AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

Map of the National Safety and Quality Health Service Standards (second edition) with the National Standards for Mental Health Services

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Introduction

This document maps the second edition of the National Safety and Quality Health Service (NSQHS) Standards with the National Standards for Mental Health Services (NSMHS). The purpose of the document is to demonstrate to mental health stakeholders the extent of alignment between the two sets of standards.

The NSQHS Standards were released in 2017. It will be mandatory for health services assessed to the NSQHS Standards under the Australian Health Service Safety and Quality Accreditation Scheme to address these actions from January 2019.

The Australian Commission on Safety and Quality in Health Care (the Commission) considers that implementation of the second edition of the NSQHS Standards provides a robust framework for safety and quality in mental health services in public and private hospitals, and community services provided by local health networks. Determination of whether public and private health services in specific states and territories are required to be assessed to the NSMHS remains a decision of state and territory health departments.

The Commission has developed a NSQHS Standards user guide for health services providing health care to people with mental health issues, to support health service organisations to implement these new actions. This will be available in the fourth quarter of 2018.

The Commission is also examining what kind of guidance may be needed by specialist mental health services to support them to fully implement the NSQHS Standards. Any guidance for specialist mental health services will be in the context of the NSMHS and actions in the Fifth National Mental Health and Suicide Prevention Plan.

Background

In 2014 the Commission, in collaboration with the National Mental Health Commission, conducted a scoping study on the implementation of national standards in mental health services. This was a large qualitative study of the issues facing services charged with implementing both the first edition of the NSQHS Standards and the NSMHS. Participants reported that being accredited to two sets of national standards was unduly burdensome, and that there was significant duplication. They also reported that neither set of standards alone was enough to ensure safety and quality in mental health services. The Commission committed to address this safety gap.

The Commission worked closely with partners to develop the second edition of the NSQHS Standards, and they now address the key safety gaps identified in the scoping study. Person-centred care is embedded throughout the NSQHS Standards, and this aligns closely to the principles of recovery-oriented service delivery. Actions have been added that directly address processes for preventing and managing self-harm and suicide; predicting, preventing and managing aggression and violence; minimising seclusion and restraint; and recognising and responding to deterioration in a person's mental state.

Key to the maps

This document contains four maps:

- A summary map of the NSQHS Standards with the NSMHS
- A summary map of the NSMHS with the NSQHS Standards
- A map of the NSQHS Standards with the NSMHS
- A map of the NSMHS with the NSQHS Standards.

The maps are designed to demonstrate the extent of the alignment between the two sets of standards. Where there is a close match between an action in the NSQHS Standards and the NSMHS, the action numbers are placed alongside each other. Note that some actions in both sets of standards contain several parts – a match may be drawn between an action in one set of standards, and part of an action in another.

The NSQHS Standards are designed to be implemented in all types of healthcare settings. For this reason, actions are articulated in broad terms. There are actions in the NSMHS that do not directly align with an action in the NSQHS Standards. However, if a mental health service were to implement the NSQHS Standards consistent with their intent, they would substantially meet a relevant action in the NSMHS. These have been highlighted in light green in the summary maps, with commentary provided in the larger maps. There are a small number of actions in the NSMHS that do not align directly with any actions in the NSQHS Standards. These are highlighted in red.

NSQHS Standard	NSMHS	Legend
1.1	2.13	Good match between actions
1.9		Partial match
1.17		No direct match

Appendix 1 contains the map of the NSMHS with the first edition of the NSQHS Standards. When compared to the map of the NSMHS with the second edition of the NSQHS Standards, this demonstrates the significant increase in alignment between the two sets of standards.

Further steps

The maps can be used now by stakeholders wishing to familiarise themselves with the alignment between the two sets of standards. They can contribute to the actions described in the Fifth National Mental Health and Suicide Prevention Plan.

The Commission will work with stakeholders to determine if additional resources are required in order for mental health services to effectively implement the second edition of the NSQHS Standards.

Summary map NSQHS Standards with NSMHS

Green = partial match **Red** = no match

SQ1	MH
1.1	2.13
	8.3
1.2	
1.3	
1.4	
1.5	2.8
1.6	8.7
1.7	1.2
	2.6
	8.4
1.8	8.11
1.9	
1.10	2.9
	2.12
	8.10
1.11	
1.12	
1.13	1.16
	3.2
1.14	1.16
1.15	4.1
	4.2
	4.3
	10.2.1
1.16	1.14
	6.15
	8.9
1.17	
1.18	
1.19	1.5
1.20	2.10
	8.7
1.21	
1.22	8.7
1.23	8.6
	10.4.2
1.24	8.6
1.25	8.7
1.26	8.7
1.27	10.4.1
	10.5.1
	10.5.7
1.28	

SQ1	MH
1.29	2.6
	2.12
1.30	2.6
	2.12
1.31	
1.32	6.16
1.33	

SQ2	MH
2.1	
2.2	
2.3	1.1
	1.4
	1.5
	6.1
	6.3
	7.4
	10.1.2
2.4	1.3
	6.8
2.5	6.8
2.6	1.10
	1.11
	1.12
	6.7
	6.10
	7.10
	10.1.6
	10.6.4
2.7	6.7
	7.2
	7.16
	10.1.6
2.8	10.2.2
2.9	
2.10	1.6
	1.7
	6.9
	10.5.3
	10.5.7
	10.5.15
	10.6.2
2.11	3.1
	6.17
	10.1.8
2.12	3.3
	3.5
2.13	4.3
2.14	

SQ3	MH
3.1	2.7
3.2	2.7
3.3	2.7
3.4	
3.5	2.6
	2.7
3.6	
3.7	
3.8	
3.9	
3.10	
3.11	2.6
	2.12
3.12	
3.13	
3.14	
3.15	
3.16	

SQ4	MH
4.1	
4.2	2.4
4.3	2.4
	10.5.8
4.4	2.4
	10.5.6
4.5	2.4
	10.5.8
4.6	2.4
	10.5.8
4.7	2.4
4.8	2.4
4.9	2.4
4.10	2.4
	10.5.8
4.11	2.4
4.12	
4.13	2.4
4.14	10.5.6
4.15	10.5.6

SQ5	MH
5.1	
5.2	
5.3	10.5.2
	10.5.11
5.4	6.6
	9.1
	10.3.3
	10.3.8
	10.4.2
	10.4.8
5.5	9.2
5.6	
5.7	10.2.1
	10.3.3
5.8	
5.9	10.1.6
5.10	2.11
5.11	2.11
5.12	
5.13	6.13
	7.2
	7.10
	7.12
	9.3
	10.4.3
	10.4.4
	10.4.8
	10.5.2
	10.5.11
	10.6.3
5.14	10.4.5
	10.4.8
5.15	
5.16	
5.17	
5.18	
5.19	
5.20	
5.21	
5.22	
5.23	
5.24	
5.25	

SQ5	MH
5.26	
5.27	
5.28	
5.29	
5.30	
5.31	2.3
	7.10
5.32	
5.33	2.6
	2.10
5.34	2.6
	2.10
	7.10
5.35	2.2
5.36	2.2

SQ6	MH
6.1	
6.2	
6.3	
6.4	9.3
	10.5.9
6.5	
6.6	
6.7	2.11
6.8	6.13
	7.12
	10.4.5
	10.6.4
6.9	2.11
	7.9
6.10	2.11
	7.10
6.11	

SQ7	MH
7.1	
7.2	
7.3	
7.4	
7.5	
7.6	
7.7	
7.8	
7.9	
7.10	

SQ8	MH
8.1	
8.2	
8.3	
8.4	2.11
8.5	2.11
8.6	10.4.5
8.7	10.4.5
8.8	
8.9	
8.10	
8.11	
8.12	
8.13	

Summary map NSMHS with NSQHS Standards

Green = partial match Red = no match

MH1	SQ
1.1	2.3
1.2	1.7
1.3	2.4
1.4	2.3
1.5	1.19
	2.3
1.6	2.10
1.7	2.10
1.8	
1.9	
1.10	2.6
1.11	2.6
1.12	2.6
1.13	
1.14	1.16
1.15	
1.16	1.13
	1.14
1.17	

MH2	SQ
2.1	
2.2	5.35
	5.36
2.3	5.31
2.4	4.2
	4.3
	4.4
	4.5
	4.6
	4.7
	4.8
	4.9
	4.10
	4.11
	4.13
2.5	
2.6	1.7
	1.29
	1.30
	3.5
	3.11
	5.33
	5.34
2.7	3.1
	3.2
	3.3
	3.5
2.8	1.5
2.9	1.10
2.10	1.20
	5.33
	5.34
2.11	5.10
	5.11
	6.7
	6.9
	6.10
	8.4
	8.5
2.12	1.10
	1.29
	1.30
	3.11
2.13	1.1

MH3	SQ
3.1	2.11
3.2	1.13
3.3	2.12
3.4	
3.5	2.12
3.6	
3.7	

MH4	SQ
4.1	1.15
4.2	1.15
4.3	1.15
	2.13
4.4	
4.5	
4.6	

MH5	SQ
5.1	
5.2	
5.3	
5.4	
5.5	
5.6	

MH6	SQ
6.1	2.3
6.2	
6.3	2.3
6.4	
6.5	
6.6	5.4
6.7	2.6
	2.7
6.8	2.4
	2.5
6.9	2.10
6.10	2.6
6.11	
6.12	
6.13	5.13
	6.8
6.14	
6.15	1.16
6.16	1.32
6.17	2.11
6.18	

MH7	SQ
7.1	
7.2	2.7
	5.13
7.3	
7.4	2.3
7.5	
7.6	
7.7	
7.8	
7.9	6.9
7.10	2.6
	5.13
	5.31
	5.34
	6.10
7.11	
7.12	5.13
	6.8
7.13	
7.14	
7.15	
7.16	2.7
7.17	

MH8	SQ
8.1	
8.2	
8.3	1.1
8.4	1.7
8.5	
8.6	1.23
	1.24
8.7	1.6
	1.20
	1.22
	1.25
	1.26
8.8	
8.9	1.16
8.10	1.10
8.11	1.8

MH9	SQ
9.1	5.4
9.2	5.5
9.3	5.13
	6.4
9.4	
9.5	

MH10	SQ
10.1.1	
10.1.2	2.3
10.1.3	
10.1.4	
10.1.5	
10.1.6	2.6
	2.7
	5.9
10.1.7	
10.1.8	2.11
10.1.9	
10.1.10	

MH10	SQ
10.2.1	1.15
	5.7
10.2.2	2.8
10.2.3	
10.2.4	

MH10	SQ
10.3.1	
10.3.2	
10.3.3	5.4
	5.7
10.3.4	
10.3.5	
10.3.6	
10.3.7	
10.3.8	5.4

MH10	SQ
10.4.1	1.27
10.4.2	1.23
	5.4
10.4.3	5.13
10.4.4	5.13
10.4.5	5.14
	6.8
	8.6
	8.7
10.4.6	
10.4.7	
10.4.8	5.4
	5.13
	5.14

MH10	SQ
10.5.1	1.27
10.5.2	5.3
	5.13
10.5.3	2.10
10.5.4	
10.5.5	
10.5.6	4.4
	4.14
	4.15
10.5.7	1.27
	2.10
10.5.8	4.3
	4.5
	4.6
	4.10
10.5.9	6.4
10.5.10	
10.5.11	5.3
	5.13
10.5.12	
10.5.13	
10.5.14	
10.5.15	2.10
10.5.16	
10.5.17	

