe, accurate, timely and ethical way to strengthen decision-making, drive improvement and support high-quality care.

Purpose		Requirements
Data governance supports a learning organisation to use data appropriately	1.28	The board, executive and leaders have organisational systems to: a. systematically collect, analyse, communicate and report on clinical quality and risk data to improve care b. maintain data governance systems to collect, use, store, share and retain data and de-identify data when shared or linked c. ensure data are accurate, consistent, fit for purpose and communicated to those people who need to use it d. protect data from unauthorised access e. ensure governance and oversight of health data that is collected and used for clinical research purposes
The right data are collected and used to assess and improve healthcare quality	1.29	The board, executive and leaders have organisational systems to review and use clinical quality and risk data that: a. recognise Aboriginal and Torres Strait Islander peoples and communities' right to own and govern the creation, collection, access, analysis, interpretation, management, dissemination and reuse of Aboriginal and Torres Strait Islander data b. collaborate with Aboriginal and Torres Strait Islander peoples and communities to interpret, respond to and act on data in culturally appropriate and safe ways c. engage with consumers in analysing and reviewing data to improve care d. provide clinicians with concise and timely information about the quality of care they provide, including feedback, complaints, patient experience and outcomes, so that care can be improved e. guide resource allocation to improve care f. assess the extent to which the health service is delivering all dimensions of high-quality care g. support clinicians to review and improve their performance, the multidisciplinary care team's performance, models of care and patient outcomes h. identify and manage key risks and inform organisational decision-making i. continuously assess, monitor and improve data quality

Purpose		Requirements
Digital systems are optimised to improve continuity of care and integration	1.30	The executive and leaders have organisational digital data systems that: a. use national clinical terminologies and specifications b. use interoperable data formats for seamless information extraction and exchange c. monitor system performance to optimise the accuracy, completeness and quality of the data d. support continuity of care and informed decision-making
Data are analysed, monitored and reported to improve health care	1.31	The executive and leaders have organisational systems to use data from multiple sources to: a. identify, investigate and reduce unwarranted clinical variation b. measure whether care is evidence-informed and high-quality c. measure performance at all levels of the health service d. assess how effectively patient care is integrated within the health service and across providers and settings e. compare and report on performance with target ranges, peer organisations, state or territory and national benchmarks and trends over time f. identify opportunities to drive service and practice improvement and innovation
Clinical quality registries support safety and quality improvements	1.32	The executive and leaders have organisational systems that: a. contribute complete and accurate clinical data of all eligible patients to relevant clinical quality registries b. support clinicians to contribute clinical data to clinical quality registries c. use reports from clinical quality registries and administrative, clinical and performance data insights to benchmark, identify priorities, guide quality improvement activities and provide feedback to the board, consumers, workforce and community

Person-Centred Practice Standard

Person-Centred Practice Standard

Person-centred practice is how care is delivered to build trusting relationships between the health care workforce, the person receiving care and those who matter to the person receiving care.

Person-centred practice ensures care is respectful, responsive and tailored to what matters to each person. It is supported by shared understanding and open communication, so people have clear information about their care, what to expect and the options available. This enables people to participate in decisions and achieve the best possible outcomes.

Intention of this Standard

A supportive healthcare setting enables person-centred practice by promoting teamwork, open communication and shared decision making. The relationship between the health service workforce and the care setting shape everyday practice and influences how safe people feel to participate in their care.

Key areas

Partnering with patients in their healthcare
Caring for the whole person
Care environment
Effective communication and teamwork
Recognising and responding to acute deterioration
Coordinated and connected care
Communicating about clinical research

Partnering with patients in their healthcare

Partnering with patients in their healthcare involves building respectful, trusting relationships and actively involving people in decisions about their care. This includes supporting understanding and choice, recognising lived experience, responding to what matters to the person throughout the health care journey and discussing appropriate care options to support informed choice.

Purpose		Requirements
Patients are understood and able to have trust in their care	2.01	Clinicians: a. use the *Australian Charter of Health Care Rights*[10] to guide therapeutic relationships b. communicate with patients, their family and carers in a manner that upholds a person's dignity and is culturally safe and free from bias, racism and discrimination c. use validated techniques to confirm that relevant information has been effectively communicated, understood and likely to be recalled by patients, their family and carers d. use authorised interpreters, translated materials, communication tools and culturally appropriate communication methods in line with the needs of the patient e. implement reasonable adjustments to ensure equitable care
Patients understand their condition, treatment or intervention options and their potential benefits, risks and consequences for them	2.02	Clinicians: a. are trained by the health service in person-centred care, shared decision making and consent b. comply with their legal obligations and recognise that consent is an ongoing process that is revisited or reconfirmed at key points in care delivery or when clinical changes occur c. use informed consent principles to guide their practice consistent with all relevant jurisdictional requirements and evidence-informed guidance d. tailor communication to the patient and provide information about the patient's condition, care options and what to expect e. use supports, reasonable adjustments and culturally responsive approaches where needed to enable participation in care decision-making f. inform patients of the right to decline or defer care or consider a second opinion g. support a patient's right to include their family and carers in decision-making h. ensure a suitably qualified clinician assesses a patient's capacity, supports patients to participate in decision-making and only uses substitute decision-makers where the patient is unable to make decisions despite these supports

Purpose		Requirements
Patients make **informed decisions** about their care	2.03	Clinicians: a. engage patients throughout the episode of care in establishing what matters to the patient in decisions about their care and documenting what matters in the healthcare record b. ensure patients have access to appropriate health information and decision support tools before discussions about investigations, interventions, treatment and care decisions c. document the agreed decisions and relevant information about investigations, interventions, treatments and care in the healthcare record d. involve the patient's family and carers in discussions about the patient's care, investigations, treatments and care decisions

Caring for the whole person

Caring for the whole person involves understanding and addressing an individual's physical, cognitive, psychological, cultural and social needs that influence their health outcomes.

Person-centred practice is informed by ongoing clinical assessment and judgement to ensure care remains appropriate, responsive and aligned with the person's changing needs and preferences.

Purpose		Requirements
Clinical assessment and evidence informed decision-making underpin the planning and coordination of care across the multidisciplinary care team	2.04	The multidisciplinary care team: a. uses clinical information and assessment, evidence-informed guidance and decision support tools to inform clinical decisions b. considers the patient's cultural identity, personal circumstances and social context, including the social determinants of health relevant to the care setting when planning and coordinating care c. identifies and responds to risks of domestic and family violence, supporting safe disclosure, safeguarding patients, and appropriate care and referral d. uses relevant structured clinical assessment processes tailored to the patient's needs, care goals and preferences, including when there are changes in the patient's condition, risk and care setting e. uses clinical assessments, including relevant input from patients, their family and carers, to: i. identify patient clinical needs and functional ability ii. inform clinical reasoning and diagnosis iii. identify treatments and therapy appropriate to the patient's condition, preferences and care setting iv. identify opportunities for interventions that optimise the patient's condition and functional ability before treatment or as care needs change v. identify and address patient-specific risks that may affect their safety, clinical outcomes or functional ability during care
The **plan for care** is developed, documented, reviewed and used to guide and coordinate ongoing care	2.05	The multidisciplinary care team: a. documents the plan for care and clinical decisions in the healthcare record including: i. clinical assessment findings, provisional and confirmed diagnoses ii. care goals, patient healthcare needs, treatments and therapies

