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

Draft national safety and quality standards for virtual care

Initial draft FOR CONSULTATION

3 November 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 reporting on 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 is developing national safety and quality standards for virtual care (virtual care standards) to support Australian health services to manage risk, reduce preventable harm and continuously improve care delivered virtually.

Notes to Reviewers

The Commission has developed draft national safety and quality standards for virtual care to establish clear, consistent expectations to strengthen and ensure the quality of care delivered virtually.

Development of virtual care standards

Phased approach

The Commission acknowledges that virtual care is provided across the breadth of the health system by a wide variety of healthcare service types, understands that some healthcare services that provide virtual care are unfamiliar with safety and quality standards, and that the types of virtual care services available across Australia vary greatly.

To account for this breadth, the Commission is taking a phased approach to developing and implementing virtual care standards.

Phase 1 (this phase) focuses on the content of the draft virtual care standards.

Develop virtual care standards aimed at establishing a consolidated standards starting position based on the breadth of existing guidance and standards. The draft standards are aligned to the Commission's direction for safety and quality standards based on the draft third edition of the NSQHS Standards.

Phase 2 will focus on implementation. Building on the feedback received during Phase 1, the Commission will work with stakeholders to determine how the standards should be applied across different virtual care models and provider types, and to develop an implementation approach that supports consistent, practical and effective uptake of the standards across the health system.

Phase 1 – Virtual care standards development

The draft virtual care standards use the National Model for Clinical Governance as their foundation and are informed by the draft third edition of the National Safety and Quality Health Service (NSQHS) Standards currently under development, which are aimed at hospital and day procedure services.

In developing this document and acknowledging virtual care is delivered across the spectrum of healthcare services, the Commission has incorporated relevant components of the National Safety and Quality Primary and Community Healthcare Standards and the National Safety and Quality Digital Mental Health Standards to account for the broad range of healthcare services that provide health care virtually.

The Commission also acknowledges the significant work to develop safety and quality guidance in specific settings by other parties. The Commission has also reviewed, aligned and incorporated relevant components from guidance and standards developed by:

- State and Territory health departments
- Standards Australia
- Medical Colleges
- Industry groups such as the Australian Telehealth Standards Consortium and the Telehealth Sector Working Group.

As a result, the draft virtual care standards provide a single consolidated set of expected requirements for all healthcare services that provide care virtually. The Commission acknowledges that some requirements may not be applicable to individual healthcare services.

The virtual care standards provide the baseline safety and quality that should be expect when a clinician is not physically located with the patient.

Following public consultation on the draft requirements, the Commission expects to undertake targeted consultation with specific organisations and groups based on their feedback to understand and resolve issues raised.

Once the requirements have been finalised, the Commission will then determine the form the standards will take, considering the breadth of healthcare services and the types of virtual care that are provided. The final form of standards may be:

- a single document
- a virtual care module appended to core standards such as NSQHS Standards
- separate virtual care standards for the acute sector and standards for the primary and community sector

Feedback requested

The Commission is seeking feedback on whether the draft virtual care standards clearly articulate the key safety and quality requirements for virtual care, and whether they appropriately address the clinical risks, challenges and opportunities associated with delivering high-quality care virtually from healthcare professionals in all care settings.

Feedback is welcomed from business owners and managers of telehealth and virtual care services, health care professionals as well as consumers, carers, researchers and policymakers.

Feedback is specifically requested to determine whether the draft standards:

- capture the most important safety and quality issues
- need to be adjusted to meet the needs of patients receiving care from healthcare services of varying maturity and size – it's OK to say "this does not work for me".
- identify any gaps or areas requiring further refinement.

The Commission recognises there are large differences in the size, complexity and familiarity with national safety and quality standards in healthcare services that provide virtual care. To support healthcare services of all types, application of the requirements should be proportionate to the size, scope, complexity, clinical risk profile, service model and digital maturity of the individual healthcare service.

Relationship to draft third edition NSQHS Standards feedback

If you have previously provided feedback on the draft third edition NSQHS Standards, there is **no need to repeat that feedback**.

The Commission will review feedback received on the draft third edition NSQHS Standards in parallel with feedback on this document.

Deviations from the draft third edition NSQHS Standards have been highlighted in yellow (excl. deletions).

Feedback is requested via a survey.

Written submissions may also be sent to: ACSQHCdigitalhealth@safetyandquality.gov.au.

Introduction

The vision for the first edition of the National Safety and Quality Virtual Care Standards is to establish clear, consistent expectations for high-quality care delivered virtually, supporting nationally consistent and effective systems operating across the continuum of care.

The first draft virtual care standards recognise a major shift in how care is delivered, the realities of modern clinical practice in the Australian health system and supports healthcare services to adapt and evolve while ensuring care is consistently high-quality and improving over time.

Modern practice involves increasing demand, changing consumer behaviour in seeking health care, new models of care and an increase in the role and reach of digital technology. That is why the draft virtual care standards focus beyond the minimum safety requirements for health care delivered virtually so that healthcare services develop their systems and ensures a healthy workforce culture, culturally safe and responsive health care and continuous learning across the healthcare service to provide care that ensures optimal patient outcomes.

If implemented well, virtual care standards support healthcare services and clinicians 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 when care is delivered virtually, every day.

Purpose

The draft virtual care standards:

- respond to recognised and emerging system pressures, including workforce sustainability, increase in the reach of digital technologies, the importance of equity of health outcomes and continuing system integration to ensure high-quality care and equity of outcomes
- 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
- are tailored to the unique safety and quality risks when care is delivered virtually
- aim to build the culture of the whole organisation to support the consistent delivery of high-quality care
- establish the framework for any future accreditation scheme

Overview of the Standards

The draft virtual care standards are informed by the draft third edition of the NSQHS Standards to provide a consistent approach to safety and quality for healthcare services that provide both in-person care and care delivered virtually.

The virtual care standards comprise three discrete standards that are designed to work together as a single, integrated system driving safety and quality.

Compliance with the standards requires consistent, healthcare service-wide application, recognising that **everyone has a role to play in delivering high-quality virtual care**.

Clinical Governance Standard

This Standard outlines the responsibilities of the board, directors, executive and managers for ensuring that the healthcare 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 healthcare service to deliver care that is consistently high-quality and improving.

Effective clinical governance means that boards, directors, executives, managers 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].

Roles in clinical governance

Governance models differ across Australia. Some public and private healthcare services do not have boards. Where a healthcare service does not have a board and executive, these roles fall to the key decision-maker and accountable person or group at the healthcare service.

- Boards and Directors set the strategic direction for the healthcare service and ensure processes and systems are in place to meet the healthcare service's objectives and for clinical governance. This role may also be performed by business owners.
- Executives define and oversee the required processes and systems.
- Managers operate and execute the required processes and systems.

Person-Centred Practice Standard

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

Person-centred practice is a model for providing healthcare 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 healthcare 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 between clinicians, 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 healthcare 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 requirements specific to virtual care, including infection prevention and control, medication safety, 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 healthcare service'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 healthcare service to meet patient needs and provide high-quality care.