10.6.1	
10.6.2	2.10
10.6.3	5.13
10.6.4	2.6
	6.8
10.6.5	
10.6.6	
10.6.7	
10.6.8	

Map of NSQHS Standards with NSMHS

Map of NSQHS Standards with NSMHS

	National Safety and Quality Health Service Standards (second edition) 1. Clinical Governance Standard		National Standards for Mental Health Services	Comments
1.1	The governing body: a. Provides leadership to promote a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance	2.13	The MHS has a formal process for identification, mitigation, resolution (where possible) and review of any safety issues.	Leadership actions contribute to **NSMHS 10.1.2** MHS treats consumers and carers with dignity and respect
		8.3	The MHS develops and regularly reviews its strategic plan in conjunction with all relevant service providers. The plan incorporates needs analysis, resource planning and service evaluation. This should be developed with the participation of staff, stakeholders, consumers, carers and representatives of its community.	
1.2	The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people			
1.3	The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality			

1.4	The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people			
1.5	The health service organisation considers the safety and quality of health care for patients in its business decision making	2.8	The MHS can demonstrate investment in adequate staffing and resources for the safe delivery of care.	Partial match: 'can demonstrate' (NSMHS) is stronger than 'considers' (NSQHS Standards). NSQHS Standards don't explicitly mention staffing. Also contributes to **NSMHS 8.5** allocation of resources
1.6	Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients	8.7	Staff are appropriately trained, developed and supported to safely perform the duties require of them.	
1.7	The health service organisation uses a risk management approach to: a. Set out, review and maintain the currency and effectiveness of policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements	1.2	All care is delivered in accordance with relevant Commonwealth, state/territory mental health legislation and related Acts.	
		2.6	The MHS meets their legal occupational health and safety obligations to provide a safe workplace and environment.	
		8.4	The MHS has processes in place to ensure compliance with relevant Commonwealth, state/territory mental health legislation and related Acts.	

1.8	The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems	8.11	The MHS has a formal quality improvement program incorporating evaluation of its services that result in changes to improve practice.	
1.9	The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations			Also contributes to **NSMHS 5.4**, which has a particular focus on partnerships
1.10	The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters	2.9	The MHS conducts a risk assessment of staff working conditions and has documented procedures to manage and mitigate identified risks.	
		2.12	The MHS conducts regular reviews of safety in all MHS settings, including an environmental appraisal for safety to minimise risk for consumers, carers, families, visitors and staff.	
		8.10	The MHS has an integrated risk management policy and practices to identify, evaluate, monitor, manage and communicate organisational and clinical risks.	

1.11	The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems			Contributes to **NSMHS 8.8** staff support following critical incidents
1.12	The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework b. Monitors and acts to improve the effectiveness of open disclosure processes			Contributes to **NSMHS 8.8** staff support following critical incidents
1.13	The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems	1.16	The MHS upholds the right of the consumer to express compliments, complaints and grievances regarding their care and to have them addressed by the MHS.	
		3.2	The MHS upholds the right of the consumer and their carer(s) to have their needs and feedback taken into account in the planning, delivery and evaluation of services.	

1.14	The health service organisation has an organisation-wide complaints management system and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and takes action to improve the effectiveness of the complaints management system	1.16	The MHS upholds the right of the consumer to express compliments, complaints and grievances regarding their care and to have them addressed by the MHS.	
1.15	The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care	4.1	The MHS identifies the diverse groups (Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse (CALD), religious/spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age and socio-economic status) that access the service.	Also contributes to **NSMHS 7.5** though **NSQHSS 1.15** does not explicitly mention carers Also contributes to **NSMHS 10.1.3** MHS recognises lived experience of consumers and carers
		4.2	The MHS whenever possible utilises available and reliable data on identified diverse groups to document and regularly review the needs of its community and communicates this information to staff.	
		4.3	Planning and service implementation ensures differences and values of its community are recognised and incorporated as required.	

1.15 cont.		10.2.1	Access to available services meets the identified needs of its community in a timely manner.	
1.16	The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systemic audit of clinical information e. Integrate multiple information systems, where they are used	1.14	The MHS enacts policy and procedures to ensure that personal and health related information is handled in accordance with Commonwealth, state/territory privacy legislation when personal information is communicated to health professionals outside the MHS, carers or other relevant agencies.	
		6.15	Information about consumers can be accessed by authorised persons only.	
		8.9	The MHS manages and maintains an information system that facilitates the appropriate collection, use, storage, transmission and analysis of data to enable review of services and outcomes at an individual consumer and MHS level in accordance with Commonwealth, state/territory legislation and related Acts.	
1.17	The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies			
1.18	The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system			

1.19	The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation	1.5	Staff and volunteers are provided with a written statement of the rights and responsibilities of consumers and carers, together with a written code of conduct as part of their induction to the MHS.	
1.20	The health service organisation uses it training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these Standards c. Provides access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training	2.10	Staff are regularly trained to, wherever possible, prevent, minimise and safely respond to aggressive and other difficult behaviours.	
		8.7	Staff are appropriately trained, developed and supported to safely perform the duties required of them.	
1.21	The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients			Links to **NSMHS 4.5**, staff trained to access information to provide service appropriate to diverse needs of consumers, but NSQHSS limited to Aboriginal and Torres Strait Islander people, and doesn't explicitly reference other types of diversity

1.22	The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system	8.7	Staff are appropriately trained, developed and supported to safely perform the duties required of them.	
1.23	The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered	8.6	The recruitment and selection process of the MHS ensures that staff have the skills and capability to perform the duties required of them.	
		10.4.2	Assessments are conducted during the consumer's first contact with the MHS by appropriately qualified staff experienced and trained in assessing mental health problems, and where possible in a consumer's preferred setting with consideration of safety for all involved.	
1.24	The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process	8.6	The recruitment and selection process of the MHS ensures that staff have the skills and capability to perform the duties required of them.	
1.25	The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff	8.7	Staff are appropriately trained, developed and supported to safely perform the duties required of them.	

1.26	The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate	8.7	Staff are appropriately trained, developed and supported to safely perform the duties required of them.	
1.27	The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant Clinical Care Standards developed by the Australian Commission on Safety and Quality in Health Care	10.4.1	Assessments conducted and diagnoses made are evidence-based and use accepted methods and tools, as well as internationally accepted disease classification systems.	Also contributes to **NSMHS 10.5.10** MHS ensures medication and other therapies used as part of documented plan
		10.5.1	Treatment and support provided by the MHS reflects best available evidence and emphasises early intervention and positive outcomes for consumers and their carer(s).	
		10.5.7	The MHS actively promotes adherence to evidence based treatments through negotiation and the provision of understandable information to the consumer.	
1.28	The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system			

1.29	The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities and devices and other infrastructure that are fit for purpose	2.6	The MHS meets their legal occupational health and safety obligations to provide a safe workplace and environment.	Also contributes to **NSMHS 1.9 & 6.5** least restrictive environment
		2.12	The MHS conducts regular reviews of safety in all MHS settings, including an environmental appraisal for safety to minimise risk for consumers, carers, families, visitors and staff.	Also contributes to **NSMHS 10.2.4** MHS provides ease of physical access, though **NSQHSS 1.29** does not mention proximity to public transport
1.30	The health service organisation: a. Identifies service areas where there is a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required	2.6	The MHS meets their legal occupational health and safety obligations to provide a safe workplace and environment.	Also contributes to **NSMHS 1.9 & 6.5** least restrictive environment
		2.12	The MHS conducts regular reviews of safety in all MHS settings, including an environmental appraisal for safety to minimise risk for consumers, carers, families, visitors and staff.	
1.31	The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose			Contributes to **NSMHS 10.2.4** MHS provides ease of physical access
1.32	The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet the patient's needs, when it is safe to do so	6.16	The right of the consumer to have visitors and maintain close relationships with family and friends is recognised and respected by the MHS.	
1.33	The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people			

	National Safety and Quality Health Service Standards (second edition) 2. Partnering with Consumers Standard		National Standards for Mental Health Services	Comments
2.1	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers			
2.2	The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers			

2.3	The health service organisation has a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers	1.1	The MHS upholds the right of the consumer to be treated with respect and dignity at all times.	Partial match to **NSMHS 2.1** MHS promotes optimal safety and wellbeing. Also contributes to **NSMHS 10.1.3** MHS recognises lived experience
		1.4	The MHS provides consumers and their carers with a written statement, together with a verbal explanation of their rights and responsibilities, in a way that is understandable to them as soon as possible after entering the MHS and at regular intervals throughout their care.	The Charter and the action do not explicitly mention 'responsibilities', but there is a document titled 'Roles in realising the Australian Charter of Healthcare Rights' that closely approximates the Statement of Rights and Responsibilities: https://www.safetyandquality.gov.au/wp-content/uploads/2012/01/Roles-in-Realising-the-Australian-Charter-of-Healthcare-Rights-PDF-1232-KB.pdf
		1.5	Staff and volunteers are provided with a written statement of the rights and responsibilities of consumers and carers, together with a written code of conduct as part of their induction to the MHS.	The 'Roles' document (see above) also covers the basic principles of a code of conduct
		6.1	Consumers have the right to be treated with respect and dignity at all times.	Also contributes to **NSMHS 6.2** Consumers have the right to receive service free from abuse etc., and **NSMHS 6.4** Consumers are continually educated about their rights and responsibilities

2.3 cont.		6.3	Consumers have the right to receive a written statement, together with a verbal explanation, of their rights and responsibilities in a way that is understandable to them as soon as possible after entering the MHS.	
		7.4	The MHS provides carers with a written statement, together with a verbal explanation of their rights and responsibilities in a way that is understandable to them as soon as possible after engaging with the MHS.	
		10.1.2	The MHS treats consumers and carers with respect and dignity.	The clear implication of 'having' a charter is that it is implemented in the HSO
2.4	The health service organisation ensures that its informed consent processes comply with legislation and best practice	1.3	All care delivered is subject to the informed consent of the voluntary consumer and wherever possible, by the involuntary consumer in accordance with Commonwealth and state/ territory jurisdictional and legislative requirements.	
		6.8	Informed consent is actively sought from consumers prior to any service or intervention provided or any changes in care delivery are planned, where it is established that the consumer has capacity to give informed consent.	

2.5	The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision maker if a patient does not have the capacity to make decisions for themselves	6.8	Informed consent is actively sought from consumers prior to any service or intervention provided or any changes in care delivery are planned, where it is established that the consumer has capacity to give informed consent.	Also contributes to **NSMHS 1.15** MHS upholds the right of the consumer to access advocacy and support services, but note, advocacy in the sense of representing the interests of consumers is addressed in the NSQHS Standards Advocacy in the specific sense of consumers choosing who can represent them legally is not addressed, but critical in the mental health context. Also contributes to **NSMHS 7.1** identification of carer and **NSMHS 7.7**, sharing information
2.6	The health service organisation has processes for clinicians to partner with patients and/or their substitute decision maker to plan, communicate, set goals and make decisions about their current and future care	1.10	The MHS upholds the right of the consumer to be involved in all aspects of their treatment, care and recovery planning.	Also contributes to **NSMHS 10.1.4** MHS supports consumers' and carers' self-determination
		1.11	The MHS upholds the right of the consumer to nominate if they wish to have (or not to have) others involved in their care to the extent that it does not impose serious risk to the consumer or others.	Partial match: NSQHSS action covers right, but does not specify right not to have others involved. Also contributes to **NSMHS 6.5** Consumers have the right to involve or not to involve carers and others
		1.12	The MHS upholds the right of carers to be involved in the management of the consumer's care with the consumer's informed consent.	Also contributes to **NSMHS 7.1** identification of carer

2.6 cont.		6.7	Consumers are partners in the management of all aspects of their treatment, care and recovery planning.	
		6.10	Consumers have the right to choose from the available range of treatment and support programs appropriate to their needs.	
		7.10	The MHS actively seeks information from carers in relation to the consumer's condition during assessment, treatment and ongoing care and records that information in the consumer's health record.	
		10.1.6	The MHS provides education that supports consumer and carer participation in goal setting, treatment, care and recovery planning, including the development of advance directives.	
		10.6.4	The consumer and their carer(s) and other service providers are involved in developing the exit plan. Copies of the exit plan are made available to the consumer and with the consumers' informed consent, their carer(s).	