Purpose		Requirements
		iii. critical information, medication and allergy alerts, risks and participation in clinical research iv. time frames and the actions required by clinicians, the patient, their family and carers v. plans for discharge b. assesses and updates the plan for care when there are changes in diagnosis, the patient's condition or setting and incorporate input from the patient, their family and carers where appropriate c. contemporaneously documents changes to the plan for care and the rationale for these changes in the healthcare record d. monitors the patient's condition and response to care to evaluate the effectiveness of the plan for care and acts on opportunities to improve outcomes and reduce harm
Care is delivered safely	2.06	The multidisciplinary care team: a. uses evidence-informed interventions to identify and mitigate patient risks on admission and whenever the patient's condition changes b. uses clinical unit or service-level data insights, including hospital-acquired complications, incidents, near misses, adverse events, complaints, feedback, variation in practice and other relevant data insights to improve outcomes c. communicates information about investigations, treatments and care options, including associated risks and benefits and any involvement in clinical research to support informed decision-making
Advance care planning is considered when appropriate	2.07	The multidisciplinary care team use the health service's policy and processes to initiate, consider or escalate and provide advance care planning when: a. clinically appropriate b. requested by a patient c. a patient has repeated unplanned presentations within a 12-month period
End-of-life care is compassionate and coordinated	2.08	Clinicians: a. provide evidence-informed practice, coordinated care at the end-of-life in accordance with the *National Consensus Statement on end-of-life care*[12] b. reevaluate a patient's care preferences at each admission or when a patient's condition changes or deteriorates c. use clinical unit data insights to improve end-of-life care, including when appropriate, at clinical review, morbidity and mortality meetings

Care environment

Care environments influence how people experience care. Respectful, inclusive and psychologically safe environments support dignity, wellbeing and effective interactions between patients, carers and the workforce.

Everyday behaviours and responses within care settings affect how concerns are raised, behaviours of concern are managed and how safety and effective care is delivered.

Purpose		Requirements
The workplace and care environments are respectful and psychologically safe	2.09	The clinical and non-clinical workforce: a. demonstrate respectful behaviours in day-to-day interactions with all people to support high-quality care and a positive and inclusive workplace culture b. promote a workplace environment where it is safe to ask questions, express concerns and speak up about care and safety issues and concerns c. respond to concerns in a timely and respectful manner
Practice is **inclusive and culturally respectful**	2.10	The clinical and non-clinical workforce: a. work in partnership with Aboriginal and Torres Strait Islander peoples to support culturally safe care and environments b. demonstrate culturally respectful behaviours in everyday care c. avoid assumptions, bias, discrimination and racism in all interactions
Risk of behaviours of concern are minimised and managed	2.11	The health service: a. builds workforce capability through training in evidence-informed practice strategies to prevent, recognise and manage behaviours of concern, including working with patients, their family and carers where appropriate b. identifies clinical specialty areas, operational settings and patient cohorts associated with a high risk of behaviours of concern to inform prevention, mitigation and response strategies c. provides access to appropriate care environments and evidence-informed practice interventions to prevent and support the safe management of behaviours of concern, including reducing environmental stimuli where possible and clinically appropriate d. monitors, reviews and reduces the use of chemical and physical restraint, ensuring it is used only when clinically justified, that less restrictive alternatives are considered, and that use is recorded and reported to the board e. supports workforce safety and wellbeing, including managing risks to staff when responding to behaviours of concern f. reviews and learns from behaviours of concern and related incidents, using data insights, feedback and analysis to

Purpose		Requirements
		identify contributing factors and implement improvements to reduce recurrence
Behaviours of concern are managed safely and effectively	2.12	The clinical and non-clinical workforce contribute to the safe and effective management of behaviours of concern by working in partnership with each other and with patients at risk, their family and carers to identify triggers and develop preferred de-escalation approaches

Effective communication and teamwork

Effective communication and teamwork underpin coordinated and safe care. Clear roles, shared understanding and the exchange of information support continuity of care and responsive decision-making.

Communication occurs between clinicians, with patients, their family and carers, and across the broader care and non-clinical teams and adapts as care needs change.

Purpose		Requirements
Effective communication supports person-centred care	2.13	The health service has organisational systems to: a. develop and sustain the communication capability of the workforce including in digital and virtual care delivery, through training, credentialing and ongoing professional development b. monitor and evaluate the effectiveness of communication practices and use findings to drive continuous improvement c. use digital and assistive communication technologies that are clinically appropriate and supported by training d. support communication and information sharing with patients, their family and carers, and across the clinical and non-clinical teams and other providers to enable coordinated care e. identify and respond to communication needs and preferences of patients across the episode of care, including accessibility needs, and provide communication resources and adapted methods to support shared decision making
Multidisciplinary care teams support coordinated and high-quality care	2.14	The multidisciplinary care team and non-clinical workforce working together as a team: a. foster trust and mutual respect within the team through recognising and valuing each member's contributions b. demonstrate behaviours that support a patient safety culture, including asking questions, escalating concerns and seeking assistance c. develop and maintain clinical and communication processes that support coordinated care d. understand team members' roles and responsibilities, including which clinician is responsible for coordinating care and overall clinical management e. communicate their role in care and responsibilities to the patient, their family and carers and all members of the team f. continuously review and improve their performance

Purpose		Requirements
Critical information about a patient is promptly communicated and effectively acted on	2.15	Clinicians understand and use the health service's processes for responding to critical information, including processes to: a. ensure prompt recognition, timely communication and management of critical information b. ensure prompt notification, using an escalation procedure, of the critical information to the patient and the clinician responsible for overall care c. ensure critical results are communicated, received, acknowledged and acted on d. document the escalation of the critical information and steps taken to ensure communication of the critical information

Recognising and responding to acute deterioration

Changes in a person's physical, cognitive or mental state require early recognition and timely response.

Person-centred practice includes clinical assessment, attention to concerns raised by patients, their family and carers, and appropriate escalation to prevent harm and deterioration.

Purpose		Requirements
Clinicians **respond appropriately to concerns raised** by patients, their family and carers	2.16	Clinicians: a. ensure that patients, their family and carers are informed and supported to escalate concerns about care and deterioration or changes in the patient's condition b. follow organisational systems to routinely ask patients, their family and carers to share key information and observations, including changes in condition or concerns, to support early recognition of deterioration c. ensure that concerns raised by patients, their family or carers are taken seriously, promptly and thoroughly investigated, clinically assessed, acted upon and documented as per the local escalation policy and process d. promote early recognition of physical, cognitive and mental health deterioration, and ensure appropriate monitoring, escalation and response using documented processes
Patient safety is supported by recognition and timely, appropriate **escalation of care**	2.17	The multidisciplinary care team: a. is trained in recognising the early signs of physical and cognitive deterioration, in line with health service policies and procedures b. implements vital sign monitoring plans that are tailored to the care setting and adapted to the patient's condition c. uses and maintains documented monitoring and escalation pathways, protocols and agreed parameters for escalating care, and ensures these are embedded into clinical workflows and systems d. provides a timely clinical response to deterioration by clinicians with the skills required to manage the patient's condition, including rapid referral to services that can definitively manage acute deterioration e. implements systematic review and continuous improvement of processes for identifying, documenting and managing clinical deterioration

Purpose		Requirements
Early recognition of **deterioration in a patient's mental state** is escalated in a timely and appropriate manner	2.18	The multidisciplinary care team: a. recognises, assesses and manages acute deterioration in a patient's mental state, including reported changes in behaviour, cognitive function, perception, physical function or emotional state, in the context of the patient's usual baseline b. monitors patients identified as being at risk of acute mental state deterioration c. includes the patient's known early mental health deterioration warning signs in the patient's individualised monitoring plan d. safely and effectively responds to patients experiencing suicidal distress or thoughts of self-harm, including those who have self-harmed while in hospital, and supports appropriate follow-up care e. documents and communicates observed or reported changes in a patient's mental state to other members of the multidisciplinary care team f. identifies and reduces the risk of harm from unmet needs or care fragmentation, including during transitions of care and at discharge

Coordinated and connected care

Coordinated and connected care relies on clear communication of all relevant information during the transfer of responsibility between care providers. Structured clinical handover supports safe transitions of care by promoting a shared understanding of each patient's needs when moving between care settings or upon discharge from the health service. This approach ensures effective coordination, enhances patient safety and health care outcomes, and builds capability across care settings.