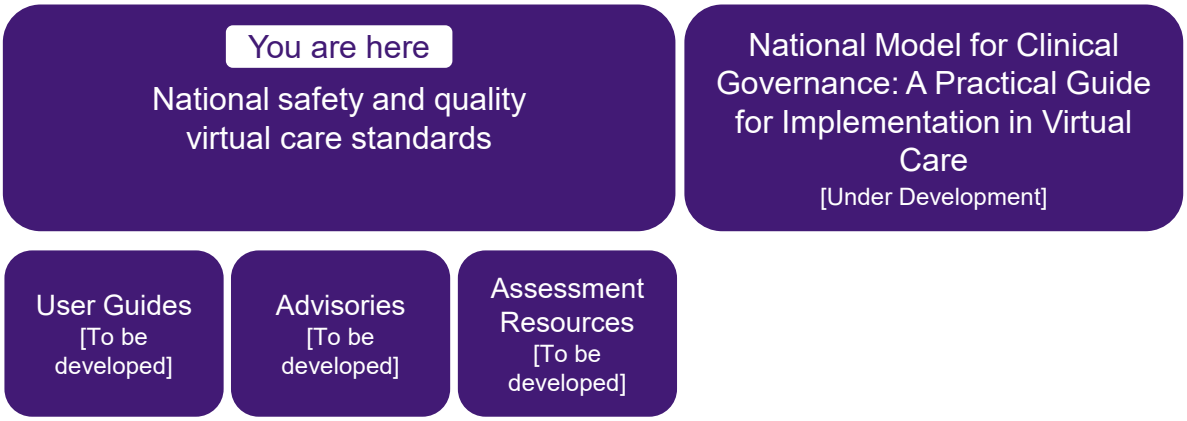
Consistent, healthcare service-wide application of the virtual care standards recognise that **everyone has a role to play in delivering high-quality virtual care.**

Structure of the virtual care standards

Document map

The draft virtual care standards provide the overarching requirements for the delivery of high-quality virtual care. The standards are supported by a range of companion and implementation resources to assist healthcare organisations to adopt the standards.

Figure 1: Document map

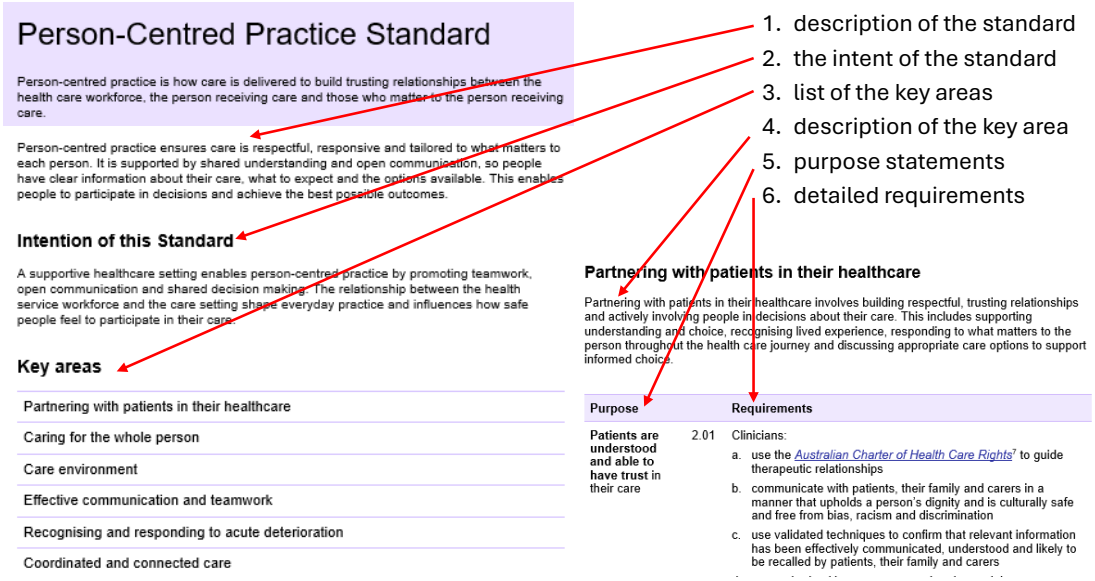


Standards structure

Each of the standards contains:

1. a description of the standard
2. the intent of the standard
3. a list of the key areas covered by the standard
4. a description of the key area
5. purpose statements which describe key elements of the standard
6. detailed requirements setting out what should be implemented to help achieve the stated purpose.

Figure 2: Standards structure



Application of the virtual care standards

The virtual care standards are applicable to services that deliver health care through virtual modalities such as:

- direct to consumer models including for a single condition
- online prescription requests
- primary and community care consultations via telephone and videoconferencing
- remote patient monitoring provided by hospitals
- outpatient appointments via telephone and videoconferencing
- virtual emergency department
- remote patient assessment such as those used by the Royal Flying Doctors Service
- paramedical services provided virtually.

Core elements underpinning the Standards

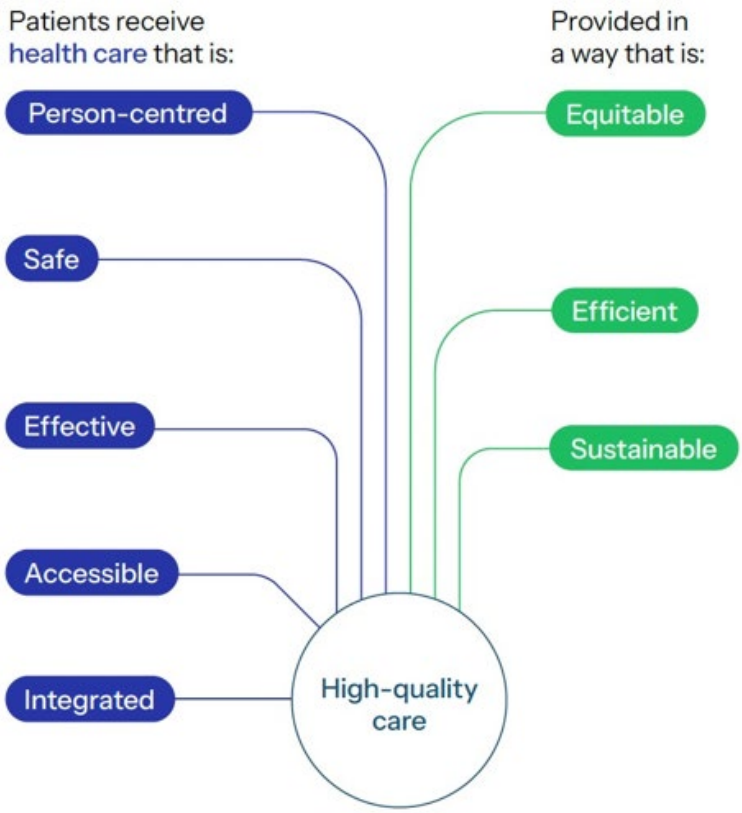
High-quality care

High-quality care, be that in-person, delivered virtually or a combination of both, 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 3**. 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 3: Domains of quality



Cultural safety

Cultural safety is:

- determined by Aboriginal and Torres Strait Islander individuals, families and communities.
- the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.
- requires organisational change through critically analysing and addressing racism, biases, assumptions, stereotypes and prejudices expressed through the organisations structures, values, policies and procedures that create barriers to provide good health care and good health outcomes.