2.7	The health service organisation supports the workforce to form partnership with patients and carers so that patients can be actively involved in their own care	6.7	Consumers are partners in the management of all aspects of their treatment, care and recovery planning.	
		7.2	The MHS implements and maintains ongoing engagement with carers as partners in the delivery of care as soon as possible in all episodes of care.	
		7.16	The MHS provides training to staff to develop skills and competencies for working with carers.	
		10.1.6	The MHS provides education that supports consumer and carer participation in goal setting, treatment, care and recovery planning, including the development of advance directives.	
2.8	The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community	10.2.2	The MHS informs its community about the availability, range of services and methods for establishing contact with its service.	Also contributes to **NSMHS 4.4** MHS has demonstrated knowledge of other services and organisation relevant to the needs of the community
2.9	Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review			

2.10	The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided at discharge	1.6	The MHS communicates with consumers, carers and other service providers and applies the rights and responsibilities of involuntary patients as per relevant Commonwealth, state/territory mental health legislation and related Acts.	**NSQHSS 2.10d** also contributes to **NSMHS 6.12** exit plan
		1.7	The MHS upholds the right of the consumer to have their needs understood in a way that is meaningful to them and appropriate services are engaged when required to support this.	
		6.9	Consumers are provided with current and accurate information on the care being delivered.	
		10.5.3	The MHS is responsible for providing the consumer and their carer(s) with information on the range and implications of available therapies.	Also contributes to **NSMHS 7.7** sharing information
		10.5.7	The MHS actively promotes adherence to evidence based treatments through negotiation and the provision of understandable information to the consumer.	
		10.5.15	Information on self-care programs or interventions is provided to consumers and their carer(s) in a way that is understandable to them.	
		10.6.2	The consumer and their carer(s) are provided with understandable information on the range of relevant services and support available in the community.	

2.11	The health service organisation: a. Involves consumers in partnerships in the governance and to design, measure and evaluate health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community	3.1	The MHS has processes to actively involve consumers and carers in planning, service delivery, evaluation and quality programs.	Also contributes to **NSMHS 7.14** though **NSQHSS 2.11** doesn't explicitly specify carers
		6.17	Consumers are engaged in development, planning, delivery and evaluation of the MHS.	
		10.1.8	The MHS demonstrates systems and processes for consumer and carer participation in the development, delivery and evaluation of services.	
2.12	The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation	3.3	The MHS provides training and support for consumers, carers and staff, which maximise consumer and carer(s) representation and participation in the MHS.	Also contributes to the part of **NSMHS 3.7** which addresses policy support for consumer and carer committee representation, but NSQHSS action does not cover payment for participation. Also contributes to **NSMHS 7.15**, though **NSQHSS 2.12** doesn't explicitly specify carers
		3.5	The MHS provides ongoing training and support to consumers and carers who are involved in formal advocacy and/or support roles within the MHS.	Also contributes to **NSMHS 6.18** training and support for consumers involved in support role (but advocacy not explicitly mention in **NSQHSS 2.12**)
2.13	The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	4.3	Planning and service implementation ensures differences and values of its community are recognised and incorporated as required.	
2.14	The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce			

	National Safety and Quality Health Service Standards (second edition) 3. Preventing and Controlling Healthcare-Associated Infection Standard		National Standards for Mental Health Services	Comments
3.1	The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for healthcare-associated infections and antimicrobial stewardship b. Managing risks associated with healthcare-associated infections and antimicrobial stewardship c. Identifying training requirements for preventing and controlling healthcare-associated infections, and antimicrobial stewardship	2.7	The MHS complies with infection control requirements.	
3.2	The health service organisation applies the quality improvement system in the Clinical Governance Standards when: a. Monitoring the performance of systems for prevention and control of healthcare-associated infections, and the effectiveness of the antimicrobial stewardship program b. Implementing strategies to improve outcomes and associated processes of systems for prevention and control of healthcare-associated infections, and antimicrobial stewardship c. Reporting on the outcomes of prevention and control of healthcare-associated infections, and the antimicrobial stewardship program	2.7	The MHS complies with infection control requirements.	

3.3	Clinicians use organisational processes from the Partnering with Consumers Standard when preventing and managing healthcare-associated infections, and implementing the antimicrobial program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	2.7	The MHS complies with infection control requirements.	
3.4	The health service organisation has a surveillance strategy for healthcare-associated infections and antimicrobial use that: a. Collects data on healthcare-associated infections and antimicrobial use relevant to the size and scope of the organisation b. Monitors, assess and uses surveillance data to reduce the risks associated with healthcare-associated infections and support appropriate antimicrobial prescribing c. Reports surveillance data on healthcare-associated infections and antimicrobial use to the workforce, the governing body, consumers and other relevant groups			
3.5	The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the *Australian guidelines for the prevention and control of infection in healthcare,* and jurisdictional requirements	2.6	The MHS meets their legal occupational health and safety obligations to provide a safe workplace and environment.	**NSMHS 2.6** is broad, **NSQHSS 3.5** forms a key part of it
		2.7	The MHS complies with infection control requirements.	

3.6	Clinicians assess infection risks and use transmission-based precautions based on the risk of transmission of infections agents, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated when clinically required during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs to manage infection risks d. The need to control the environment e. Precautions required when the patient is moved within the facility or to external services f. The need for additional environmental cleaning or disinfection g. Equipment requirements			
3.7	The health service organisation has processes for communicating relevant details of a patient's infectious status whenever responsibility for care is transferred between clinicians or health service organisations			
3.8	The health service organisation has a hand hygiene program that: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with the current National Hand Hygiene Initiative			

3.9	The health service organisation has processes for aseptic technique that: a. Identify the procedures where aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique			
3.10	The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*			
3.11	The health service organisation has processes to maintain a clean and hygienic environment – in line with the current edition of the *Australian guidelines for the prevention and control of infection in healthcare*, and jurisdictional requirements – that: a. Respond to environmental risks b. Require cleaning and disinfection in line with recommended cleaning frequencies c. Include training in the appropriate use of specialised personal protective equipment for the workforce	2.6	The MHS meets their legal occupational health and safety obligations to provide a safe workplace and environment.	
		2.12	The MHS conducts regular reviews of safety in all MHS settings, including an environmental appraisal for safety to minimise risk for consumers, carers, families, visitors and staff.	
3.12	The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Maintaining, repairing and upgrading buildings, equipment, furnishings and fittings c. Handling, transporting and storing linen			

3.13	The health service organisation has a risk-based workforce immunisation program that: a. Is consistent with the current edition of the *Australian Immunisation Handbook* b. Is consistent with jurisdictional requirements for vaccine-preventable diseases c. Addresses specific risks to the workforce and patients			
3.14	Where reusable equipment, instruments and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure			
3.15	The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard			

3.16	The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy • antimicrobial use and resistance • appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing			

	National Safety and Quality Health Service Standards (second edition) 4. Medication Safety Standard		National Standards for Mental Health Services	Comments
4.1	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management			
4.2	The health service organisation applies the quality improvement system in the Clinical Governance for Health Service Organisations Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management	2.4	The MHS minimises the occurrence of adverse medication events within all MHS settings.	NB. **NSMHS 2.4** is broad, there are multiple actions in the NSQHS Standards that together contribute to minimising adverse medication events
4.3	Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision making	2.4	The MHS minimises the occurrence of adverse medication events within all MHS settings.	
		10.5.8	The views of the consumer and their carer(s), and the history of previous treatment is considered and documented prior to administration of new medication and/or other technologies.	

4.4	The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians	2.4	The MHS minimises the occurrence of adverse medication events within all MHS settings.	
		10.5.6	Medications are prescribed, stored, transported, administered and reviewed by authorised persons in a manner consistent with Commonwealth, state/territory legislation and related Acts, regulations and professional guidelines.	
4.5	Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care	2.4	The MHS minimises the occurrence of adverse medication events within all MHS settings.	
		10.5.8	The views of the consumer and their carer(s), and the history of previous treatment is considered and documented prior to administration of new medication and/or other technologies.	
4.6	Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care	2.4	The MHS minimises the occurrence of adverse medication events within all MHS settings.	
		10.5.8	The views of the consumer and their carer(s), and the history of previous treatment is considered and documented prior to administration of new medication and/or other technologies.	
4.7	The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation	2.4	The MHS minimises the occurrence of adverse medication events within all MHS settings.	
4.8	The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system	2.4	The MHS minimises the occurrence of adverse medication events within all MHS settings.	
4.9	The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements	2.4	The MHS minimises the occurrence of adverse medication events within all MHS settings.	

4.10	The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result	2.4	The MHS minimises the occurrence of adverse medication events within all MHS settings.	
		10.5.8	The views of the consumer and their carer(s), and the history of previous treatment is considered and documented prior to administration of new medication and/or other technologies.	
4.11	The health service organisation has processes to support clinicians to provide patients with information on their individual medicines needs and risks	2.4	The MHS minimises the occurrence of adverse medication events within all MHS settings.	
4.12	The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes			
4.13	The health service organisation ensures that information and decision support tools for medicines are available to clinicians	2.4	The MHS minimises the occurrence of adverse medication events within all MHS settings.	
4.14	The health service organisation complies with manufacturers' directions, legislation and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines	10.5.6	Medications are prescribed, stored, transported, administered and reviewed by authorised persons in a manner consistent with Commonwealth, state/territory legislation and related Acts, regulations and professional guidelines.	

4.15	The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely	10.5.6	Medications are prescribed, stored, transported, administered and reviewed by authorised persons in a manner consistent with Commonwealth, state/territory legislation and related Acts, regulations and professional guidelines.	

	National Safety and Quality Health Service Standards (second edition) 5. Comprehensive Care Standard		National Standards for Mental Health Services	Comments
5.1	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care			
5.2	The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care			
5.3	Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision making	10.5.2	Treatment and services provided by the MHS are responsive to the changing needs of consumers during their episodes of care that address acute needs, promote rehabilitation and support recovery.	NSMHS implementation guidelines focus on different populations rather than changing needs
		10.5.11	The treatment and support provided by the MHS is developed and evaluated collaboratively with the consumer and their carer(s). This is documented in the current individual treatment, care and recovery plan.	

5.4	The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify at all times the clinician with overall accountability for a patient's care	6.6	A mental health professional responsible for coordinating clinical care is identified and made known to consumers.	
		9.1	The MHS ensures that a person responsible for the coordination of care is available to facilitate coordinated and integrated services throughout all stages of care for consumers and carers.	
		10.3.3	The MHS has a documented system for prioritising referrals according to risk, urgency, distress, dysfunction and disability with timely advice and/or response to all those referred, at the time of assessment.	
		10.3.8	The MHS ensures that a consumer and their carer(s) are able to identify a nominated person responsible for coordinating their care and informing them about any changes in the care management.	
		10.4.2	Assessments are conducted during the consumer's first contact with the MHS by appropriately qualified staff experienced and trained in assessing mental health problems, and where possible in a consumer's preferred setting with consideration of safety for all involved.	
		10.4.8	There is a current individual interdisciplinary treatment, care and recovery plan, which is developed in consultation with and regularly reviewed with the consumer and with the consumer's informed consent, their carer(s) and the treatment, care and recovery plan is available to both of them.	