Purpose		Requirements
Patients receive **coordinated care**	2.19	Clinicians: a. implement and maintain strategies that support coordinated and connected care across the care continuum in partnership with patients, their family and carers b. use systems and tools to support timely and effective sharing of information, including shared plans for care, between patients, their family and carers, clinicians, teams and health services c. clearly define roles, responsibilities and points of contact for ongoing care, including explicit identification of who is accountable following discharge or transfer, particularly where care is shared across clinicians, teams, health services or organisations d. monitor and review risks and outcomes associated with care coordination and transitions of care, including readmissions, delayed discharges, incidents and patient feedback, and use this information to facilitate continuous improvement
Continuity of care is supported through structured and effective **clinical handover**	2.20	The multidisciplinary care team: a. use evidence-informed practice guidance to define the information required for clinical handover b. use structured handover tools to improve continuity and quality of care c. embed consistent, coordinated communication in its routine workflows and digital systems d. regularly review and improve clinical handover processes using feedback from clinicians, patients, their family and carers and data insights from complaints e. actively involves the patient, their family and carers during clinical handover, including asking questions or raising concerns

Risks associated with **transitions across services and care settings** are reduced	2.21	The health service identifies and manages risks associated with transitions of care across services, settings and levels of clinical support, including: a. transfers within an episode of care b. where there may be a mismatch between the patient's care needs and the level of clinical support, capability or resources available c. outside of routine operating hours and where access to clinical support or resources may be reduced d. where the patient is receiving care from multiple specialty teams or services e. with clinical research, where roles, responsibilities or care arrangements change
Information exchanged at transitions of care is accurate, complete, timely and useful	2.22	The multidisciplinary care team ensures that information exchanged at transitions of care, including discharge: a. is accurate, complete and transferred in a timely manner, with clear identification of the patient and relevant healthcare provider b. supports continuity of care across services and settings c. provides patients, their family and carers with clear information about what to expect following discharge, what to look for, and what actions to take, including if their condition changes or does not progress as anticipated d. includes supporting information about a patient's cultural identity, obligations and practices and any relevant communication, accessibility or support needs e. is transmitted using information-sharing systems and processes, including National Digital Health Infrastructure (such as My Health Record)

Communicating about clinical research

Clinical research teams ensure that patients are appropriately informed, supported and protected when participating in clinical research. They provide access to suitable research options, deliver clear health information and decision support to patients before seeking informed consent. This process safeguards patient autonomy and ensures patients make informed decisions about their care.

Note: This requirement is only applicable if the health service participates in clinical research

Purpose		Requirements
Participation in clinical research is informed and transparent	2.23	The clinical research teams: a. offer patients access to approved clinical research healthcare options b. provide patients, their family and carers with access to health information and decision support before discussing research, investigations, interventions and treatment options c. obtain informed consent for participation in clinical research d. in accordance with ethical, regulatory and organisation requirements document in the patient's healthcare record: i. the decision-making process for investigations, interventions, treatments and care decisions, next steps and review points ii. discussions of potential risks, benefits and alternatives to clinical research iii. the patient's informed consent to participate in clinical research and their reasoning

Safe Clinical Systems Standard

Safe Clinical Systems Standard

Health services implement and improve clinical safety systems and processes to maximise the quality of care.

Intention of this Standard

Priority systems, policies and processes keep people safe while receiving care or working in a health service, prevent avoidable harm and support the sustainable delivery of high-quality care.

Key areas

Safe environments
Patient identification
Health care record systems
Infection prevention and control
Medicines safety and quality
Medical devices
Blood management

Note: In Australia, health services vary considerably in size, organisational structure and the scope and complexity of care they provide. Health services reflect the diverse communities they serve. The clinical and the non-clinical workforce work as a team in a systematic way to provide health care to patients.

Health services provide care so that safety and quality are not dependent on individuals, but are built into every system, process and environment ensuring every patient receives the right care, every time.

Safe environments

Care environments are safe and therapeutic through purposeful design and diligent maintenance of infrastructure.

Purpose		Requirement
Care environments are safe, culturally welcoming and therapeutic	3.01	The health service maximises the provision of high-quality care: a. through designing the environment in consultation with patients, consumers, communities, clinicians and relevant experts b. by testing and maintaining buildings, transport, plant, equipment, utilities, services for water, electricity and gases, devices and other infrastructure to ensure they are maintained fit for purpose and safe for use c. by formally partnering with local Aboriginal and Torres Strait Islander peoples and communities to co-design, implement and evaluate welcoming and culturally safe environments

Patient identification

Patients consistently receive the intended care through provision of accurate, reliable and patient-involved identification and procedure matching.

Purpose		Requirements
Robust **patient identification processes** ensure the right patient receives the intended care	3.02	The health service ensures unambiguous, safe and traceable patient identification and procedure matching by: a. defining and using at least three approved patient identifiers in accordance with best-practice guidance, documenting the process for patient-intervention matching and communicating this to the workforce b. requiring the workforce to use at least three approved patient identifiers: i. on registration and admission, on any shared information and at transfer of care ii. in health care records, care transfer documents and reports iii. before commencing any care, including specimen collection, administering medications, conducting procedures or interventions, undertaking clinical handover, or providing patient advice or education iv. while transferring or sharing sensitive or clinical research information c. taking prompt corrective action when a patient identification and matching discrepancy is identified d. introducing digital technologies to improve patient matching, including barcoding to match patients to specimens and medication
Aboriginal and Torres Strait islander patients are respectfully identified and connected to culturally appropriate care	3.03	The workforce: a. understands the importance of appropriately identifying Aboriginal and Torres Strait Islander patients and their related care needs b. applies culturally safe practices when identifying Aboriginal and Torres Strait Islander patients by: i. routinely asking all patients using a standard identification question ii. asking the question in a respectful, non-judgmental way iii. explaining in a respectful, culturally appropriate, non-judgemental manner, and when asked, the purpose of the question iv. ensuring privacy when asking the question v. respecting that some patients may not wish to answer the question c. uses the patient's identification as an Aboriginal and Torres Strait Islander person to trigger culturally safe and appropriate

Purpose	Requirements
	models of care, to inform clinical decision-making and to support improved patient experiences, care and outcomes

Health care record systems

Patient care episodes are accurately documented, informed by and integrated into their health care record, which is accessible and connected through interoperable systems.