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 virtual care standards focus on embedding cultural safety in health care and addressing racism at multiple levels.

In the virtual care 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 virtual care standards 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 healthcare services provide care that is culturally safe, as determined by Aboriginal and Torres Strait Islander peoples and communities.

The virtual care standards seek to embed cultural safety into everyday systems and processes within healthcare 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 virtual care 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 virtual care standards, to help shape the requirements for the next draft of these standards.

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 to receive high-quality health care
- tackling disparities between healthcare 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 virtual care standards are applied consistently by your healthcare 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.

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

It is a model for providing healthcare 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]

Where the virtual care 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. Healthcare 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.

Clinical Governance Standard

Clinical Governance Standard

High-quality care means that patients have access to care that is person-centred, safe, effective, accessible and integrated, in a way that is equitable, efficient and sustainable. To do this, health care must be free from bias, racism and discrimination.

Intention of this Standard

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

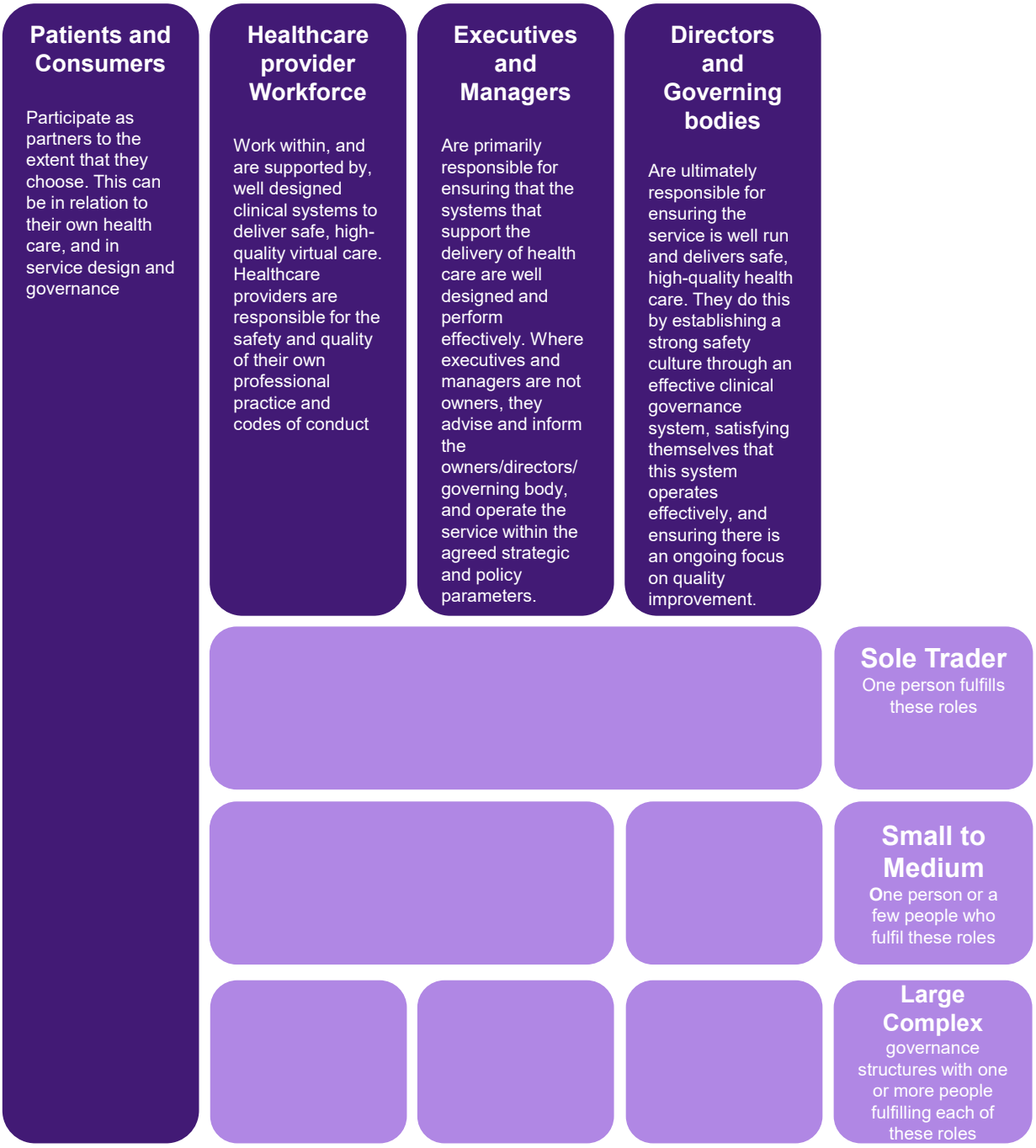
Everyone in a healthcare service contributes to leadership, working together to achieve results that could not be achieved working alone

Clinical governance roles and responsibilities

The types of healthcare services that deliver care virtually are many and varied extending, across the public and private sectors, from large acute care services, to smaller community based services, to short interaction virtual care services with national reach. Application of the clinical governance standards requires the most senior decision makers of the healthcare service to take responsibility for setting the culture and systems to enable the delivery of high quality virtual care.

Figure 4 below provides a framework to support healthcare services of different sizes to understand clinical governance roles and responsibilities.

Figure 4: Clinical governance roles and responsibilities



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, directors, executive and managers are accountable for the organisation's strategy and culture. They establish, maintain and continually improve organisational systems to achieve high-quality virtual care with better patient outcomes and experiences and an engaged, empowered workforce.

Purpose		Requirements
The board and directors are accountable for **high-quality care**	1.01	The board or director(s) govern 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 and directors are accountable for **organisation-wide culture, systems and structures**	1.02	The board or director(s) governs organisational systems to: a. build partnerships with consumers 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, directors, executive and managers are accountable for creating a **healthy workforce culture**	1.03	The board, director(s), executive and managers 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 discrimination and racism, ensuring concerns and reports of risks, incidents, adverse events and complaints are investigated and required action is taken

The board, directors, executive and managers are accountable for **digitally enabled care**	1.04	The board, director(s), executive and managers 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 jurisdictional requirements, including requirements for clinicians operating remotely c. detect, respond to and report on information security risks and incidents, including the use of unauthorised digital tools d. integrate digital tools and technologies downtime and cybersecurity planning and preparedness into governance systems including where virtual care services use consumer and remote patient monitoring devices 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, directors, executive and managers are accountable for **working with Aboriginal and Torres Strait Islander leaders to deliver cultural governance and systemic reform**	1.05	The board, director(s), executive and managers work with[5] Aboriginal and Torres Strait Islander leaders to establish accountability for: a. embedding a robust cultural governance framework 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 b. undertaking system and business model reform to mitigate practices that limit Aboriginal and Torres Strait Islander peoples' empowerment, to share decision making and co-design to achieve high quality care c. implementing evaluation mechanisms, in partnership with Aboriginal and Torres Strait Islander peoples, that demonstrate monitoring, evaluation and system improvement
The board, directors, executive and managers are accountable for the **environmental sustainability** of health care	1.06	The board, director(s), executive and managers establish and maintain systems to adapt clinical practices to reduce their environmental impacts.