5.5	The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team	9.2	The MHS has formal processes to support and sustain interdisciplinary care teams.	
5.6	Clinicians work collaboratively to plan and deliver comprehensive care			
5.7	The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion	10.2.1	Access to available services meets the identified needs of its community in a timely manner.	
		10.3.3	The MHS has a documented system for prioritising referrals according to risk, urgency, distress, dysfunction and disability with timely advice and/or response to all those referred, at the time of assessment.	Also contributes to **NSMHS 8.2** early identification, NSQHSS addresses prevention of risk, but not prevention of onset of condition
5.8	The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems			
5.9	Patients are supported to document clear advance care plans	10.1.6	The MHS provides education that supports consumer and carer participation in goal setting, treatment, care and recovery planning, including the development of advance directives.	
5.10	Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues and risks of harm c. To identify social and other circumstances that may compound these risks	2.11	The MHS conducts risk assessment of consumers throughout all stages of the care continuum, including consumers who are being formally discharged from the service, exiting the service temporarily and/or are transferred to another service.	Also contributes to **NSMHS 10.3.5** Entry to MHS minimises delay, but reducing duplication not specifically mentioned

5.11	Clinicians comprehensively assess the conditions and risks identified through the screening process	2.11	The MHS conducts risk assessment of consumers throughout all stages of the care continuum, including consumers who are being formally discharged from the service, exiting the service temporarily and/or are transferred to another service.	
5.12	Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record			
5.13	Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies any support people a patient wants involved in communications and decision making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and where available f. Is consistent with best practice and evidence	6.13	Consumers are actively involved in follow-up arrangements to maintain continuity of care.	Also contributes to **NSMHS 6.12**, exit plan, which in addition specifies re-entry information
		7.2	The MHS implements and maintains ongoing engagement with carers as partners in the delivery of care as soon as possible in all episodes of care.	Also contributes to **NSMHS 7.11** identification of carers in development of relapse prevention plans
		7.10	The MHS actively seeks information from carers in relation to the consumer's condition during assessment, treatment and ongoing care and records that information in the consumer's health record.	
		7.12	The MHS engages carers in discharge planning involving crisis management and continuing care prior to discharge from all episodes of care.	
		9.3	The MHS facilitates continuity of integrated care across programs, sites and other related services with appropriate communication, documentation and evaluation to meet the identified needs of consumers and carers.	Also contributes to **NSMHS 10.6.5** MHS provides consumers, carers and service providers with follow-up information

5.13 cont.		10.4.3	The MHS, with the consumer's informed consent includes carers, other service providers and others nominated by the consumer in assessment.	
		10.4.4	The MHS actively plans as early as possible in the course of psychiatric inpatient admission, for the discharge of the consumer from inpatient care.	
		10.4.8	There is a current individual interdisciplinary treatment, care and recovery plan, which is developed in consultation with and regularly reviewed with the consumer and with the consumer's informed consent, their carer(s) and the treatment, care and recovery plan is available to both of them.	Also contributes to **NSMHS 10.5.10** MHS ensures medication and other therapies used as part of documented plan
		10.5.2	Treatment and services provided by the MHS are responsive to the changing needs of consumers during their episodes of care that address acute needs, promote rehabilitation and support recovery.	
		10.5.11	The treatment and support provided by the MHS is developed and evaluated collaboratively with the consumer and their carer(s). This is documented in the current individual treatment, care and recovery plan.	
		10.6.3	The MHS has a process to commence development of an exit plan at the time the consumer enters the service.	

5.14	The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur	10.45	The MHS conducts a review of a consumer's treatment, care and recovery plan when the consumer: • Requests a review • Declines treatment and support • Is at significant risk of injury to themselves or another person • Receives involuntary treatment or is removed from an involuntary order • Is transferred between service sites • Is going to exit the MHS • Is observed through monitoring of their outcomes (satisfaction with service, measure of quality of life, measure of functioning) to be in decline.	
		10.4.8	There is a current individual interdisciplinary treatment, care and recovery plan, which is developed in consultation with and regularly reviewed with the consumer and with the consumer's informed consent, their carer(s) and the treatment, care and recovery plan is available to both of them.	
5.15	The health service organisation has processes to identify patients who are at the end of life that are consistent with the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*			
5.16	The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice			

5.17	The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record			
5.18	The health service organisation provides access to supervision and support for the workforce providing end-of-life care			
5.19	The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care			
5.20	Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*			
5.21	The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines			
5.22	Clinicians providing care to patients at risk of developing, or with, a pressure injury, conduct comprehensive skin inspections in accordance with best-practice time frames and frequency			
5.23	The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries			

5.24	The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management			
5.25	The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls			
5.26	Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies			
5.27	The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice			
5.28	The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking			

5.29	The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation			
5.30	Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care			
5.31	The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed	2.3	The MHS assesses and minimises the risk of deliberate self harm and suicide within all MHS settings.	
		7.10	The MHS actively seeks information from carers in relation to the consumer's condition during assessment, treatment and ongoing care and records that information in the consumer's health record.	

5.32	The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts			Partial match to **NSMHS 10.6.8** MHS has procedure for follow-up of consumers within 7 days, but NSQHSS action restricted to people who have harmed themselves or reported suicidal thoughts
5.33	The health service organisation has processes to identify and mitigate situations that may precipitate aggression	2.6	The MHS meets their legal occupational health and safety obligations to provide a safe workplace and environment.	Also contributes to **NSMHS 1.9 & 6.5** least restrictive environment
		2.10	Staff are regularly trained to, wherever possible, prevent, minimise and safely respond to aggressive and other difficult behaviours.	
5.34	The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers and families, and the workforce	2.6	The MHS meets their legal occupational health and safety obligations to provide a safe workplace and environment.	Also contributes to **NSMHS 1.9 & 6.5** least restrictive environment
		2.10	Staff are regularly trained to, wherever possible, prevent, minimise and safely respond to aggressive and other difficult behaviours.	
		7.10	The MHS actively seeks information from carers in relation to the consumer's condition during assessment, treatment and ongoing care and records that information in the consumer's health record.	
5.35	Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body	2.2	The MHS reduces and where possible eliminates the use of restraint and seclusion within all MHS settings.	Also contributes to **NSMHS 1.9 & 6.5** least restrictive environment

5.36	Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation c. Report use of seclusion to the governing body	2.2	The MHS reduces and where possible eliminates the use of restraint and seclusion within all MHS settings.	Also contributes to **NSMHS 1.9 & 6.5** least restrictive environment

	National Safety and Quality Health Service Standards (second edition) 6. Communicating for Safety Standard		National Standards for Mental Health Services	Comments
6.1	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication			
6.2	The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes			
6.3	Clinicians use organisation processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision making			

6.4	The health service organisation has clinical communication processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	9.3	The MHS facilitates continuity of integrated care across programs, sites and other related services with appropriate communication, documentation and evaluation to meet the identified needs of consumers and carers.	**NSQHSS 6.4b** links to **NSMHS 9.4**, which additionally specifies primary care provider
		10.5.9	The MHS ensures that there is continuity of care or appropriate referral and transfer between inpatient, outpatient, day patient, community settings and other health/support services.	
6.5	The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated			
6.6	The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care			
6.7	The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover	2.11	The MHS conducts risk assessment of consumers throughout all stages of the care continuum, including consumers who are being formally discharged from the service, exiting the service temporarily and/or are transferred to another service.	Also contributes to **NSMHS 10.6.5** MHS provides consumers, carers and service providers with follow-up information

6.8	Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care	6.13	Consumers are actively involved in follow-up arrangements to maintain continuity of care.	
		7.12	The MHS engages carers in discharge planning involving crisis management and continuing care prior to discharge from all episodes of care.	
		10.4.5	The MHS conducts a review of a consumer's treatment, care and recovery plan when the consumer: • Requests a review • Declines treatment and support • Is at significant risk of injury to themselves or another person • Receives involuntary treatment or is removed from an involuntary order • Is transferred between service sites • Is going to exit the MHS • Is observed through monitoring of their outcomes (satisfaction with service, measure of quality of life, measure of functioning) to be in decline.	
		10.6.4	The consumer and their carer(s) and other service providers are involved in developing the exit plan. Copies of the exit plan are made available to the consumer and with the consumer's informed consent, their carer(s).	

6.9	Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient	2.11	The MHS conducts risk assessment of consumers throughout all stages of the care continuum, including consumers who are being formally discharged from the service, exiting the service temporarily and/or are transferred to another service.	
		7.9	The MHS provides carers with non-personal information about the consumer's mental health condition, treatment and ongoing care and if applicable, rehabilitation.	
6.10	The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	2.11	The MHS conducts risk assessment of consumers throughout all stages of the care continuum, including consumers who are being formally discharged from the service, exiting the service temporarily and/or are transferred to another service.	
		7.10	The MHS actively seeks information from carers in relation to the consumer's condition during assessment, treatment and ongoing care and records that information in the consumer's health record.	
6.11	The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan			

	National Safety and Quality Health Service Standards (second edition) 7. Blood Management Standard		National Standards for Mental Health Services	Comments
7.1	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management			
7.2	The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management			
7.3	Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision making			

7.4	Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patient's own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks			
7.5	Clinicians document decisions related to blood management, transfusion history and transfusion details in the healthcare record			
7.6	The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria			
7.7	The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria			
7.8	The health service organisation participates in haemovigilance activities, in accordance with the national framework			
7.9	The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer			

7.10	The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage			

	National Safety and Quality Health Service Standards (second edition) 8. Recognising and Responding to Acute Deterioration Standard		National Standards for Mental Health Services	Comments
8.1	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration			
8.2	The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems			
8.3	Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision making			

8.4	The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	2.11	The MHS conducts risk assessment of consumers throughout all stages of the care continuum, including consumers who are being formally discharged from the service, exiting the service temporarily and/or are transferred to another service.	
8.5	The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible cause for acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state	2.11	The MHS conducts risk assessment of consumers throughout all stages of the care continuum, including consumers who are being formally discharged from the service, exiting the service temporarily and/or are transferred to another service.	

8.6	The health service organisation has protocols that specify agreed criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling for emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration	10.4.5	The MHS conducts a review of a consumer's treatment, care and recovery plan when the consumer: • Requests a review • Declines treatment and support • Is at significant risk of injury to themselves or another person • Receives involuntary treatment or is removed from an involuntary order • Is transferred between service sites • Is going to exit the MHS • Is observed through monitoring of their outcomes (satisfaction with service, measure of quality of life, measure of functioning) to be in decline.	
8.7	The health service organisation has processes for patients, carers or families to directly escalate care	10.4.5	The MHS conducts a review of a consumer's treatment, care and recovery plan when the consumer: • Requests a review • Declines treatment and support • Is at significant risk of injury to themselves or another person • Receives involuntary treatment or is removed from an involuntary order • Is transferred between service sites • Is going to exit the MHS • Is observed through monitoring of their outcomes (satisfaction with service, measure of quality of life, measure of functioning) to be in decline.	