Purpose		Requirements
Accurate, integrated patient information is available to reduce risk and improve continuity of care	3.04	The health service has healthcare record systems that: a. use national healthcare identifiers that are verified against the *National Healthcare Identifiers Service* b. are interoperable with: i. National Digital Health Infrastructure (such as My Health Record) to support access, sharing and exchange of health information in accordance with national legislative and policy requirements ii. diagnostic testing reporting systems iii. Point of Care Testing devices to capture findings c. are able to share and exchange information in alignment with national requirements, specifications and infrastructure d. have alert systems that minimise alert fatigue, support decision-making and highlight patient risks to the clinical and non-clinical workforce e. are accessible to clinicians at the point of care f. contain accurate, integrated, comprehensive and up-to-date patient care information that can be used by the workforce to provide high-quality care, support continuity of care and improve patient experiences and outcomes

Infection prevention and control

Safe, high-quality care is supported and maintained by reducing infection risks through evidence-informed practice precautions, surveillance, workforce protection and providing a clean, well-managed environment.

Purpose		Requirements
Infection risks are effectively identified, managed and reported	3.05	The health service: a. has multidisciplinary care teams to identify and manage risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems b. applies standard and transmission-based precautions in accordance with the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[13] c. complies with relevant profession-specific infection prevention and control guidance, jurisdictional legislation, requirements and policies, including work health and safety legislation d. assesses the workforce's competency in applying standard and transmission-based precautions and provides training and training updates e. measures and improves ongoing compliance with standard and transmission-based precautions components, including hand hygiene, and reports the results and recommendations to the clinical and non-clinical workforce, board, executive, leaders and community f. has outbreak detection processes, response systems and governance mechanisms, including linkage with public health and staff health units
Infections are prevented through **evidence-informed use of invasive medical device**	3.06	The health service demonstrates processes for the use and management of invasive medical devices in accordance with the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[13], Therapeutic Goods Administration (TGA) regulations and manufacturers' instructions for use

Purpose		Requirements
Infection prevention and control is improved through **surveillance, benchmarking and targeted improvements**	3.07	The health service: a. collects and analyses data on healthcare-associated infections, infection prevention and control practices including hand hygiene, antimicrobial resistance and the appropriateness of antimicrobial use b. benchmarks its performance and reports the results and recommendations to the workforce, board, executive, leaders and community c. uses surveillance, feedback mechanisms and benchmarking data to identify gaps, implement and evaluate quality improvement activities d. uses surveillance systems with validated processes to collect data and standardised case definitions, where available
Workforce infection transmission is prevented and managed	3.08	The health service: a. aligns its processes with state or territory work, health and safety regulations, *Safe Work Australia Model Code of Practice: Managing the risks of biological hazards at work*[14] and the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[13], including workforce screening and exclusion periods b. provides respiratory protection programs, has exposure management systems and monitors workforce transmission risks c. provides a workforce immunisation program in accordance with jurisdictional requirements for vaccine preventable diseases and the *Australian Immunisation Handbook*[15] d. supports non-attendance or remote attendance of the workforce when there is a suspected or known infection in the workforce, and implements additional controls to minimise transmission when absence is not possible
A **safe and hygienic environment** is maintained for the delivery of care	3.09	The health service: a. identifies, evaluates and addresses infection risks associated with new and existing equipment, medical devices, products and the physical environment b. cleans, maintains, repairs and upgrades buildings, transport, infrastructure, utilities, fittings, equipment, medical devices and furnishings to provide safe, appropriate and sustainable infection prevention and control

Medicines safety and quality

Safe, high-quality medication management across prescribing, dispensing and administration is delivered by maintaining accurate histories, managing allergies and reactions, reviewing medicines, communicating clearly, managing medicines sustainably and building collaborative stewardship to guide safe practice.

Purpose		Requirements
Accurate and safe **medication management** is provided throughout care	3.10	Clinicians use a structured approach to: a. take and document the Best Possible Medication History (BPMH) on a patient's presentation, or as early as possible when it is not practical at presentation b. verify and use the BPMH to reconcile the patient's medicines against their medication management plan c. review and update the reconciled medicines throughout the patient's care d. communicate medicine changes to the patient, their family and carers, all relevant clinicians, including primary care teams when there is a transition of care
Harm is minimised through effective documentation, assessment, management and reporting of **adverse medicine events**	3.11	Clinicians: a. identify and manage medicine allergies and adverse events b. assess the accuracy and clinical relevance of reported allergies and adverse events c. document: i. known medicine allergies and adverse events on presentation, in accordance with BPMH requirements ii. new or suspected medicine allergies and adverse events during the patient's care and communicate these to the patient, their family and carers, all relevant clinicians including primary care teams d. report new or suspected medicine allergies and adverse reactions to the incident management system and the TGA
Medicines are optimised through ongoing reviews across the care continuum	3.12	Clinicians: a. review a patient's medicines throughout their care and at transitions of care b. perform and document patient medication reviews using a structured approach that: i. accords with evidence-informed practice ii. informs the appropriateness of initiating, continuing, modifying or deprescribing a patient's medicines based on their care needs

Purpose		Requirements
Medicines information is communicated clearly and accurately	3.13	Clinicians: a. provide patients with information about their individual medicine needs, risks and benefits b. routinely generate and update a patient's medicines list c. document why the patient's medication regimen has changed and inform the patient, their family and carers and all relevant clinicians including primary care teams of the change d. provide an updated medicines list and relevant information to the patient, their family and carers at discharge, in a form they understand and transmit the medicines list to the primary care teams at transitions of care
Medicines are safely procured, stored, distributed and disposed of	3.14	The workforce adheres to the manufacturers' directions of use, legislative and jurisdictional requirements and evidence-informed practice guidance for the: a. safe and secure storage and distribution of medicines b. sustainable medicines procurement and usage practices c. disposal of unused, unwanted or expired medicines to reduce environmental impact
Safe and consistent use of medicines, including antimicrobials, is supported through **effective stewardship**	3.15	The workforce demonstrates quality use of medicines practices that: a. identify medicines that pose a high risk to patients b. engage and inform the multidisciplinary care team on prescribing, dispensing and administering of medicines c. align with evidence-informed practice guidance d. apply surveillance methods to measure high-risk medicines use and reports the results to the workforce, board, executive, leaders e. analyse and act on the results of the high-risk medicines use to demonstrate and promote quality improvement

Medical devices

Medical devices are safely selected, used, maintained and monitored throughout their lifecycle in alignment with regulatory and manufacturer requirements.

Purpose		Requirements
Safe, compliant and reliable medical devices are provided	3.16	The health service has organisational systems that: a. ensure applicable medical devices and software comply with regulations and are on the Australian Register of Therapeutic Goods b. ensure the selection of medical devices for use in the health service is based on evidence of effectiveness and free from commercial influence c. ensure new medical devices go through a defined selection process, acceptance testing and commissioning to assess that the devices meet the manufacturer's stated specifications and requirements for patient care d. evaluate the implementation and performance of new medical devices and take appropriate action to address any issues identified
Medical devices are used as intended	3.17	The health service has organisational systems that ensure: a. medical devices are used for their intended purpose in accordance with the manufacturer's instructions of use and communicate this to the workforce b. investigational or unapproved medical devices are used for their intended purpose in accordance with the clinical research protocol and product information sheet and communicate this to the clinicians and non-clinical workforce c. regular quality assurance of medical devices so the devices perform optimally during use d. medical devices undergo planned maintenance and repairs according to the manufacturer's instructions of use and have their performance tested after maintenance and repair e. investigational or unapproved medical devices are serviced, certified and updated in accordance with the clinical research protocol and product information sheet f. active management of aging, obsolete and sub-optimally performing medical devices