The board, directors, executive and managers are accountable for **minimising unwarranted variation and low-value care**	1.07	The board, director(s), executive and managers 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 care d. investigate reported instances of unwarranted clinical variation

Partnering with consumers

Boards, directors and executives lead systems that build a culture of person-centred care that empowers consumers as partners in governance at every level of the healthcare service. Organisational clinical governance structures and systems systematically engage consumers in planning, design, review and measurement to improve virtual 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 healthcare 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	1.08	The board, director(s), executive and managers 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. support 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 healthcare service with the community and use this information to improve care
Patient rights underpin how health care is provided	1.09	The board, director(s), executive and managers 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 care c. provide equitable access to health care for people with a disability and identify and action the need for reasonable adjustments d. measure patient experiences of how their healthcare rights are respected by the workforce and act to improve care

Purpose		Requirements
		e. embed open disclosure, consistent with the *Australian Open Disclosure Framework*[11], at all levels of the healthcare service f. monitor and improve the use and effectiveness of open disclosure
Partnerships with Aboriginal and Torres Strait Islander peoples and communities shape health care	1.9	The board, director(s), executive and managers have organisational systems to: a. build respectful and reciprocal partnerships with Aboriginal and Torres Strait Islander peoples, organisations and community-controlled healthcare organisations b. encourage involvement of Aboriginal and Torres Strait Islander peoples and community members in the co-designing of services, delivering and evaluating care
Health care is improved through **patient and consumer feedback**	1.10	The board, director(s), executive and managers have organisational systems for healthcare delivery 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 healthcare service 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
There is a culture where the **workforce is supported, engaged and empowered** to provide high-quality care	1.11	The executive and managers 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 virtual high-quality care e. provide regular training programs that enable the workforce to meet privacy, consent and occupational health and safety regulations f. respond to risks to patient care arising from workforce gaps or pressures g. 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	1.12	The executive and managers have organisational systems in place to: a. educate the workforce about the healthcare 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. support clinicians to meet relevant National Boards' professional obligations including when prescribing and providing care through digital and virtual care, and emerging models of care

Purpose		Requirements
		d. enable the workforce to escalate concerns about deterioration in a patient's condition e. review and discuss performance with the workforce routinely and when there are concerns about performance or behaviour and act to improve performance f. provide practical support and training to the workforce to select and integrate digital tools and technologies into their practice and evaluate their effects
Clinicians and teams are supported to be high-functioning	1.13	The executive and managers 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 clinicians and 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 clinician and team performance and continuous improvement activities
The healthcare service is **culturally safe for the Aboriginal and Torres Strait Islander workforce**	1.14	The executive and managers have organisational systems in place to: a. enable the Aboriginal and Torres Strait Islander workforce to actively lead and meaningfully contribute to leadership decision making at all levels of the healthcare service 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 healthcare service's clinical governance systems. The healthcare service 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	1.15	The executive and managers 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 delivering the virtual care services and the appropriate use of digital tools. c. provide clinicians with access to escalation pathways for senior clinician support and after-hours advice d. align the skills, capability and experience of clinicians with patients' care requirements e. conduct regular performance reviews and monitor and manage clinicians' professional performance and fulfilment of professional development requirements f. 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 g. ensure treatment decisions, including prescribing, align with best practice and are free from commercial influence
Clinicians actively contribute to clinical governance activities	1.16	The executive and managers have organisational systems to: a. involve clinicians from across the healthcare service, and where in place, different clinical groups in clinical governance roles b. report to the governing body on clinical perspectives of care quality c. support clinicians to implement and evaluate new clinical practice innovations, including those supported by digital tools and technologies
Clinicians are supported to undertake **quality improvement activities**	1.17	The executive and managers have organisational systems to: a. assist clinicians to conduct quality improvement activities b. engage clinicians in quality improvement activities c. consider evidence of engagement in quality improvement activities as part of credentialing and recredentialing requirements
Systems for **credentialling**	1.18	The executive and managers have fair and transparent systems for credentialing and defining scope of practice to:

Purpose		Requirements
and defining scope of practice protect patient safety		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 the service-specific scope of practice c. review credentials and service-specific scope of practice regularly, when new models of care, 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 service-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	1.19	The executive and managers have organisational systems to: a. provide clinicians with access to Clinical Care Standards, evidence-informed guidelines, care pathways and decision support tools b. determine patient suitability to a virtual care service, using evidence informed patient inclusion and exclusion criteria, including confirming patients have an appropriately safe and quiet location. c. support clinicians to use the evidence-informed tools to provide high-quality care and in shared decision making with patients d. provide clinicians with timely, tailored information about the quality and outcomes of care they provide e. support clinicians to participate in clinical and peer review and quality improvement activities
Clinical Care Standards are effectively used for quality improvement	1.20	The executive and managers 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 healthcare service clinical risks, unwarranted variation, or other data insights indicating a need for quality improvement, or are required for implementation by a relevant authority c. collect, monitor and act on indicator data for relevant Clinical Care Standards
Health care is coordinated and connected across the healthcare service and with other providers and settings	1.21	The executive and managers have organisational systems to: a. collaborate with consumers and clinicians to design and improve integrated models of care within the healthcare service and across the continuum of care, including with care providers in other settings

Purpose	Requirements
	b. coordinate patient care across providers and settings, including sharing information at transitions of care and when a single instance of care is provided

Managing and reducing risk

The healthcare service 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 healthcare service.

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 **healthcare service**	1.22	The board, executive and managers 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 and business 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. support patients to self-report adverse events, deterioration and incidents to the healthcare service that provided the care or their usual health care provider(s) e. use governance structures to enable effective and transparent communication and reporting on risk and risk management across the healthcare service f. regularly assess the effectiveness of risk identification and management including review of priority areas of risk g. provide workforce education and training programs that identify, assess and manage risks h. use information from the risk management system to improve patient care, workflows, service design and policy i. direct patients to alternative care pathways as needed including where the provision of a virtual care service has been declined j. define parameters that identify when a patient's condition requires escalation tailored to the service being provided and the individual patient's risk profile
Effective risk management supports high-quality care	1.23	The board, directors, executive and managers have organisational systems to: a. identify and manage high-risk activities and common causes of harm b. recognise, monitor and report bias, discrimination and racism as a clinical and organisational risk and act to improve anti-racist practices and cultural safety.