8.8	The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance			
8.9	The workforce uses the recognition and response systems to escalate care			
8.10	The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration			
8.11	The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support			
8.12	The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated			Contributes to **NSMHS 10.2.3** MHS makes provision for consumers to access acute services 24/7
8.13	The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration			

Map of NSMHS with NSQHS Standards

Map of NSMHS with NSQHS Standards

	National Standards for Mental Health Services Standard 1: Rights and responsibilities		National Safety and Quality Health Service Standards (second edition)	Comments
1.1	The MHS upholds the right of the consumer to be treated with respect and dignity at all times.	2.3	The health service organisation has a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers	
1.2	All care is delivered in accordance with relevant Commonwealth, state/territory mental health legislation and related Acts.	1.7	The health service organisation uses a risk management approach to: a. Set out, review and maintain the currency and effectiveness of policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements	
1.3	All care delivered is subject to the informed consent of the voluntary consumer and wherever possible, by the involuntary consumer in accordance with Commonwealth and state/territory jurisdictional and legislative requirements.	2.4	The health service organisation ensures that its informed consent processes comply with legislation and best practice	

1.4	The MHS provides consumers and their carers with a written statement, together with a verbal explanation of their rights and responsibilities, in a way that is understandable to them as soon as possible after entering the MHS and at regular intervals throughout their care.	2.3	The health service organisation has a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers	The Charter and the action do not explicitly mention 'responsibilities', but there is a document titled 'Roles in realising the Australian Charter of Healthcare Rights' that closely approximates the Statement of Rights and Responsibilities: https://www.safetyandquality.gov.au/wp-content/uploads/2012/01/Roles-in-Realising-the-Australian-Charter-of-Healthcare-Rights-PDF-1232-KB.pdf
1.5	Staff and volunteers are provided with a written statement of the rights and responsibilities of consumers and carers, together with a written code of conduct as part of their induction to the MHS.	1.19	The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation	
		2.3	The health service organisation has a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers	The 'Roles' document (see above) also covers the basic principles of a code of conduct

1.6	The MHS communicates with consumers, carers and other service providers and applies the rights and responsibilities of involuntary patients as per relevant Commonwealth, state/territory mental health legislation and related Acts.	2.10	The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided at discharge	Could also link to **NSQHSS 1.7**, compliance with legislation
1.7	The MHS upholds the right of the consumer to have their needs understood in a way that is meaningful to them and appropriate services are engaged when required to support this.	2.10	The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided at discharge	
1.8	The MHS upholds the right of the consumer to have their privacy and confidentiality recognised and maintained to the extent that it does not impose serious risk to the consumer or others.			Partial match: **NSQHSS 1.16** covers privacy and confidentiality related to healthcare records, but not other communications

1.9	The MHS upholds the right of the consumer to be treated in the least restrictive environment to the extent that it does not impose serious risk to the consumer or others.			No direct NSQHSS match in terms of upholding the right, but following NSQHSS actions support delivering least restrictive care: **NSQHSS 1.29 & 1.30** (safe environment); **NSQHSS 5.33 & 5.34** (preventing and minimising risks related to aggression); **NSQHSS 5.35 & 5.36** (minimising restrictive practices)
1.10	The MHS upholds the right of the consumer to be involved in all aspects of their treatment, care and recovery planning.	2.6	The health service organisation has processes for clinicians to partner with patients and/or their substitute decision maker to plan, communicate, set goals and make decisions about their current and future care	
1.11	The MHS upholds the right of the consumer to nominate if they wish to have (or not to have) others involved in their care to the extent that it does not impose serious risk to the consumer or others.	2.6	The health service organisation has processes for clinicians to partner with patients and/or their substitute decision maker to plan, communicate, set goals and make decisions about their current and future care	Partial match: NSQHSS action covers right, but does not specify right not to have others involved
1.12	The MHS upholds the right of carers to be involved in the management of the consumer's care with the consumer's informed consent.	2.6	The health service organisation has processes for clinicians to partner with patients and/or their substitute decision maker to plan, communicate, set goals and make decisions about their current and future care	
1.13	The MHS upholds the right of consumers to have access to their own health records in accordance with Commonwealth, state/territory legislation.			Does not specify right of access to healthcare records. Some link to **NSQHSS 1.17a & 1.18a**

1.14	The MHS enacts policy and procedures to ensure that personal and health related information is handled in accordance with Commonwealth, state/territory privacy legislation when personal information is communicated to health professionals outside the MHS, carers or other relevant agencies.	1.16	The health service organisation has healthcare records systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systemic audit of clinical information e. Integrate multiple information systems, where they are used	
1.15	The MHS upholds the right of the consumer to access advocacy and support services.			Advocacy in the sense of representing the interests of consumers is addressed in the NSQHS Standards (e.g. 2.5) Advocacy in the specific sense of consumers choosing who can represent them legally is not addressed, but critical in the mental health context
1.16	The MHS upholds the right of the consumer to express compliments, complaints and grievances regarding their care and to have them addressed by the MHS.	1.13	The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems	

1.16 cont.		1.14	The health service organisation has an organisation-wide complaints management system and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and takes action to improve the effectiveness of the complaints management system	
1.17	The MHS upholds the right of the consumer, wherever possible, to access a staff member of their own gender.			Choice re gender of staff member not addressed in NSQHS Standards

	National Standards for Mental Health Services Standard 2: Safety		National Safety and Quality Health Service Standards (second edition)	Comments
2.1	The MHS promote the optimal safety and wellbeing of the consumer in all mental health settings and ensures that the consumer is protected from abuse and exploitation.			NSQHS Standards address promotion of safety and wellbeing, but do not explicitly address protection from abuse and exploitation Link to **NSQHSS 2.3** Charter of Healthcare Rights
2.2	The MHS reduces and where possible eliminates the use of restraint and seclusion within all MHS settings.	5.35	Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body	
		5.36	Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation c. Report use of seclusion to the governing body	
2.3	The MHS assesses and minimises the risk of deliberate self harm and suicide within all MHS settings.	5.31	The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed	

2.4	The MHS minimises the occurrence of adverse medication events within all MHS settings.	4.2	The health service organisation applies the quality improvement system in the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management	
		4.3	Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision making	
		4.4	The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians	
		4.5	Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care	
		4.6	Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care	

2.4 cont.		4.7	The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation	
		4.8	The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system	
		4.9	The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements	
		4.10	The health service organisation has processes: a. To undertake medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews based on a patient's clinical needs and minimising the risk of medicine-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result	
		4.11	The health service organisation has processes to support clinicians to provide patients with information on their individual medicines needs and risks	
		4.13	The health service organisation ensures that information and decision support tools for medicines are available to clinicians	

2.5	The MHS complies with relevant Commonwealth and state/territory transport policies and guidelines, including the current National Safe Transport Principles.			ACSQHC working with transport services to develop strategies to implement the NSQHS Standards
2.6	The MHS meets their legal occupational health and safety obligations to provide a safe workplace and environment.	1.7	The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements	
		1.29	The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities and devices and other infrastructure that are fit for purpose	
		1.30	The health service organisation: a. Identifies service areas where there is a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required	
		3.5	The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the *Australian guidelines for the prevention and control of infection in healthcare*, and jurisdictional requirements	

2.6 cont.		3.11	The health service organisation has processes to maintain a clean and hygienic environment – in line with the current edition of the *Australian guidelines for the prevention and control of infection in healthcare*, and jurisdictional requirements – that: a. Respond to environmental risks b. Require cleaning and disinfection in line with recommended cleaning frequencies c. Include training in the appropriate use of specialised personal protective equipment for the workforce	
		5.33	The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
		5.34	The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers and families, and the workforce	
2.7	The MHS complies with infection control requirements.	3.1	The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for healthcare-associated infections and antimicrobial stewardship b. Managing risks associated with healthcare-associated infections and antimicrobial stewardship c. Identifying training requirements for preventing and controlling healthcare-associated infections, and antimicrobial stewardship	

2.7 cont.		3.2	The health service organisation applies the quality improvement system in the Clinical Governance Standards when: a. Monitoring the performance of systems for prevention and control of healthcare-associated infections, and the effectiveness of the antimicrobial stewardship program b. Implementing strategies to improve outcomes and associated processes of systems for prevention and control of healthcare-associated infections, and antimicrobial stewardship c. Reporting on the outcomes of prevention and control of healthcare-associated infections, and the antimicrobial stewardship program	
		3.3	Clinicians use organisational processes from the Partnering with Consumers Standard when preventing and managing healthcare-associated infections, and implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
		3.5	The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the *Australian guidelines for the prevention and control of infection in healthcare,* and jurisdictional requirements	
2.8	The MHS can demonstrate investment in adequate staffing and resources for the safe delivery of care.	1.5	The health service organisation considers the safety and quality of health care for patients in its business decision-making	Partial match: 'can demonstrate' (NSMHS) is stronger than 'considers' (NSQHS Standards). Also, NSQHS Standards don't explicitly mention staffing

2.9	The MHS conducts a risk assessment of staff working conditions and has documented procedures to manage and mitigate identified risks.	1.10	The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters	
2.10	Staff are regularly trained to, wherever possible, prevent, minimise and safely respond to aggressive and other difficult behaviours.	1.20	The health service organisation uses it training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these Standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training	
		5.33	The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
		5.34	The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers and families, and the workforce	

2.11	The MHS conducts risk assessment of consumers throughout all stages of the care continuum, including consumers who are being formally discharged from the service, exiting the service temporarily and/or are transferred to another service.	5.10	Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues and risks of harm c. To identify social and other circumstances that may compound these risks	
		5.11	Clinicians comprehensively assess the conditions and risks identified through the screening process	
		6.7	The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover	
		6.9	Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient	
		6.10	The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	

2.11 cont.		8.4	The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	
		8.5	The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible cause for acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state	

2.12	The MHS conducts regular reviews of safety in all MHS settings, including an environmental appraisal for safety to minimise risk for consumers, carers, families, visitors and staff.	1.10	The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters	
		1.29	The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities and devices and other infrastucture that are fit for purpose	
		1.30	The health service organisation: a. Identifies service areas where there is a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm b. Provides access to a calm and quiet environment when it is clinically required for patients, carers, families, consumers and the workforce	
		3.11	The health service organisation has processes to maintain a clean and hygienic environment – in line with the current edition of the *Australian guidelines for the prevention and control of infection in healthcare*, and jurisdictional requirements – that: a. Respond to environmental risks	

2.12 cont.		3.11 cont.	b. Require cleaning and disinfection in line with recommended cleaning frequencies c. Include training in the appropriate use of specialised personal protective equipment for the workforce	
2.13	The MHS has a formal process for identification, mitigation, resolution (where possible) and review of any safety issues.	1.1	The governing body: a. Provides leadership to promote a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance	The remainder of the Clinical Governance for Health Service Organisations Standard outlines the formal process in detail, under the criteria of: • Management and executive leadership • Clinical leadership • Policies and procedures • Quality improvement • Risk management • Incident management systems and open disclosure • Feedback and complaints management • Diversity and high-risk groups • Healthcare records • Safety and quality training • Performance management • Credentialling and scope of clinical practice • Safety and quality roles and responsibilities • Evidence-based care • Variation in clinical practice and health outcomes

	National Standards for Mental Health Services Standard 3: Consumer and carer participation		National Safety and Quality Health Service Standards (second edition)	Comments
3.1	The MHS has processes to actively involve consumers and carers in planning, service delivery, evaluation and quality programs.	2.11	The health service organisation: a. Involves consumers in partnerships in the governance and to design, measure and evaluate health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community	
3.2	The MHS upholds the right of the consumer and their carer(s) to have their needs and feedback taken into account in the planning, delivery and evaluation of services.	1.13	The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems	
3.3	The MHS provides training and support for consumers, carers and staff, which maximise consumer and carer(s) representation and participation in the MHS.	2.12	The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation	
3.4	Consumers and carers have the right to independently determine who will represent their views to the MHS.			Link to **NSQHSS 2.6** clinicians partner with patients and substitute decision maker