Purpose		Requirements
Device traceability improves patient safety, recall effectiveness and quality improvement	3.18	Where a medical device has Unique Device Identification, the health service has organisational systems that are in alignment with regulation to: a. capture the receipt of the medical device and its location in the health service b. capture the medical device's use on or implantation into a patient and record the unique device identifier into the healthcare record c. include the unique device identifier in recording medical device adverse events in the incident management system and report the event to the TGA d. respond to safety alerts and recalls, use the information collected for post market surveillance and quality improvement, and where applicable, for clinical registries
Reusable medical devices are safely reprocessed and are traceable	3.19	The health service demonstrates processes: a. for reprocessing of reusable medical devices that: i. align with national and international standards ii. comply with manufacturers' instructions of use b. that identify and trace the patient, their procedure and the critical and semi-critical medical devices used
Point of Care Testing devices are safe and used appropriately to support patient care	3.20	Health services using approved, investigational or unapproved Point of Care Testing devices adhere to evidence-informed guidance to operate, maintain and dispatch the devices
Medical device incidents are reported	3.21	The health service reports near missed and adverse events for: a. approved medical devices into the incident management system, to the manufacturer and the TGA b. investigational or unapproved medical devices, in accordance with regulation, into the incident management system and to relevant agencies

Blood management

Safe, appropriate and accountable use of blood and blood products is ensured through effective transfusion, patient blood management practice, haemovigilance and sustainable blood management.

Purpose		Requirements
Blood and blood products are used safely and appropriately	3.22	Clinicians use national guidance and criteria to: a. optimise, in consultation with the patient, a patient's own red cell mass, haemoglobin and iron stores b. identify and manage patients with, or at risk of, bleeding c. assess and document the clinical need for blood and blood products and the related risks d. discuss potential blood and blood product requirements with patients, their family and carers, including risks and alternatives, before use and document these discussions in the healthcare record e. report transfusion-related incidents into the incident management system
Blood and blood products are safely managed, traceable and available when needed.	3.23	The health service adheres to manufacturers' directions of use, legislation and jurisdictional requirements for: a. the safe storage, management, distribution and handling of blood and blood products for patient use and for clinical research b. tracing of blood and blood products from receipt by the health service through to transfusion, discard or transfer c. managing blood availability to meet clinical need, eliminating avoidable wastage and responding effectively during times of blood shortage
Patients experience **safer blood management through monitoring and improvement**	3.24	The health service: a. has a surveillance system with validated processes to collect and analyse data on blood and blood product management b. participates in haemovigilance activities and reporting in accordance with the *Strategic framework for the National Haemovigilance Framework*[16] c. benchmarks its performance against national and jurisdictional data and reports the findings to the workforce, board, executive, leaders and community d. uses surveillance, feedback mechanisms, structured reviews of clinical practice and benchmarking data to identify gaps, implement and evaluate quality improvement activities

Glossary

The following definitions used by the Commission apply across the NSQHS Standards. Where appropriate, definitions from external sources have been adapted to fit the context of the NSQHS Standards and are referenced accordingly.

Term	Definition
Accessible[3]	Delivered at the right time and the right place.
Advance care planning[17]	A voluntary process that allows people to explore what they value most in life, to guide their current and future health and personal care.
Adverse event[18]	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.
Allergy[19]	An immune response, in which a person's immune system reacts to foreign substances (allergens) that are harmless to most people.
Antimicrobials[20]	Medicines that kill or slow the growth of microorganisms (bacteria, fungi, parasites and viruses) that cause disease.
Antimicrobial resistance[19]	When microorganisms (bacteria, fungi, parasites and viruses) that cause infections resist the effects of the medicines used to treat them.
Approved patient identifier	Specific data items approved for use as patient identifiers, for example, patient name (family and given names), date of birth, gender, address including postcode, healthcare record number and individual healthcare identifier.
Behaviours of concern[21]	Behaviours of such intensity, frequency or duration that the physical safety or emotional wellbeing of the person, or others around them, is at significant risk.
Benchmark	A standard or point of reference by which others measure their performance or outcomes.

Term	Definition
Best Possible Medication History[22]	A Best Possible Medication History is an accurate and complete list of medicines the patient is currently taking. The list includes the name, dose, route and frequency of the medicine.
Bias	Refers to a systematic deviation from neutrality or fairness, where judgments, decisions or processes are influenced by personal beliefs, assumptions or external factors.
Blood management[23]	A process that improves outcomes for patients through strategies which ensure optimisation and conservation of a patient's own blood, the appropriate use of blood and blood products and, good stewardship to improve patient safety and reduce risk associated with the use of allogeneic blood and blood products.
Blood product[24]	A biological substance derived from blood that are is used to treat patients. It includes blood components, plasma derived and recombinant products.
Board	The individual or group with ultimate responsibility for the governance, direction, oversight, performance, and compliance of a health service. This may include a chief executive officer, organisation owner, partnership, board of directors, or other highest-level governing body responsible for strategic and operational decision-making and for monitoring the organisation's business, affairs, and operations. The individuals or group whose responsibilities include governing, directing and monitoring a health service's business, affairs and operations, including overall organisational performance and compliance.
Care environment	The physical, social and organisational setting in which health care is delivered. It is designed to enable the delivery of high-quality care, be safe and welcoming, appropriately meet patients' needs and support their independence, function, interaction and overall well-being.
Care goals	What a patient wants to achieve during an episode of care within the context of their clinician situation.
Care pathway	A person-centred, structured, evidence-based, multidisciplinary approach that organises and coordinates care processes and clinical interventions for a defined group of patients over a specified period, mapping the sequence, timing, and expected outcomes of care.

Term	Definition
Carer[25]	A person who provides ongoing, unpaid care and support to a family member, neighbour, or friend who needs help with their day to day living because they live with a disability, terminal illness, chronic illness, mental illness or ageing. A collective approach to carer responsibilities by those close to the person receiving care is also possible, particularly for Aboriginal and Torres Strait Islander peoples and people with different cultural or social identities culturally and linguistic diverse people there may be a collective approach to carer responsibilities.
Clinical assessment[26]	A systematic and dynamic process of collecting and analysing data about a patient's health. It involves an evaluation of a patient's symptoms and physical condition, information gathered from physical and diagnostic examinations, the patient's medical history and illness course, and the determination of a prognosis and treatment.
Clinical Care Standards	Are quality statements in line with current best evidence that describe the care patients should be offered by health professionals and health services for a specific clinical condition or defined clinical pathway.
Clinical governance	The combination of organisational culture, systems and structures that enables everyone in a health service to deliver care that is consistently high- quality and improving. It is central to providing the best possible outcomes for patients. Effective clinical governance means that boards, executives, clinical leaders and the workforce are clearly accountable to patients, families, carers and the community for providing high-quality care.
Clinical handover[27]	The structured transfer of professional responsibility and accountability for some or all aspects of care for a patient or group of patients, to another clinician or multidisciplinary care team on a temporary or permanent basis within a health service.
Clinical leader[28]	A healthcare professional who works within a clinical setting and exercises leadership to improve the quality of patient care. They combine hands-on clinical expertise with the ability to guide and influence teams to shape workplace culture, drive positive behavioural change, and enhance practice and performance.
Clinical research[29]	A branch of health and medical research undertaken in a clinical setting to improve understanding of health and disease by evaluating the safety, effectiveness and development of medical interventions; it includes both observational and interventional studies and involves people, their data or biological samples.