Purpose		Requirements
The **incident management system** draws together findings from across the **healthcare service** to develop effective responses	1.24	The executive and managers 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, to governance or the director, including those related to digitally enabled care and the use of digital tools and technologies and to the TGA where the device is regulated 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**	1.25	The executive and managers 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. effectively communicate service changes or interruptions to consumers when the virtual care modality becomes unavailable c. 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, directors, executive, managers and clinicians have the information to determine whether they are providing high-quality virtual 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 virtual care.

Purpose		Requirements
Data governance supports a learning organisation to use data appropriately	1.26	The board, directors, executive and managers 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
The right data are collected and used to assess and improve healthcare quality	1.27	The board, directors, executive and managers 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. encourage consumer involvement 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. assess the extent to which the healthcare service is delivering all dimensions of quality health care f. support clinicians to review and improve their performance, models of care and patient outcomes g. identify and manage key risks and inform organisational decision-making h. continuously assess, monitor and improve data quality
Digital systems are optimised to improve continuity of	1.28	The executive and managers have organisational digital data systems that: a. use national clinical terminologies and specifications

Purpose		Requirements
care and integration		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, informed decision-making and quality assurance activities
Data are analysed, monitored and reported to improve health care	1.29	The healthcare service: a. uses reports from its administrative, clinical and performance data to identify priorities for quality improvement b. acts on, reviews and monitors identified priorities for quality improvement c. measures changes in safety and quality indicators and outcomes d. provides timely information on safety and quality improvement and performance to the governing body, the workforce and patients

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 healthcare 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

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 or treatment options and their potential benefits, risks and consequences for them	2.02	Clinicians: a. are trained by the healthcare 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 is appropriate, responsive and aligned with the person's needs and preferences.

Purpose		Requirements
Clinical assessment and evidence informed decision-making underpin the planning and coordination of care across the health-care team	2.04	The treating clinician or 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 including assessing inclusion and exclusion criteria for the specific virtual care service ii. inform clinical reasoning and diagnosis iii. identify and agree on 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 f. assesses the patient's ability to physically and cognitively participate in a virtual care service, including carers and advocates involved in the care g. assesses the patient's access to technical infrastructure e.g. internet connectivity and mobile devices, when considering use of virtual care service

Purpose		Requirements
		h. provide information to patients and their family on accessing alternate services where the scope of the service does not meet or is not appropriate for them
The **plan for care** is developed, documented, reviewed and used to guide and coordinate ongoing care	2.05	The treating clinician or 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 iii. critical information, medication and allergy alerts and risks iv. time frames and the actions required by clinicians, the patient, their family and carers v. plans for transferring care to another health care provider 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 e. supports health education and promotion, illness prevention and early intervention for patients, considering its patient population f. recalls patients for follow-up health care when appointments are missed or new information leads to a change in care or treatment
Care is delivered safely	2.06	The treating clinician or multidisciplinary care team: a. uses evidence-informed interventions to identify and mitigate patient risks at the start of the episode of care and whenever the patient's condition changes b. uses patient cohort and/or condition 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 to support informed decision-making
Advance care planning is considered	2.07	The treating clinician or multidisciplinary care team use the healthcare service's policy and processes to initiate, consider or escalate and provide advance care planning when:

Purpose		Requirements
when appropriate		a. clinically appropriate b. requested by a patient c. a patient has repeated unplanned episodes of care 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 episode of care or when a patient's condition changes or deteriorates

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.

Virtual environments bring unique considerations where the written or spoken communications can be mis-understood with the loss of visual cues.

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. provide culturally safe care and environments for Aboriginal and Torres Strait Islander peoples 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 healthcare 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 specialties, 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. supports workforce safety and wellbeing, including managing risks to staff when responding to behaviours of concern e. reviews and learns from behaviours of concern and related incidents, using data insights, feedback and analysis to identify contributing factors and implement improvements to reduce recurrence

Purpose		Requirements
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 healthcare 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 health 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
Clinicians and multidisciplinary care teams support coordinated and high-quality care	2.14	The treating clinicians and/or 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 healthcare 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 and associated risks to the patient, carers and family in accordance with their preferences 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 treating clinicians and/or multidisciplinary care team: a. is trained in recognising the early signs of physical and cognitive deterioration, in line with healthcare service policies and procedures b. implements physiological monitoring that is tailored to the care setting and adapted to the patient's condition, including where remote patient monitoring is being used 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 sudden deterioration and/or provide information to patients on accessing alternate services where the patient's needs are beyond the scope of the service 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 treating clinicians and/or multidisciplinary care team: a. recognises, assesses and manages sudden 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 or present a risk to harming others (including crisis intervention), 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

Coordinated and connected care

Coordinated and connected care relies on clear communication of all relevant information during the transfer of responsibility between care providers. Safe transitions of care are supported by promoting a shared understanding of each patient's needs when moving between care settings or healthcare services. 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 and medication lists, between patients, their family and carers, clinicians, teams and healthcare services c. clearly define roles, responsibilities and points of contact for ongoing care, including explicit identification of who is accountable at the conclusion of the episode of care or transfer to another service, and where care is shared across clinicians, teams, healthcare services d. monitor and review risks and outcomes associated with care coordination and transitions of care, including recent episodes of care, emergency department presentations or hospital admission and use this information to facilitate continuous improvement
Risks associated with **transitions across services and care settings** are reduced	2.20	The healthcare service identifies and manages risks associated with transitions of care across services, settings and levels of clinical support, including: a. where there may be a mismatch between the patient's care needs and the level of clinical support, capability or resources available b. outside of routine operating hours and where access to clinical support or resources may be reduced c. where the patient is receiving care from multiple teams or services
Information exchanged at transitions of care is accurate, complete, timely and useful	2.21	The treating clinician and the multidisciplinary care team ensure that information exchanged at transitions of care at the end of the episode of care: 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 and harm mitigation across services and settings by providing relevant care and treatment information such as episode of care summaries, medication lists, changes to medications, referrals and/or care plans

	c. provides patients, their family and carers with clear information about what to expect following the episode of care, 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 to the patient's regular care provider using digital systems and processes, including National Digital Health Infrastructure when available

Safe Clinical Systems Standard

Safe Clinical Systems Standard

Healthcare 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 healthcare service, prevent avoidable harm and support the sustainable delivery of high-quality care.

Key areas

The virtual care service
Safe environments
Patient identification
Health care record systems
Infection prevention and control
Medicines safety and quality
Medical devices and patient monitoring

Note: In Australia, healthcare services vary considerably in size, organisational structure and the scope and complexity of care they provide. Healthcare 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.

Healthcare 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.