3.5	The MHS provides ongoing training and support to consumers and carers who are involved in formal advocacy and/or support roles within the MHS.	2.12	The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation	
3.6	Where the MHS employs consumers and carers, the MHS is responsible for ensuring mentoring and supervision is provided.			Peer workforce not addressed in NSQHS Standards
3.7	The MHS has policies and procedures to assist consumers and carers to participate in the relevant committees, including payment (direct or in-kind) and/or reimbursement of expenses when formally engaged in activities undertaken for the MHS.			Link to **NSQHSS 2.11 & 2.12** for policies and procedures Remuneration for participation not covered in NSQHS Standards, cf. Remuneration Tribunal Determination

	National Standards for Mental Health Services Standard 4: Diversity responsiveness		National Safety and Quality Health Service Standards (second edition)	Comments
4.1	The MHS identifies the diverse groups (Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse (CALD), religious/spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age and socio-economic status) that access the service.	1.15	The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using it services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care	
4.2	The MHS whenever possible utilises available and reliable data on identified diverse groups to document and regularly review the needs of its community and communicates this information to staff.	1.15	The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using it services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care	
4.3	Planning and service implementation ensures differences and values of its community are recognised and incorporated as required.	1.15	The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using it services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care	
		2.13	The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	

4.4	The MHS has demonstrated knowledge of and engagement with other service providers or organisations with diversity expertise/programs relevant to the unique needs of its community.			Link to **NSQHSS 2.8** HSO communicates to diversity of consumers and local communities
4.5	Staff are trained to access information and resources to provide services that are appropriate to the diverse needs of its consumers.			Links to **NSQHSS 1.21** cultural competency in relation to Aboriginal and Torres Strait Islanders, but not other groups
4.6	The MHS addresses issues associated with prejudice, bias and discrimination in regards to its own staff to ensure non-discriminatory practices and equitable access to services.			**NSQHSS 1.20** (training), **NSQHSS 1.21** (cultural competence re Aboriginal and Torres Strait Islander people), **NSQHSS 1.22** (performance management) and **NSQHSS 2.2** (QI for partnering with consumers) may all contribute to meeting **NSMHS 4.6**, but do not directly address workforce prejudice

	National Standards for Mental Health Services Standard 5: Promotion and prevention		National Safety and Quality Health Service Standards (second edition)	Comments
5.1	The MHS develops strategies appropriate to the needs of its community to promote mental health and address early identification and prevention of mental health problems and/or mental illness that are response to the needs of its community, by establishing and sustaining partnership with consumers, carers, other service providers and relevant stakeholders.			Health promotion not covered in NSQHS Standards Early identification and prevention partially covered under **NSQHSS 1.15** diversity of consumers using services and higher risk groups
5.2	The MHS develops implementation plans to undertake promotion and prevention activities, which include the prioritisation of the needs of its community and the identification of resources required for implementation, in consultation with their partners.			See **NSMHS 5.1**
5.3	The MHS, in partnership with other sectors and settings supports the inclusion of mental health consumers and carers in strategies and activities that aim to promote health and wellbeing.			See **NSMHS 5.1**
5.4	The MHS evaluates strategies, implementation plans, sustainability of partnership and individual activities in consultation with their partners. Regular progress reports on achievements are provided to consumers, carers, other service providers and relevant stakeholders.			**NSQHSS 1.9** asks the health service organisation to report on safety and quality systems and performance, including to consumers, the local community and other relevant health service organisations, but not explicitly on established partnerships

5.5	The MHS identifies a person who is accountable for developing, implementing and evaluating promotion and prevention activities.			See **NSMHS 5.1**
5.6	The MHS ensures that their workforce is adequately trained in the principles of mental health promotion and prevention and their applicability to the specialised mental health service context with appropriate support provided to implement mental health promotion and prevention activities.			See **NSMHS 5.1**

	National Standards for Mental Health Services Standard 6: Consumers		National Safety and Quality Health Service Standards (second edition)	Comments
6.1	Consumers have the right to be treated with respect and dignity at all times.	2.3	The health service organisation has a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers	
6.2	Consumers have the right to receive service free from abuse, exploitation, discrimination, coercion, harassment and neglect.			Link to **NSQHSS 2.3** Charter of healthcare rights
6.3	Consumers have the right to receive a written statement, together with a verbal explanation, of their rights and responsibilities in a way that is understandable to them as soon as possible after entering the MHS.	2.3	The health service organisation has a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers	
6.4	Consumers are continually educated about their rights and responsibilities.			Link to **NSQHSS 2.3** charter, and **NSQHSS 2.10** communication so that information needs are met
6.5	Consumers have the right to receive the least restrictive treatment appropriate, considering the consumer's preference, the demands on carers, and the availability of support and safety of those involved.			See **NSMHS 1.9** least restrictive: No direct NSQHS Standard match in terms of upholding the right, but following NSQHS Standard actions support delivering least restrictive care: **NSQHSS 1.29 & 1.30** (safe environment); **NSQHSS 5.33 & 5.34** (preventing and minimising risks related to aggression); **NSQHSS 5.35 & 5.36** (minimising restrictive practices)

6.6	A mental health professional responsible for coordinating clinical care is identified and made known to consumers.	5.4	The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify at all times the clinician with overall accountability for a patient's care	
6.7	Consumers are partners in the management of all aspects of their treatment, care and recovery planning.	2.6	The health service organisation has processes for clinicians to partner with patients and/or their substitute decision maker to plan, communicate, set goals and make decisions about their current and future care	
		2.7	The health service organisation supports the workforce to form partnership with patients and carers so that patients can be actively involved in their own care	
6.8	Informed consent is actively sought from consumers prior to any service or intervention provided or any changes in care delivery are planned, where it is established that the consumer has capacity to give informed consent.	2.4	The health service organisation ensures that its informed consent processes comply with legislation and best practice	
		2.5	The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision maker if a patient does not have the capacity to make decisions for themselves	

6.9	Consumers are provided with current and accurate information on the care being delivered.	2.10	The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided at discharge	
6.10	Consumers have the right to choose from the available range of treatment and support programs appropriate to their needs.	2.6	The health service organisation has processes for clinicians to partner with patients and/or their substitute decision maker to plan, communicate, set goals and make decisions about their current and future care	
6.11	The right of consumers to involve or not to involve carers and others is recognised and respected by the MHS.			The right to involve is covered in NSQHS Standards (e.g. **NSQHSS 2.6**), but the right not to involve, frequent in the mental health context, is not
6.12	Consumers have an individual exit plan with information on how to re-enter the service if needed.			Link to **NSQHSS 2.10d** information needs for ongoing care are provided at discharge and **NSQHSS 5.13e** referral to follow up services

6.13	Consumers are actively involved in follow-up arrangements to maintain continuity of care.	5.13	Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies any support people a patient wants involved in communications and decision making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and where available f. Is consistent with best practice and evidence	
		6.8	Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care	

6.14	The right of consumers to have access to their own health records is recognised in accordance with relevant Commonwealth and state/territory legislation/guidelines.			See **NSMHS 1.13** Link to **NSQHSS 1.16, 1.17, 1.18**
6.15	Information about consumers can be accessed by authorised persons only.	1.16	The health service organisation has healthcare records systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used	
6.16	The right of the consumer to have visitors and maintain close relationships with family and friends is recognised and respected by the MHS.	1.32	The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet the patient's needs, when it is safe to do so	
6.17	Consumers are engaged in development, planning, delivery and evaluation of the MHS.	2.11	The health service organisation: a. Involves consumers in partnerships in the governance and to design, measure and evaluate health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community	

6.18	Training and support is provided for consumers involved in a formal advocacy and/or support role within the MHS.			Link to **NSQHSS 2.12** orientation, support and education for consumers who partner in design, management and evaluation (note advocacy not specified). Not applicable if referring to peer workforce, which is not covered in NSQHS Standards

	National Standards for Mental Health Services Standard 7: Carers		National Safety and Quality Health Service Standards (second edition)	Comments
7.1	The MHS has clear policies and service delivery protocols to enable staff to effectively identify carers as soon as possible in all episodes of care, and this is recorded and prominently displayed within the consumer's health record.			Link to **NSQHSS 2.5** identification of substitute decision maker, **NSQHSS 2.6** partner with patients and SDM on shared decision making, **NSQHSS 2.10** communication with patients and carers to meet information needs
7.2	The MHS implements and maintains ongoing engagement with carers as partners in the delivery of care as soon as possible in all episodes of care.	2.7	The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care	
		5.13	Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies any support people a patient wants involved in communications and decision making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and where available f. Is consistent with best practice and evidence	

7.3	In circumstances where a consumer refused to nominate their carer(s), the MHS reviews this status at regular intervals during the episode of care in accordance with Commonwealth and state/territory jurisdictional and legislative requirements.			Very specific to mental health
7.4	The MHS provides carers with a written statement, together with a verbal explanation of their rights and responsibilities in a way that is understandable to them as soon as possible after engaging with the MHS.	2.3	The health service organisation has a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers	
7.5	The MHS considers the needs of carers in relation to Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse (CALD) persons, religious/spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age profile and socio-economic status.			Link to **NSQHSS 1.15** recognising diversity, and **NSQHSS 1.21** cultural awareness, but note NSQHS Standards (2nd ed.) doesn't specify carers in these actions
7.6	The MHS considers the special needs of children and aged person as carers and makes appropriate arrangements for their support.			Not addressed with this specificity in NSQHS Standards
7.7	The MHS has documented policies and procedures for clinical practice in accordance with Commonwealth, state/territory privacy legislation and guidelines that address the issues of sharing confidential information with carers.			Not explicitly addressed, but links to **NSQHSS 1.16** healthcare record, **NSQHSS 2.5** identifying SDM, **NSQHSS 2.10** information that meets needs
7.8	The MHS ensure information regarding identified carers is accurately recorded in the consumer's health record and reviewed on a regular basis.			Documentation not explicitly addressed

7.9	The MHS provides carers with non-personal information about the consumer's mental health condition, treatment and ongoing care and if applicable, rehabilitation.	6.9	Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient	
7.10	The MHS actively seeks information from carers in relation to the consumer's condition during assessment, treatment and ongoing care and records that information in the consumer's health record.	2.6	The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care	
		5.13	Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies any support people a patient wants involved in communications and decision making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and where available f. Is consistent with best practice and evidence	

7.10 cont.		5.31	The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed	
		5.34	The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers and families, and the workforce	
		6.10	The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	
7.11	The MHS actively encourages routine identification of carers in the development of relapse prevention plans.			Links to inclusion of support people in development of comprehensive care plan **NSQHSS 5.13**, but not this explicit

7.12	The MHS engages carers in discharge planning involving crisis management and continuing care prior to discharge from all episodes of care.	5.13	Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies any support people a patient wants involved in communications and decision making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and where available f. Is consistent with best practice and evidence	
		6.8	Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care	

7.13	The MHS provides information about and facilitates access to services that maximise the wellbeing of carers.			Not explicitly addressed
7.14	The MHS actively seeks participation of carers in the policy development, planning, delivery and evaluation of services to optimise outcomes for consumers.			Links to **NSQHSS 2.11,** but doesn't explicitly mention carers
7.15	The MHS provides ongoing training and support to carers who participate in representational and advocacy roles.			Links to **NSQHSS 2.12**, though doesn't explicitly mention carers or advocacy
7.16	The MHS provides training to staff to develop skills and competencies for working with carers.	2.7	The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care	
7.17	The MHS has documented policies and procedures for working with carers.			