Term	Definition
Clinical review[30]	A retrospective, structured, systematic process of examining health related evidence, medical care and treatment decisions to evaluate whether care met accepted standards of necessity, safety and quality. Reviews are used to regularly review a clinician's work, and they also occur in response to a defined list of clinical issues, and triggers, such as substandard performance or questionable care decisions.
Clinical trials[31]	A type of research that studies new tests and treatments and evaluates their effects on human health outcomes. People volunteer to take part in clinical trials to test medical interventions including drugs, cells and other biological products, surgical procedures, radiological procedures, devices, behavioural treatments and preventive care.
Clinician[32]	Refers to trained and qualified individuals, including registered and non-registered practitioners, who provide direct clinical care to patients. Clinicians include Aboriginal and Torres Strait Islander Health practitioners, allied health practitioners, ambulance officers and paramedics, medical and medical radiation practitioners, midwives, nurses, scientists, technicians and students who provide health care under supervision.
Co-design[33]	A collaborative process in which stakeholders, including end users, work together as equal partners with experts to design structures, systems, policies, processes and services. It is collective creativity that is applied across the whole span of a design process.
Co-design (with Aboriginal and Torres Strait Islander peoples)	An equitably resourced partnership process that is Aboriginal and Torres Strait Islander-led and build on authentic relationships, communicating through agreed mechanisms, two-way understanding, cumulative evaluation and reflection to generate and sustain shared development pathways to outcome delivery and reform. To be described as co-design respective activities, arrangements and claims must: • ensure early and consistent involvement of Aboriginal and Torres Strait Islander peoples and communities through the design process for transparency and accountability • prioritise and respect the voices of Aboriginal and Torres Strait Islander peoples to determine and drive the agenda and design solutions for health reform; and address the interface between the health, disability and aged care sectors facilitate knowledge-sharing, power-sharing, shifts in control consistent with the National Agreement and capability building between the healthcare system, Aboriginal and Torres Strait Islander experts and patients

Term	Definition
Community[34]	Refers to a group of people who share a common location, identity, culture, interests or experiences, and who are connected through social relationships, networks and a sense of belonging. In healthcare, communities play an important role in shaping health needs, experiences and outcomes.
Consumer	A consumer advocate or representative who provides a consumer perspective, contributes consumer experiences, advocates for the interests of current and potential health service users, and takes part in decision-making processes.
Continuum of care	A person-centred, longitudinal conceptual framework that organises all health services across a person's healthcare journey within an integrated system, providing coordinated, consistent care across discrete encounters while accounting for the individual's medical needs, personal context, and the integration of multiple services and teams.
Continuing professional development	The systematic maintenance, improvement and continuous acquisition and reinforcement of the life-long knowledge, skills and competencies of clinicians.
Continuity of care	The degree to which health care is experienced by a person as coherent, connected and consistent over time and across settings. It is achieved though ongoing relationships and seamless coordination across providers, teams, and care settings.
Credentialing[35]	The formal process used by a health service organisation to verify the qualifications, experience, professional standing, behaviours, competencies and other relevant professional attributes of clinicians, so that the organisation can form a view about the clinician's competence, performance and professional suitability to provide safe, high quality healthcare services within specific organisational environments.
Credentials[34]	The practical experience, qualifications, professional awards and statements of competency issued by an authorised and recognised body that attest to a clinician's education, training and competence and relevant practical experience.
Critical information	Information that has a considerable impact on a patient's health, wellbeing or ongoing care, and may require clinicians to reassess or change the patient's plan for care.
Critical medical device	An item that confers a high risk for infection if they are contaminated with any microorganism and must be sterile at the time of use. This includes any device that enters sterile tissue or the vascular system, because any microbial contamination could transmit disease.

Term	Definition
Cultural safety	It is determined by individuals, families and communities. In health service's culturally safe practice is the ongoing critical reflection of knowledge, skills, attitudes, practicing behaviours and power differentials in delivering safe, accessible and responsive health care, free from bias, discrimination and racism.
Cultural safety (Aboriginal and Torres Strait Islander peoples)	It is determined by Aboriginal and Torres Strait Islander peoples, families and communities. The health service's culturally safe practices for Aboriginal and Torres Strait Islander peoples also include • acknowledging colonisation and systemic racism, and the social, cultural, behavioural and economic factors which impact individual and community health • acknowledging and addressing individual racism, discrimination, biases, assumptions, stereotypes and prejudices and providing care that is holistic, free from bias, discrimination and racism • Recognising the importance of self-determined decision-making, partnership and collaboration in health care which is driven by the individual, family and community Fostering a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander peoples and colleagues.
Cybersecurity	Measures and practices used to protect the confidentiality, security, integrity and availability of information technology and operational technology systems, data, computer systems, networks and devices.
Data	Are measurements or observations that are collected as a source of information, and in the healthcare context, refer to clinical and non-clinical information such as patient records, test results, vital signs and service data that are collected to inform diagnosis, treatment, care planning and health system management and healthcare improvements.
Data governance	Ensures that data is accurate, accessible, secure and responsibly managed, while establishing policies, processes, structures, roles and responsibilities to enable effective management and use of data as a strategic asset for decision-making and service delivery.
Data insights	MA meaningful interpretations of analysed data that explains patterns, trends, or relationships and can be used to inform decisions, policy, or action.
Data quality	Refers to the extent to which data is fit for purpose and meets standards for accuracy, reliability and usability.
Deprescribing	A planned and supervised process of medication reduction or withdrawal intended to achieve improved health outcomes through discontinuation of one or more medications that may be causing harm, no longer required or beneficial.

Term	Definition
Deterioration	Refers to physiological, psychological or cognitive changes in a patient that indicate a worsening of the patient's condition.
Deterioration in mental state	Refers to negative changes in a person's mood or thinking, behaviour, cognitive function, perception or emotional state.
Digital downtime	Refers to a period when electronic systems are unavailable or only partially available or not functioning as intended, disrupting access to information and healthcare service delivery.
Digital maturity	Refers to the health service's level of digital capability, including its ability to effectively adopt, use, integrate and improve its digital systems and data over time to support high-quality care.
Digital systems	Are information and communication technology-based systems, tools and services that support healthcare delivery and coordination by enabling the management, storage, sharing and access of information, facilitating patient care, and supporting the collection and exchange of health data.
Digitally enabled care	The appropriate use and integration of digital health tools and technologies in clinical settings to support the sharing of information, collaboration and to deliver connected, coordinated and high-quality healthcare.
Directions of use	The instructions provided with a medicine that enable it to be used safely and effectively.
Discrimination	Any distinction, exclusion or preference that impairs equality of opportunity or treatment and occurs when a person is treated less favourably because of personal characteristics.
Diversity	Refers to a range of social, economic and geographic differences among people and populations, including variations in cultural background, language, beliefs, experiences and disability status and personal characteristics.
Effective[3]	Evidence-based and results in outcomes that benefit the person receiving care.
Efficient[3]	Minimises cost and waste while achieving the best possible outcomes for people.
Environmental sustainability	Fulfilling the environmental needs of current generations without compromising the needs of future generations, while ensuring a balance between economic growth, environmental care and social wellbeing.
Episode of care	Refers to the period from a patient's initial contact with a health service for a specific health problem through to the completion of treatment or final interaction for that specific health problem.