The virtual care service (new section)

The virtual care service(s) provided by the healthcare service is designed and managed to support clinicians in delivering high-quality virtual care and minimising patient harm

Purpose		Requirement
The virtual service(s) is designed for high-quality	3.01	The healthcare service: a. assesses the needs of the population it aims to service b. documents the purpose and intent of the service(s) and how it will operate c. documents the model(s) of care for each virtual care service offered d. identifies and provides the clinical and non-clinical workforce required to deliver the service e. identifies and provides the physical and technical resources required to deliver the service f. identifies and establishes a training program(s) for the workforce to cater for the unique aspects of virtual care accounting for: i. patient assessment where physical contact is not possible ii. the tools used to deliver the virtual care service including software platforms and monitoring devices (if used) iii. follow-up and escalation pathways for patient deterioration and emergencies assessing patient suitability for the virtual care service(s) iv. monitors and evaluates the delivery and performance of the service through the health care service's clinical governance framework v. documents the processes clinicians must use to provide input to monitoring and evaluation of the virtual care service(s)
Patients understand the scope and purpose of the virtual care service(s)	3.02	The healthcare service provides patients with access to information about the virtual care service(s) including: a. the purpose, intent, limitations and exclusions of virtual care services offered b. the terms of service including service costs to ensure the providers and consumers' obligations are clear c. privacy policy d. the patient characteristics suitable for the services offered and who can register for the services, including exclusion criteria

e. the service operating hours, how the service is provided and how to access the services including the technologies required from the patient

f. the information required for registration or requesting the service such as a referral

g. languages in which the service is provided

h. non-service costs such as estimated data usage

i. alternative health care options in an emergency when the virtual care service is closed

j. supporting patients with using technology required to access and use the virtual care service

k. providing virtual care service information in a range of languages aligned to their service's population

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	3.03	The healthcare service maximises the provision of high-quality virtual care: a. through designing the environment in consultation with patients, consumers, communities, clinicians and relevant experts b. by testing and maintaining buildings, 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 encouraging Aboriginal and Torres Strait Islander peoples and communities' participation in co-design, implementing and evaluating welcoming and culturally safe environments d. by providing a calm and quiet environment, free from background noise, for clinicians to provide care virtually e. by advising patients to be located in an appropriately private and quiet environment, free from background noise, for virtual care modalities f. by training clinicians in identifying and managing the risks of coercive control by unseen third parties during the delivery of virtual care

Patient identification

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

Purpose		Requirements
Robust **patient identification processes** ensure the right patient receives the intended care	3.04	The healthcare service ensures unambiguous, safe and traceable patient identification and intervention 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 at the start of the episode of care, on any shared information and at transfer of care ii. in health care records, care transfer documents and reports iii. before commencing any care, medication administration supervision, conducting interventions, transiting care, or providing patient advice or education c. taking prompt corrective action when a patient identification and matching discrepancy is identified d. checking the patient's photo ID where it is available when video-conferencing is being used
Aboriginal and Torres Strait Islander patients are respectfully identified and connected to culturally appropriate care	3.05	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 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	3.06	The healthcare 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, where used 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	3.07	The healthcare service: a. identifies and manages 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. has outbreak detection processes, response systems and governance mechanisms, including meeting jurisdictional reporting requirements
Infections are prevented through **evidence-informed use of medical device**	3.08	The healthcare service demonstrates processes for the use and management of 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
Workforce infection transmission is prevented and managed	3.09	The healthcare 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, and shared equipment such as keyboards, headsets and microphones b. 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	3.010	The healthcare service: a. identifies, evaluates and addresses infection risks associated with new and existing equipment, medical devices, products and the physical environment

Purpose	Requirements
	b. cleans, maintains, repairs and upgrades buildings, 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	3.11	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 using multiple sources c. review and update the reconciled medicines in the patient's health care record d. communicate medication plans and medicine changes to the patient, their family and carers, all relevant clinicians, including their usual primary care teams
Harm is minimised through effective documentation, assessment, management and reporting of **adverse medicine events**	3.12	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 an incident management system and the TGA
Medicines are optimised through ongoing reviews across the care continuum	3.13	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	3.14	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 transfer of care or at the end of the episode of care, 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	3.15	The workforce adheres to the manufacturers' directions of use, legislative and jurisdictional requirements and best 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
Safe and consistent use of medicines, including antimicrobials, is supported through **effective stewardship**	3.16	The workforce demonstrates quality use of medicines practices that: a. identify medicines that pose a high risk to patients b. align with evidence-informed practice guidance c. apply surveillance methods to measure high-risk medicines use and reports the results to the workforce, board, director, executive, managers d. analyse and act on the results of the high-risk medicines use to demonstrate and promote quality improvement
Patients are prescribed medications safely	3.17	The healthcare service has processes and guidelines to: a. support clinicians in obtaining an accurate history and assessment of patients when prescribing b. provide alternate pathways to patients when virtual services cannot adequately assess a request for medicine(s).

Medical devices and patient monitoring

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	3.18	The healthcare 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 healthcare 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	3.19	The healthcare 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. medical devices that are not listed on the Australian Register of Therapeutic Goods (ARTG) 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. medical devices that are not listed on the ARTG 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
Medical device incidents are reported	3.20	The healthcare service reports near missed and adverse events for: a. approved medical devices into the incident management system, to the manufacturer and the TGA b. medical devices that are not listed on the ARTG in accordance with regulation, into the incident management system and to relevant agencies

Purpose		Requirements
Remote Patient Monitoring (RPM) is used safely and appropriately resourced	3.21	Healthcare services use RPM safely by: a. Defining the type of monitoring to be provided and fit with the target patient population and the level of symptom severity and co-morbidities the service can support b. Determining the clinician and non-clinical resources and resource mix required to provide safe monitoring including hours of operation and staff-to-patient ratios c. Determining the technical resources required to support the service d. Identifying external healthcare services that can support the patient if they require care outside the virtual modality offered e. Developing patient assessment tools to determine the appropriateness of the RPM service for individual patients f. Designing RPM device delivery and pick-up systems including tracking notifications for the patient g. Identifying any costs to the patient including data transmission (internet), device hire, consumables required for the device delivery or pick up. h. Aligning RPM service disruption planning with the healthcare services emergency preparedness and response frameworks
Clinicians and patients are supported in obtaining accurate information from Remote Patient Monitoring	3.22	Healthcare services have processes and systems to support clinicians in: a. discussing RPM and alternative monitoring options with the patient b. confirming the patient's willingness and consent to engage with and learn how to use RPM. c. assessing the patient's cognitive and physical ability to use the proposed RPM device and read its outputs (where appropriate) d. training patients on the use of the RPM device including infection control and device cleaning considerations e. providing instructions for the use and care of the device to patients in line with the manufacturer's instructions f. providing guides to patients to assist in determining if the RPM system or device(s) are not operating and the steps to take to manage their health and reporting channels g. confirming any planned RPM solution downtime with patients including downtime monitoring, contact and escalation procedures

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[15]	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[16]	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[17]	An immune response, in which a person's immune system reacts to foreign substances (allergens) that are harmless to most people.
Antimicrobials[18]	Medicines that kill or slow the growth of microorganisms (bacteria, fungi, parasites and viruses) that cause disease.
Antimicrobial resistance[17]	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[19]	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[20]	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.
Board	The individual or group with ultimate responsibility for the governance, direction, oversight, performance, and compliance of a healthcare service. This may include a chief executive officer, healthcare service owner, partnership, board of directors, or other highest-level governing body responsible for strategic and operational decision-making and for monitoring the healthcare service's business, affairs, and operations. The individuals or group whose responsibilities include governing, directing and monitoring a healthcare 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.
Carer[21]	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[22]	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.