	National Standards for Mental Health Services Standard 8: Governance, leadership and management		National Safety and Quality Health Service Standards (second edition)	Comments
8.1	The governance of the MHS ensures that its services are integrated and coordinated with other services to optimise continuity of effective care for its consumers and carers.			Coordination of individual's care addressed, but not integration with other services
8.2	The MHS has processes to ensure accountability for developing strategies to promote mental health and address early identification and prevention of mental health problems and/or mental illness.			Early identification of mental health problems covered in comprehensive care, but not promotion of mental health
8.3	The MHS develops and regularly reviews its strategic plan in conjunction with all relevant service providers. The plan incorporates needs analysis, resource planning and service evaluation. This should be developed with the participation of staff, stakeholders, consumers, carers and representatives of its community.	1.1	The governing body: a. Provides leadership to promote a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance	

8.4	The MHS has processes in place to ensure compliance with relevant Commonwealth, state/territory mental health legislation and related Acts.	1.7	The health service organisation uses a risk management approach to: a. Set out, review and maintain the currency and effectiveness of policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements	
8.5	Identified resources are allocated to support the documented priorities of the MHS.			Links to **NSQHSS 1.5**, HSO considers S & Q in business decision making
8.6	The recruitment and selection process of the MHS ensures that staff have the skills and capability to perform the duties required of them.	1.23	The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered	
		1.24	The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process	

8.7	Staff are appropriately trained, developed and supported to safely perform the duties required of them.	1.6	Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients	
		1.20	The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory graining program to meet its requirements arising from these Standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training	
		1.22	The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system	
		1.25	The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff	

8.7 cont.		1.26	The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate	
8.8	The MHS has a policy and process to support staff during and after critical incidents.			Links to **NSQHSS 1.11** incident management and **NSQHSS 1.12** open disclosure
8.9	The MHS manages and maintains an information system that facilitates the appropriate collections, use, storage, transmission and analysis of data to enable review of services and outcomes at an individual consumer and MHS level in accordance with Commonwealth, state/territory legislation and related Acts.	1.16	The health service organisation has healthcare records systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used	
8.10	The MHS has an integrated risk management policy and practices to identify, evaluate, monitor, manage and communicate organisational and clinical risks.	1.10	The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters	

8.11	The MHS has a formal quality improvement program incorporating evaluation of its services that result in changes to improve practice.	1.8	The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems	

	National Standards for Mental Health Services Standard 9: Integration		National Safety and Quality Health Service Standards (second edition)	Comments
9.1	The MHS ensures that a person responsible for the coordination of care is available to facilitate coordinated and integrated services throughout all stages of care for consumers and carers.	5.4	The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify at all times the clinician with overall accountability for a patient's care	
9.2	The MHS has formal processes to support and sustain interdisciplinary care teams.	5.5	The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team	

9.3	The MHS facilitates continuity of integrated care across programs, sites and other related services with appropriate communication, documentation and evaluation to meet the identified needs of consumers and carers.	5.13	Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies any support people a patient wants involved in communications and decision making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and where available f. Is consistent with best practice and evidence	
		6.4	The health service organisation has clinical communication processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	

9.4	The MHS establishes links with the consumers' nominated primary health care provider and has procedures to facilitate and review internal and external referral processes.			Links to **NSQHSS 6.4b** HSO has clinical communications processes to support effective communication between organisations, but does not specify primary care provider as lynchpin
9.5	The MHS has formal processes to develop inter-agency and intersectoral links and collaboration.			

	National Standards for Mental Health Services Standard 10: Delivery of care		National Safety and Quality Health Service Standards (second edition)	Comments
10.1	**Supporting recovery**			
10.1.1	The MHS actively supports and promotes recovery oriented values and principles in its policies and practices.			Links to Partnering with Consumers standard. Note that subsequent to NSMHS 2010, Health Ministers have endorsed a more complete *Framework for recovery-oriented mental health services* (2013)
10.1.2	The MHS treats consumers and carers with respect and dignity.	2.3	The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers	
10.1.3	The MHS recognises the lived experience of consumers and carers and supports their personal resourcefulness, individuality, strengths and abilities.			Links to **NSQHSS 2.3** Charter, **NSQHSS 1.15** diversity
10.1.4	The MHS encourages and supports the self determination and autonomy of consumers and carers.			Links to **NSQHSS 2.6** Set goals, make decisions
10.1.5	The MHS promotes the social inclusion of consumers and advocates for their rights of citizenship and freedom from discrimination.			Contains two related, but discrete actions

10.1.6	The MHS provides education that supports consumer and carer participation in goal setting, treatment, care and recovery planning, including the development of advance directives.	2.6	The health service organisation has processes for clinicians to partner with patients and/or their substitute decision maker to plan, communicate, set goals and make decisions about their current and future care	
		2.7	The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care	
		5.9	Patients are supported to document clear advance care plans	
10.1.7	The MHS supports and promotes opportunities to enhance consumers' positive social connections with family, children, friends and their valued community.			Not covered in these terms, but note *National framework for recovery oriented mental health services* (2013)
10.1.8	The MHS demonstrates systems and processes for consumer and carer participation in the development, delivery and evaluation of services.	2.11	The health service organisation: a. Involves consumers in partnerships in the governance and to design, measure and evaluate health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community	
10.1.9	The MHS has a comprehensive knowledge of community services and resources and collaborates with consumers and carers to assist them to identify and access relevant services.			
10.1.10	The MHS provides access for consumers and their carer(s) to a range of carer-inclusive approaches to service delivery and support.			

	National Standards for Mental Health Services Standard 10: Delivery of care		National Safety and Quality Health Service Standards (second edition)	Comments
10.2	**Access**			
10.2.1	Access to available services meets the identified needs of its community in a timely manner.	1.15	The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using it services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care	
		5.7	The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'minimising patient harm' criterion	
10.2.2	The MHS informs its community about the availability, range of services and methods for establishing contact with its service.	2.8	The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community	
10.2.3	The MHS makes provision for consumers to access acute services 24 hours per day by either providing the service itself or information about how to access such care from a 24/7 public mental health service or alternate mental health service.			Links to **NSQHSS 8.12**, but stronger
10.2.4	The MHS, wherever possible, is located to provide ease of physical access with special attention being given to those people with physical disabilities and/or reliance on public transport.			Links to **NSQHSS 1.29 & 1.31**, but proximity to public transport not covered

	National Standards for Mental Health Services Standard 10: Delivery of care		National Safety and Quality Health Service Standards (second edition)	Comments
10.3	**Entry**			
10.3.1	The MHS has a written description of its entry process, inclusion and exclusion criteria and means of facilitating access to alternative care for people not accepted by the service.			Alternate service advice not covered
10.3.2	The MHS makes known its entry process, inclusion and exclusion criteria to consumers, carers, other service providers, and relevant stakeholders including police, ambulance services and emergency departments.			Links to **NSQHSS 2.8**, communication for partnerships
10.3.3	The MHS has a documented system for prioritising referrals according to risk, urgency, distress, dysfunction and disability with timely advice and/or response to all those referred, at the time of assessment.	5.4	The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify at all times the clinician with overall accountability for a patient's care	
		5.7	The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'minimising patient harm' criterion	

10.3.4	The entry process to the MHS is a defined pathway with service specific entry points that meet the needs of the consumer, their carer(s) and its community that are complementary to any existing generic health or welfare intake systems.			
10.3.5	Entry to the MHS minimises delay and the need for duplication in assessment, treatment, care and recovery planning and care delivery.			Link to **NSQHSS 5.10** screening in Comp Care, but minimising duplication not explicitly stated
10.3.6	Where admission to an inpatient psychiatric service is required, the MHS makes every attempt to facilitate voluntary admission for the consumer and continue voluntary status for the duration of the stay.			
10.3.7	When the consumer requires involuntary admission to the MHS the transport occurs in the safest and most respectful manner possible and complies with relevant Commonwealth and state/territory policies and guidelines, including the National Safe Transportation Principles.			
10.3.8	The MHS ensures that a consumer and their carer(s) are able to identify a nominated person responsible for coordinating their care and informing them about any changes in the care management.	5.4	The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify at all times the clinician with overall accountability for a patient's care	

	National Standards for Mental Health Services Standard 10: Delivery of care		National Safety and Quality Health Service Standards (second edition)	Comments
10.4	**Assessment and review**			
10.4.1	Assessments conducted and diagnoses made are evidence-based and use accepted methods and tools, as well as internally accepted disease classification systems.	1.27	The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant Clinical Care Standards developed by the Australian Commission on Safety and Quality in Health Care	
10.4.2	Assessments are conducted during the consumer's first contact with the MHS by appropriately qualified staff experienced and trained in assessing mental health problems, and where possible in a consumer's preferred setting with consideration of safety for all involved.	1.23	The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered	

		5.4	The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify at all times the clinician with overall accountability for a patient's care	
10.4.3	The MHS, with the consumer's informed consent includes carers, other service providers and others nominated by the consumer in assessment.	5.13	Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies any support people a patient wants involved in communications and decision making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and where available f. Is consistent with best practice and evidence	

10.4.4	The MHS actively plans as early as possible in the course of psychiatric inpatient admission, for the discharge of the consumer from inpatient care.	5.13	Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies any support people a patient wants involved in communications and decision making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and where available f. Is consistent with best practice and evidence	
10.4.5	The MHS conducts a review of a consumer's treatment, care and recovery plan when the consumer: • Requests a review • Declines treatment and support • Is at significant risk of injury to themselves or another person • Receives involuntary treatment or is removed from an involuntary order • Is transferred between service sites • Is going to exit the MHS • Is observed through monitoring of their outcomes (satisfaction with service, measure of quality of life, measure of functioning) to be in decline.	5.14	The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur	

10.4.5 cont.		6.8	Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care	
		8.6	The health service organisation has protocols that specify agreed criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling for emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration	
		8.7	The health service organisation has processes for patients, carers or families to directly escalate care	

10.4.6	The MHS conducts assessment and review of the consumer's treatment, care and recovery plan, whether involuntary or voluntary, at least every three months (if not previously required for reasons state in criteria 10.4.5 above).			Set period for review not driven by clinical condition not specified in NSQHS Standards (2nd ed.)
10.4.7	The MHS has a procedure for appropriate follow-up of those who decline to participate in an assessment.			
10.4.8	There is a current individual interdisciplinary treatment, care and recovery plan, which is developed in consultation with and regularly reviewed with the consumer and with the consumer's informed consent, their carer(s) and the treatment, care and recovery plan is available to both of them.	5.4	The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify at all times the clinician with overall accountability for a patient's care	

10.4.8 cont.		5.13	Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies any support people a patient wants involved in communications and decision making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and where available f. Is consistent with best practice and evidence	
		5.14	The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur	

	National Standards for Mental Health Services Standard 10: Delivery of care		National Safety and Quality Health Service Standards (second edition)	Comments
10.5	**Treatment and support**			
10.5.1	Treatment and support provided by the MHS reflects best available evidence and emphasises early intervention and positive outcomes for consumers and their carer(s).	1.27	The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant Clinical Care Standards developed by the Australian Commission on Safety and Quality in Health Care	
10.5.2	Treatment and services provided by the MHS are responsive to the changing needs of consumers during their episodes of care that address acute needs, promote rehabilitation and support recovery.	5.3	Clinicians use organisational processes from the partnering with consumers standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision making	

10.5.2 cont.		5.13	Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies any support people a patient wants involved in communications and decision making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and where available f. Is consistent with best practice and evidence	
10.5.3	The MHS is responsible for providing the consumer and their carer(s) with information on the range and implications of available therapies.	2.10	The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided at discharge	
10.5.4	Any participation of the consumer in clinical trials and experimental treatments is subject to the informed consent of the consumer.			