Term	Definition
Escalation pathway	An escalation pathway is a structured process used to identify patient deterioration and initiate an increase in care to ensure a timely and appropriate response. The pathway can be activated by clinicians in response to abnormal physiological measurements or other observed deterioration or by a patient and their support people when they are concerned about a decline in the patient's condition.
Equitable[3]	Provides quality care to all people while responding to the needs of different groups to minimise differences in outcomes.
Equity	The absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability or sexual orientation).
Evidence-informed practice	An intervention that is based on best available evidence and experience to produce optimal patient outcomes and is established or proposed as a standard suitable for widespread adoption.
Executive	Refers to key decision-makers or accountable people responsible for providing strategic and operational direction of the health service and ensuring the delivery of high-quality care.
Facility-specific scope of practice	The extent of a clinician's approved clinical practice within a particular facility or organisation or setting, based on the clinician's credentials, competence, performance and professional suitability; the needs of the facility; the capacity of the facility to provide safe and appropriate care and the capability of the facility to support the clinician's scope of practice. It is specific to an individual, their role and the facility in which they work.

Term	Definition

Formal partnership[5]	As defined in the clauses 28 to 33 of the National Agreement on Closing the Gap and enshrines agreed joint decision-making by setting out who makes decision, how decisions are made, and what decisions will be about.
	
	Formal Partnerships provide Aboriginal and Torres Strait Islander entities with a level of power that is equal to or higher than other parties.
	
	Formal Partnerships:
	• require formal signed agreements between Aboriginal and Torres Strait Islander peoples, governments, and other parties that sets out how they will each work to together to achieve agreed goals and aims
	• allow Aboriginal and Torres Strait Islander peoples to choose their own representatives.
	• provide adequate funding to support Aboriginal and Torres Strait Islander parties to be partners in Formal Partnerships for activities to
	  ○ engage independent policy advice
	  ○ meet independently of governments to determine their own policy positions
	  ○ support strengthened governance between and across Aboriginal and Torres Strait Islander organisations and entities
	
	engage with and seek advice from Aboriginal and Torres Strait Islander peoples from all relevant groups within affected communities, including but not limited to, Elders, Traditional Owners and Native Titles Holders.

Governance	The exercise of authority, oversight and decision-making over an organisation such as a health service to direct and manage its business affairs and operations, ensuring organisational performance and objectives are achieved while maintaining compliance with legislated regulatory requirements and legal, ethical and community expectations.
Healthcare-associated infections	Infections acquired in a health service, during care or because of an intervention, that were not present or incubating at the time of admission. These infections may become apparent after discharge.
Healthcare Identifier	A unique number assigned to individuals, healthcare providers and health services to accurately identify and match health information. For further information visit: https://www.health.gov.au/topics/health-technologies-and-digital-health/about/healthcare-identifiers

Term	Definition
Health literacy	The personal knowledge and competencies that accumulate through daily activities, social interactions and across generations that enabling people to access, understand, appraise and use information and services in ways that promote and maintain health and well-being.
Health service	A separately constituted organisation that is responsible for implementing corporate and clinical governance, administration and financial management of a service unit or service units providing health care to a community at the direction of a board.
High-risk medicines	Medicines that have a high risk of causing significant injury or patient harm when they are misused or used in error.
High-quality care	Person-centred, safe, effective, accessible and integrated, provided in a way that is equitable, efficient and sustainable. Cultural safety, as determined by Aboriginal and Torres Strait Islander peoples, is necessary for high-quality care. Cultural safety must be embedded in each domain of high-quality care to improve health outcomes for Aboriginal and Torres Strait Islander peoples.
Incident[18]	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.
Incident management system	An organisational system that supports the identification, reporting and investigation of incidents to enable learning, inform risk management, and drive continuous quality improvement.
Individual Healthcare Identifier	A unique number that ensures healthcare providers can accurately match records to the person they are treating.
Infection	When pathogens (germs) such as bacteria, viruses, parasites and fungi get onto or enter the body, multiply and cause disease.
Information security management system	An organisational system that includes controls to manage information security risks and protect the confidentiality, integrity and availability of health information.
Informed consent	When a person voluntarily agrees to a healthcare treatment, procedure or other intervention with accurate and relevant information about the health care and alternative options available, and adequate knowledge and understanding of the benefits and risks of the proposed health care relevant to that person.
Integrated[3]	Coordinated and continuous care within and between all parts of the healthcare system and other care settings and throughout the person's healthcare journey.
Interoperable	The ability of a system or product to transfer information within and between systems or products without special effort on the part of the user.

Term	Definition
Intervention	Any action taken by a clinician to prevent, diagnose, treat, or manage a disease, injury, or health condition with the goal of improving or maintaining a person's health.
Interventional procedure	An invasive diagnostic or therapeutic procedure involving the use of instruments to directly act on the body.
Invasive medical devices	A device intended by the manufacturer to be used, in whole or in part, inside the body. This includes devices that enter a body orifice or that penetrate the surface of the body, or that enter the body in the context of a surgical operation.
Jurisdictional requirements	Encompasses legislation, regulations and policy instruments that govern what must be done within a jurisdiction in Australia. This includes (Commonwealth, state or territory jurisdictional requirements).
Leaders	The individuals who guide and influence teams within the health system to achieve high- quality care, irrespective of their formal role or title.
Medication reconciliation	A formal process of obtaining, verifying and documenting an accurate list of each patient's current medicines and matching the medicines the patient should be prescribed to those they are prescribed.
Medication review	A systematic assessment of a patient's medication management with the aim of optimising the quality use of medicines and minimising medicine related harm.
Medicine	Therapeutic goods that contain active ingredients intended to prevent, diagnose, cure, treat or alleviate symptoms of disease, injuries, and medical conditions or to change how the body works.
Medicines list	An up-to-date list of the medicines a person: a. is known to be taking and includes: i. prescription, non-prescription and complementary medicines ii. the medicine name, form, strength, intended use and directions for use b. should not be taking and includes: i. those causing allergies and adverse drug reactions the medicine name, the reaction type and the date the reaction was experienced.
Models of care	Frameworks guiding how multidisciplinary care teams' function to deliver healthcare in different settings and contexts.
Multidisciplinary care team	A group of clinicians from different disciplines who work together to plan, deliver and review a patient's care.

Term	Definition
My Health Record	The national secure consumer-controlled national electronic health record system that contains an online summary of an individual's key health information.
National clinical terminologies	Standardised collections of coded medical terms used across Australia's healthcare system to consistently record, communicate, and share clinical information in digital health systems.
National Digital Health Infrastructure	The nationally coordination digital systems, platforms, standards and services that support the secure exchange, use and management of health information across health services, providers and jurisdictions. Examples include: • My Health Record • Healthcare Identifier Service • Provider Connect Australia Health Connect Australia Provider Directory
Near miss[36]	An incident or potential incident that was averted and did not cause harm but had the potential to do so.
Open disclosure	An open discussion with a patient and their family or carers about an incident that resulted in harm to the patient while receiving health care. The criteria of open disclosure are an expression of regret, a factual explanation of what happened, the potential consequences and the steps taken to manage the event and prevent recurrence.
Organisational culture	A set of values, expectations, formal and informal practices and behaviours that define the unique organisational environment. 'The way things are done around here'.
Organisational systems	The resources, policies, processes, and procedures the health service organises, integrates, regulates, and delivers to accomplish a stated goal.
Orientation	The formal process of introducing a new employee to a health service and providing them with critical information and training that addresses workforce culture, organisational systems and expectations.
Patient safety culture	Focuses on the aspects of organisational culture that relate to patient safety. It is defined as a pattern of individual and organisational behaviour, based upon shared beliefs and values that continuously seeks to minimise patient harm, which may result from the process of care delivery.
Person-centred[3]	Respects the person receiving care, their family and carers, and responds to the person's preferences, needs and values