Term	Definition
Clinical Care Standards	Are quality statements in line with current best evidence that describe the care patients should be offered by health professionals and healthcare services for a specific clinical condition or defined clinical pathway.
Clinical governance[2]	The combination of organisational culture, systems and structures that enables everyone in a healthcare 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[23]	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 healthcare service.
Clinical leader[24]	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 review[25]	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[26]	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[27]	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.

Term	Definition
Co-design[28]	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
Community[29]	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 healthcare service users, and takes part in decision-making processes.
Continuum of care	A person-centred, longitudinal conceptual framework that organises all healthcare 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 through ongoing relationships and seamless coordination across providers, teams, and care settings.

Term	Definition
Credentialing[30]	The formal process used by a healthcare service to verify the qualifications, experience, professional standing, behaviours, competencies and other relevant professional attributes of clinicians, so that the healthcare service 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[30]	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.
Cultural safety	It is determined by individuals, families and communities. In healthcare 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 healthcare 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.

Term	Definition
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	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.
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 healthcare 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.
Director[31]	A person responsible for overseeing the affairs of a company, who must comply with their legal obligations as a director under the Corporations Act 2001.

Term	Definition
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 healthcare service for a specific health problem through to the completion of treatment or final interaction for that specific health problem.
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 healthcare service and ensuring the delivery of high-quality care.

Term	Definition
Facility-specific scope of practice	The extent of a clinician's approved clinical practice within a particular facility or healthcare service 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.

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 decisions, 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 healthcare 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 healthcare 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.

Term	Definition
Healthcare Identifier	A unique number assigned to individuals, healthcare providers and healthcare 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
Health literacy	The personal knowledge and competencies that accumulate through daily activities, social interactions and across generations that enable people to access, understand, appraise and use information and services in ways that promote and maintain health and well-being.
Healthcare 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[16]	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.

Term	Definition
Integrated	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.
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.

Term	Definition
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.
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 coordinated digital systems, platforms, standards and services that support the secure exchange, use and management of health information across healthcare services, providers and jurisdictions. Examples include: • My Health Record • Healthcare Identifier Service • Provider Connect Australia Health Connect Australia Provider Directory
Near miss[32]	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 healthcare service organises, integrates, regulates, and delivers to accomplish a stated goal.
Orientation	The formal process of introducing a new employee to a healthcare 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.

Term	Definition
Person-centred[3]	Respects the person receiving care, their family and carers, and responds to the person's preferences, needs and values
Person-centred care[3, 9, 33]	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, 34]	A model for providing health care services that has its 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 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[35]	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.

Term	Definition
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.
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.
Remote Patient Monitoring[36]	A way of delivering care that uses digital health technologies for the remote collection, transmission and analysis of consumers' health data.
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 healthcare 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 healthcare 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.

Term	Definition
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.
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.

Term	Definition
Stewardship	The careful and responsible management of something entrusted to one's care.
Substitute decision-maker	A person who is authorised to make 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[37]	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[38]	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[39]	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 healthcare services
Unwarranted variation[40]	Variation in the utilisation of healthcare services that cannot be explained by variation in patient illness or patient preferences.
Virtual Care	Any interaction between a patient and clinician(s), occurring remotely with the use of information technologies.
Workforce	Refers to all people working in a healthcare 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.

Term	Definition
Workforce culture[41]	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.

References

[1] Australian Commission on Safety and Quality in Health Care. Strategic plan 2025–30. Sydney: ACSQHC; 2025. https://www.safetyandquality.gov.au/resources/strategic-plan-2025-30 (accessed July 2026)

[2] Australian Commission on Safety and Quality in Health Care. National Model for Clinical Governance. The foundations of high-quality care. Sydney: ACSQHC; 2026. https://www.safetyandquality.gov.au/clinical-topics/clinical-governance/2026-national-model (accessed June 2026)

[3] Australian Commission on Safety and Quality in Health Care. *Definition of high-quality care* [Internet]. Sydney (NSW): ACSQHC; 2026 [cited 2026 Jul 8]. Available from: https://www.safetyandquality.gov.au/about-us/definition-high-quality-care

[4] Australian Health Practitioner Regulation Agency. Aboriginal and Torres Strait Islander Health Strategy. Melbourne: Ahpra; 2020. https://www.ahpra.gov.au/About-Ahpra/Aboriginal-and-Torres-Strait-Islander-Health-Strategy.aspx (accessed May 2026)

[5] Coalition of Aboriginal and Torres Strait Islander Peak Organisations, Commonwealth of Australia, State and Territory Governments, Australian Local Government Association. *National Agreement on Closing the Gap* [Internet]. Canberra (ACT): Commonwealth of Australia; 2020 [cited 2026 Jul 8]. Available from: https://www.closingthegap.gov.au/national-agreement

[6] Australian Government, State and Territory Governments. *Addendum to the National Health Reform Agreement 2026–2031* [Internet]. Canberra (ACT): Council on Federal Financial Relations; 2026 [cited 2026 Jul 8]. https://federalfinancialrelations.gov.au/agreements/national-health-reform-agreement

[7] Australian Commission on Safety and Quality in Health Care. NSQHS Standards user guide for health service organisations providing care for patients from migrant and refugee backgrounds. Sydney: ACSQHC; 2021. https://www.safetyandquality.gov.au/resources/nsqhs-standards-user-guide-health-service-organisations-providing-care-patients-migrant-and-refugee-backgrounds (accessed May 2026)

[8] Te Tāhū Hauora Health Quality & Safety Commission. Learning and education modules on understanding bias in health care. [Internet] Wellington, New Zealand: Te Tāhū Hauora; 2022. https://www.hqsc.govt.nz/resources/resource-library/learning-and-education-modules-on-understanding-bias-in-health-care/ (accessed May 2026)

[9] McCormack, B., & McCance, T. (2017). Person-centred Practice in Nursing and Health Care

[10] Australian Commission on Safety and Quality in Health Care. Australian Charter of Healthcare Rights. Sydney: ACSQHC; 2019. https://www.safetyandquality.gov.au/your-rights/understanding-your-healthcare-rights (accessed May 2026)

[11] Australian Commission on Safety and Quality in Health Care. Australian open disclosure framework. Sydney: ACSQHC; 2026. https://www.safetyandquality.gov.au/clinical-topics/open-disclosure (accessed July 2026)