10.5.5	The MHS provides the least restrictive and most appropriate treatment and support possible. Consideration is given to the consumer's needs and preferences, the demands on carers, and the availability of support and safety of those involved.			
10.5.6	Medications are prescribed, stored, transported, administered and reviewed by authorised persons in a manner consistent with Commonwealth, state/territory legislation and related Acts, regulations and professional guidelines.	4.4	The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians	
		4.14	The health service organisation complies with manufactures' directions, legislation and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines	
		4.15	The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely	

10.5.7	The MHS actively promotes adherence to evidence based treatments through negotiation and the provision of understandable information to the consumer.	1.27	The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant Clinical Care Standards developed by the Australian Commission on Safety and Quality in Health Care	
		2.10	The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided at discharge	
10.5.8	The views of the consumer and their carer(s), and the history of previous treatment is considered and documented prior to administration of new medication and/or other technologies.	4.3	Clinicians use organisational processes from the partnering with consumers standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision making	
		4.5	Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care	

10.5.8 cont.		4.6	Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care	
		4.10	The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirement for documentation of medication reviews, including actions taken as a result	
10.5.9	The MHS ensures that there is continuity of care or appropriate referral and transfer between inpatient, outpatient, day patient, community settings and other health/support services.	6.4	The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	
10.5.10	The MHS ensures that medication and or other therapies when required, are only used as part of a documented continuum of treatment strategies.			Links to **NSQHSS 1.27** evidence based care and **NSQHSS 5.13** development of comprehensive care plan

10.5.11	The treatment and support provided by the MHS is developed and evaluated collaboratively with the consumer and their carer(s). This is documented in the current individual treatment, care and recovery plan.	5.3	Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision making	
		5.13	Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies any support people a patient wants involved in communications and decision making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and where available f. Is consistent with best practice and evidence	
10.5.12	The MHS facilitates access to an appropriate range of agencies, programs and/or interventions to meet the consumer's needs for leisure, relationships, recreation, education, training, work, accommodation and employment in settings appropriate to the individual consumer.			Out of scope for NSQHS Standards (2nd ed.)

10.5.13	The MHS supports and/or provides information regarding self-care programs that can enable the consumer to develop or re-develop the competence to meet their everyday living needs.			Out of scope for NSQHS Standards (2nd ed.)
10.5.14	The setting for the learning or re-learning of self-care activities is the most familiar and/or appropriate for the skills required.			Out of scope for NSQHS Standards (2nd ed.)
10.5.15	Information on self-care programs or interventions is provided to consumers and their carer(s) in a way that is understandable to them.	2.10	The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided at discharge	
10.5.16	The MHS endeavours to provide access to a range of accommodation and support options that meet the needs of the consumer and gives the consumer the opportunity to choose between these options.			Out of scope for NSQHS Standards (2nd ed.)
10.5.17	The MHS promotes access to vocational support systems, education and employment programs.			Out of scope for NSQHS Standards (2nd ed.)

	National Standards for Mental Health Services Standard 10: Delivery of care		National Safety and Quality Health Service Standards (second edition)	Comments
10.6	**Exit and re-entry**			
10.6.1	The MHS ensures that on exiting the service the consumer has access to services that promote recovery and aim to minimise psychiatric disability and prevent relapse.			Internal links to **NSMHS 10.1.1** and National Framework for recovery oriented mental health services
10.6.2	The consumer and their carer(s) are provided with understandable information on the range of relevant services and support available in the community.	2.10	The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided at discharge	
10.6.3	The MHS has a process to commence development of an exit plan at the time the consumer enters the service.	5.13	Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies any support people a patient wants involved in communications and decision making about their care	

10.6.3 cont.		5.13 cont.	d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and where available f. Is consistent with best practice and evidence	
10.6.4	The consumer and their carer(s) and other service providers are involved in developing the exit plan. Copies of the exit plan are made available to the consumer and with the consumers' informed consent, their carer(s).	2.6	The health service organisation has processes for clinicians to partner with patients and/or their substitute decision maker to plan, communicate, set goals and make decisions about their current and future care	Part 2 of the NSMHS action, re copies of the plan, not explicitly covered in NSQHS Standard action. Note NSMHS guidelines focus on collaborative development of plan more than who holds a copy
		6.8	Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care	
10.6.5	The MHS provides consumers, their carers and other service providers involved in follow-up with information on the process of re-entering the MHS if required.			Links to **NSQHSS 5.13e & 6.7** handover information that meets needs of consumers and carers, but re-entry not explicitly covered

10.6.6	The MHS ensures ease of access for consumers re-entering the MHS.			Link to Comprehensive care
10.6.7	Staff review the outcomes of treatment and support as well as ongoing follow-up arrangements for each consumer prior to their exit from the MHS.			Two actions: reviewing: a. Outcomes b. Follow-up plans While reviewing outcomes implicit in discharge planning, this is not specifically stated in NSQHS Standards
10.6.8	The MHS, in conjunction with the treating clinician, has a procedure for appropriate follow-up of all consumers within 7 days after discharge from inpatient care wherever possible, and has a follow-up procedure for those consumers who do not keep the planned follow-up arrangements.			Links to **NSQHSS 5.32**, but this is specific to suicide, whereas NSMHS covers all mental health conditions

Appendix 1: Map of NSHMHS with the first edition of NSQHS Standards

From the Accreditation Workbook for Mental Health Services. Sydney, ACSQHC 2014.

MH	SQ	
C	C	AR
1.1	1.17	1.17.1
1.2	1.1	1.1.1
1.3	1.18	1.18.2
1.4	1.17	1.17.2
1.5	1.17	1.17.1
1.6	1.1	1.1.1
1.7	1.17	1.17.3
1.8	1.19	1.19.2
1.9		
1.10	1.18	1.18.1
1.11	1.18	1.18.1
1.12	1.18	1.18.1
1.13	1.1	1.1.1
1.14	1.1	1.1.1
1.15		
1.16	1.15	1.15.1
		1.15.2
		1.15.3
		1.15.4
1.17		

MH	SQ	
C	C	AR
2.1		
2.2		
2.3	1.8	1.8.1
2.4	4.2	4.2.1
		4.2.2
2.5		
2.6	3.7	3.7.1
2.7	3.1	3.1.1
		3.1.2
		3.1.3
		3.1.4
	3.5	3.5.1
		3.5.2
		3.5.3
2.8	1.2	1.2.2
2.9	3.7	3.7.1
2.10	1.4	1.4.2
2.11	1.8	1.8.1
2.12	3.15	3.15.1
		3.15.2
		3.15.3
2.13	1.2	1.2.2
	1.14	1.14.1
		1.14.2
		1.14.3
		1.14.4
		1.14.5
	3.3	3.3.1
		3.3.2

MH	SQ	
C	C	AR
3.1	2.1	2.1.1
	2.2	2.2.1
		2.2.2
	2.4	2.4.1
	2.5	2.5.1
3.2	1.20	1.20.1
	2.5	2.5.1
	2.9	2.9.1
3.3	2.3	2.3.1
	2.6	2.6.1
3.4		
3.5	2.3	2.3.1
3.6	2.3	2.3.1
3.7	2.1	2.1.1

MH	SQ	
C	C	AR
4.1		
4.2		
4.3	2.1	2.1.2
4.4		
4.5		
4.6		

MH	SQ	
C	C	AR
5.1		
5.2		
5.3		
5.4		
5.5		
5.6		

MH	SQ	
C	C	AR
7.1		
7.2		
7.3		
7.4	1.17	1.17.2
7.5	2.1	2.1.2
7.6		
7.7	1.1	1.1.1
7.8		
7.9		
7.10	6.5	6.5.1
7.11		
7.12	6.5	6.5.1
7.13		
7.14	2.2	2.2.1
7.15	2.3	2.3.1
7.16	2.6	2.6.1
7.17	2.2	2.2.1

MH	SQ	
C	C	AR
8.1	6.1	6.1.1
8.2		
8.3	1.1	1.1.2
8.4	1.1	1.1.1
8.5	1.10	1.10.3
8.6	1.10	1.10.2
8.7	1.3	1.3.1
		1.3.2
	1.4	1.4.1
		1.4.4
	1.10	1.10.5
	1.11	1.11.1
		1.11.2
	1.12	1.12.1
8.8	1.16	1.16.1
		1.16.2
8.9	1.9	1.9.2
8.10	1.2	1.2.1
	1.5	1.5.1
		1.5.2
8.11	1.2	1.2.2
	1.6	1.6.1
		1.6.2

MH	SQ	
C	C	AR
9.1		
9.2		
9.3	1.9	1.9.1
	4.12	4.12.1
		4.12.2
		4.12.3
		4.12.4
9.4	6.1	6.1.1
9.5		

MH	SQ	
C	C	AR
10.1.1		
10.1.2	1.17	1.17.1
10.1.3		
10.1.4		
10.1.5		
10.1.6	1.18	1.18.4
	9.8	9.8.1
10.1.7		
10.1.8	2.2	2.2.1
10.1.9		
10.1.10		
10.2.1		
10.2.2		
10.2.3		
10.2.4		
10.3.1		
10.3.2		
10.3.3		
10.3.4		
10.3.5		
10.3.6	1.1	1.1.1
10.3.7		
10.3.8		
10.4.1	1.7	1.7.1
10.4.2		
10.4.3	1.18	1.18.1
10.4.4		
10.4.5	1.8	1.8.3
	9.9	9.9.1
10.4.6		
10.4.7		
10.4.8		

MH	SQ	
C	C	AR
10.5.1	1.7	1.7.1
10.5.2	1.8	1.8.2
10.5.3	1.18	1.18.3
	4.13	4.13.1
10.5.4		
10.5.5		
10.5.6	4.1	4.1.1
		4.1.2
	4.10	4.10.1
		4.10.2
		4.10.3
		4.10.4
		4.10.5
		4.10.6
10.5.7	1.7	1.7.2
	4.15	4.15.1
		4.15.2
10.5.8	1.18	1.18.1
	4.6	4.6.1
	4.14	4.14.1
10.5.9	6.1	6.1.1
10.5.10	4.14	4.14.1
10.5.11	1.18	1.18.1
10.5.12		
10.5.13		
10.5.14		
10.5.15		
10.5.16		
10.5.17		
10.6.1		
10.6.2		
10.6.3		
10.6.4	6.5	6.5.1
10.6.5		
10.6.6		
10.6.7		
10.6.8		

National Standards for Mental Health Services (MH)

1. Rights and Responsibilities
2. Safety
3. Consumer and Carer Participation
4. Diversity Responsiveness
5. Promotion and Prevention
6. Consumers
7. Carers
8. Governance, Leadership and Management
9. Integration
10. Delivery of care:
    - 10.1 Supporting Recovery
    - 10.2 Access
    - 10.3 Entry
    - 10.4 Assessment and Review
    - 10.5 Treatment and Support
    - 10.6 Exit and Re-entry

Legend:

MH = National Standards for Mental Health Services
SQ = National Safety and Quality Health Service Standards
C = Criteria
AR = Action Required

Note:

Blue font indicates a match between standards

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