Term	Definition
Person-centred care[3,9, 37]	An approach to the planning, provision and evaluation of health care that is founded on partnership between clinicians, patients, families, carers and communities, where care is tailored to the needs of the person, based on their expressed beliefs, hopes and expectations. Person-centred care is respectful of, and responsive to, the preferences, needs and values of patients, families, carers and communities.
Person-centred practice[9,38]	A model for providing health care services that has its focus the provision of person-centred care. It is achieved through building effective collaborative relationships between clinicians who facilitate evidence-informed shared decision-making with patients and consumers. Person-centred practice is realised in organisational cultures that are psychologically safe, embrace inclusive governance and strive for cultures of continuous improvement and innovation.
Physical environment	External surroundings and conditions including both natural and man-made elements. In healthcare the physical environment can include air space, water supply and buildings.
Plan for care	A plan for care is a collaborative process in which a patient, their family and carers work with clinicians to identify the patient's care goals and plan services to achieve them. The plan for care involves shared decision making about interventions and other aspects of care and is informed by the patient's values, needs and preferences, a clinical assessment, best-practice guidance, and the setting and service being provided.
Point of care	The time and location at which health care is delivered to a patient by a clinician.
Point of Care Testing devices[39]	Medical devices used at or near the patient to provide rapid results that support immediate clinical decision-making.
Procedure (medical)	A specific, structured clinical activity performed by a clinician that involves a defined technique or method to diagnose, treat, prevent, or manage a health condition.
Procedure (policy framework)	A set of detailed instructions describing how to perform a process or specific task.
Psychosocial safety	The proactive creation of a work environment that minimises risks to psychological and physical wellbeing, where people feel safe to speak up with ideas, questions, concerns or mistakes without fear of punishment, humiliation or negative consequences.
Quality improvement	The combined efforts of the clinical and non-clinical workforce and consumers, patients, their family and carers, researchers, planners and educators to make changes that will lead to better health outcomes, better system performance and better professional development.

Term	Definition
Racism	The unfair treatment or denial of equal opportunities based on race, skin colour or origin, and includes not only individual behaviours and attitudes, but also as well as systemic barriers that limit people's ability to experience dignity and equality.
Regularly	Refers to actions undertaken consistently and repeatedly over time at recurring intervals as part of an ongoing process, with the frequency informed by best practice guidance, a risk-based approach, and the nature of the activity.
Restraint	Any action, intervention or practice that restricts an individual's rights or freedom of movement, including the use of physical, mechanical or chemical means, to prevent harm or enable care.
Reusable medical device	An item intended for use on more than one patient for diagnostic or treatment purposes, which is designated by the manufacturer as suitable for reprocessing between uses to ensure it is safe.
Risk assessment	The systematic process of identifying, analysing, and evaluating risks to determine which events may lead to issues in the future and minimising their likelihood and consequences.
Risk management	The systematic application of risk policies, processes and practices to direct the application of resources to minimise, monitor and control the likelihood or consequences of events.
Routine operating hours	The planned scheduled hours during which a health service provides its standard health care.
Safe[3]	Minimises risks of physical, psychological, psychosocial and cultural harms and factors that can contribute to actual or potential injury to the person receiving care.
Safety culture	The aspects of a health service's organisational culture that relate to health and safety management. It is defined as a product of individual and group values, attitudes, perceptions, competencies and patterns of behaviour that determine the commitment to, and the style and proficiency of an organisation's health and safety management.
Screening	The systematic assessment of the workforce to identify those who may have, or are at risk of, an infection, enabling early detection and the timely implementation of infection prevention and control measures.
Semi-critical medical device	A reusable item that comes into contact with mucous membranes or non-intact skin and is to be sterilised after each use. If sterilisation is not possible, high-level disinfection is to occur.

Term	Definition
Shared decision making (with Aboriginal and Torres Strait Islander peoples)	Processes mutually described as shared between government and Aboriginal and Torres Strait Islander peoples. Activities characterised as shared decision making must adhere to the definition of shared decision making in the National Agreement on Closing the Gap, namely: By consensus, where the voice of Aboriginal and Torres Strait Islander entities holds as much weight as the governments Transparent, where matters for decision are in terms that are easily understood by all entities and where there is enough information and time to understand the implications of the decision Where Aboriginal and Torres Strait Islander representatives can speak without fear of reprisals or repercussions Where a wide variety of groups of Aboriginal and Torres Strait Islander peoples, including women, young people, Elders and Aboriginal and Torres Strait Islander peoples with a disability can have their voice heard Where self-determination is supported, and Aboriginal and Torres Strait Islander lived experience is understood and respected Where relevant funding for programs and services align with jointly agreed community priorities, noting governments retain responsibility for funding decisions Where all entities have access to the same data and information, in an easily accessible format, on which any decisions are made.
Shared decision making (with the patient)	A collaborative process in which a patient and clinician work together to make health decisions, using the best available evidence and considering the patient's values, preferences, and circumstances, including discussion of the benefits and risks of available options.
Social determinants of health	Encompasses the non-medical factors and wider social, economic and political forces that shape daily living conditions and influence health outcomes. It includes the circumstances in which people are born, grow, live, work and age, the social norms and policies, their education, sex and gender, food, resources, housing and climate.
Standard	A standard is an agreed, best practice statement that defines the agreed attributes, processes and expected performance levels that is used to ensure a service or method is delivered consistently at the required level.
Standard precautions	The minimum standard work practices for infection prevention and control for the care and treatment of all patients.
Stewardship	The careful and responsible management of something entrusted to one's care.

Term	Definition
Substitute decision-maker	A person who is authorised to makes a health care or medical treatment decision for a person who has lost decision-making capacity.
Supervision	Structured oversight and guidance to support safe practice and reduce clinical risk.
Surveillance[40]	The ongoing, systematic collection, analysis, interpretation and dissemination of health-related data for the planning, implementation and evaluation of public health practice.
Sustainable[3]	Minimises environmental impact and reduces emissions while achieving the best possible outcomes for people
Team	A group of people who work together to achieve a common goal.
Timely	Coming early or at the right time; done or occurring at a favourable or useful time.
Trace	The ability to track and trace the history, location, and application of an item, person, or process throughout all stages of care.
Transition of care	When all or part of a person's health care is transferred between health professionals when a person moves between healthcare settings to receive care.
Transmission-based precautions[41]	The second tier of basic infection control and are used in addition to standard precautions for patients who may be infected or colonised with certain infectious agents for which additional precautions are needed to prevent infection transmission.
Unique Device Identifier[42]	A globally unique code assigned to a medical device that enables its identification and traceability throughout the supply chain and healthcare system. Only mentioned at 3.18 so may not need a definition if a reasonably common occurrence in health services
Unwarranted variation[43]	Variation in the utilisation of health services that cannot be explained by variation in patient illness or patient preferences.
Workforce	Refers to all peopled working in a health service, including employed or contracted, locum, agency, student, volunteer or peer workers. The health workforce is large and diverse and includes a wide range of professionals and operational staff who are all integral to providing high- quality care.
Workforce culture[44]	The shared values, behaviours, attitudes and ways of working that shape how people interact, support one another, make decisions and deliver care. It influences staff wellbeing, teamwork, learning and the delivery of safe, high-quality care.

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