[12] Australian Commission on Safety and Quality in Health Care. National consensus statement: Essential elements for safe and high-quality end-of-life care. Sydney: ACSQHC; 2023. https://www.safetyandquality.gov.au/resources/national-consensus-statement-essential-elements-safe-and-high-quality-end-life-care (accessed May 2026)

[13] National Health and Medical Research Council and Australian Commission on Safety and Quality in Health Care. Australian guidelines for the prevention and control of infection in healthcare. Canberra: NHMRC; 2019. https://www.safetyandquality.gov.au/resources/australian-guidelines-prevention-and-control-infection-healthcare (accessed May 2026)

[14] Safe Work Australia. Model code of practice: Managing the risks of biological hazards at work. Canberra: Safe Work Australia; 2026. https://www.safeworkaustralia.gov.au/doc/model-code-practice-managing-risks-biological-hazards-work (accessed May 2026)

[15] Department of Health, Western Australia. Advance care planning. [Internet]. Perth: WA Government; 2026. https://www.health.wa.gov.au/Articles/A_E/Advance-Care-Planning (accessed May 2026)

[16] Human Factors and Ergonomics Society of Australia, Australian Institute of Health Innovation, Macquarie University, The University of Sydney, NSW Clinical Excellence Commission. *A human factors resource for health professionals and health services staff*. Sydney (NSW): Human Factors and Ergonomics Society of Australia; 2019.

[17] Australasian Society of Clinical Immunology and Allergy. What is allergy? [Internet]. Sydney: ASCIA; 2025. https://www.allergy.org.au/patients/about-allergy/what-is-allergy (accessed May 2026)

[18] Australian Government Department of Health, Disability and Ageing. What is AMR? [Internet]. Canberra: Australian Government; 2022. https://www.amr.gov.au/about-amr/what-amr (accessed May 2026)

[19] NSW Department of Communities and Justice. Behaviours of concern. Sydney: NSW Government; 2024. https://dcj.nsw.gov.au/documents/children-and-families/links-training-and-support/Behaviours_of_concern.pdf (accessed May 2026)

[20] Clinical Excellence Commission. Best possible medication history [Internet]. Sydney: NSW Government. https://cec.health.nsw.gov.au/keep-patients-safe/medication-safety/cmm/bpmh (accessed May 2026)

[21] NSW Health. Carers [Internet]. Sydney (AU): NSW Government; 2024 [cited 2026 May 28]. Available from: https://www.health.nsw.gov.au/carers/pages/default.aspx (accessed May 2026)

[22] OpenStax. Fundamentals of nursing: The nurse's role in assessment [Internet]. Houston USA (TX): OpenStax: 2024; [cited 2026 May 28]. Available from: https://openstax.org/books/fundamentals-nursing/pages/12-1-the-nurses-role-in-assessment (accessed May 2026)

[23] Clinical Excellence Commission. Clinical handover [Internet]. Sydney: NSW Health; [cited 2026 May]. Available from: Clinical Handover of Patient Care (accessed July 2026)

[24] Science Insights. What is a clinical leader and why does it matter? [Internet]. 2026 Mar 18 [cited 2026 May 28]. Available from: https://scienceinsights.org/what-is-a-clinical-leader-and-why-does-it-matter/

[25] Science Insights. What is a clinical review and how does it work? [Internet]. 2026 Mar 9 [cited 2026 May 28]. Available from: https://scienceinsights.org/what-is-a-clinical-review-and-how-does-it-work/ (accessed May 2026)

[26] World Health Organization. Clinical trials [Internet]. Geneva: WHO; [cited 2026 May]. Available from: https://www.who.int/health-topics/clinical-trials/#tab=tab_1

[27] Australian Institute of Health and Welfare. Workforce glossary [Internet]. Canberra: AIHW, 2024; [cited 2026 May]. Available from: https://www.aihw.gov.au/reports-data/health-welfare-services/workforce/glossary (accessed May 2026)

[28] Sanders EB-N, Stappers PJ. Co-creation and the new landscapes of design. CoDesign. 2008;4(1):5–18.

[29] Lewis VJ, Macmillan J, Harris-Roxas B. Defining community health services in Australia: a qualitative exploration. *Aust J Prim Health*. 2022;28(6):482-489. doi:10.1071/PY21265. [connectsci.au]

[30] Australian Commission on Safety and Quality in Health Care. Credentialing and defining scope of practice. Guidance for health services and clinicians. Sydney: ACSQHC; 2026. https://www.safetyandquality.gov.au/resources/credentialing-and-defining-scope-practice-guidance-health-professionals-and-clinicians (accessed May 2026)

[31] Australian Business Registry Service, Definitions, Albury: Australian Government. https://www.abrs.gov.au/definitions (accessed July 2026)

[32] Taylor-Adams S, Vincent C. *Systems Analysis of Clinical Incidents: The London Protocol*. London: Imperial College London; 2004.

[33] Coulter A, Oldham J. Person-centred care: what is it and how do we get there? *Future Healthc J*. 2016;3(2):114-116. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC6465833/

[34] McCormack B, McCance T, Bulley C, Brown D, McMillan A, Martin S, editors. *Fundamentals of Person-Centred Healthcare Practice*. Chichester (UK): Wiley Blackwell; 2021.

[35] International Organization for Standardization. *ISO 22870:2016 Point-of-care testing (POCT)—Requirements for quality and competence*. 2nd ed. Geneva: ISO; 2016

[36] Agency for Clinical Innovation. Remote patient monitoring. Sydney: NSW Government. https://aci.health.nsw.gov.au/virtual-care-in-practice/delivery/remote-monitoring (accessed July 2026)

[37] Centers for Disease Control and Prevention. Updated guidelines for evaluating public health surveillance systems [Internet]. Atlanta USA: CDC; 2001/50(RR13):1-35. Available from: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5013a1.htm (accessed May 2026)

[38] Centers for Disease Control and Prevention. Transmission-based precautions [Internet]. Atlanta USA(GA): CDC; 2024. Available from: https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html (accessed May 2026)

[39] Therapeutic Goods Administration. *About UDI in Australia* [Internet]. Canberra: Australian Government Department of Health, Disability and Ageing; 2026 [cited 2026 Jul 1]. Available from: https://www.tga.gov.au/products/medical-devices/labelling-and-advertising/unique-device-identification-udi-hub/about-udi-australia

[40] Atsma F, Elwyn G, Westert G. Understanding unwarranted variation in clinical practice: a focus on network effects, reflective medicine and learning health systems [Internet]. International Journal for Quality in Health Care. 2020;32(4):271–274. https://academic.oup.com/intqhc/article/32/4/271/5822111

[41] NSW Health. Workplace culture [Internet]. Sydney: NSW Health; 2024 [cited 2026 Jul 8]. Available from: https://www.health.nsw.gov.au/workforce/culture/Pages/default.aspx

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