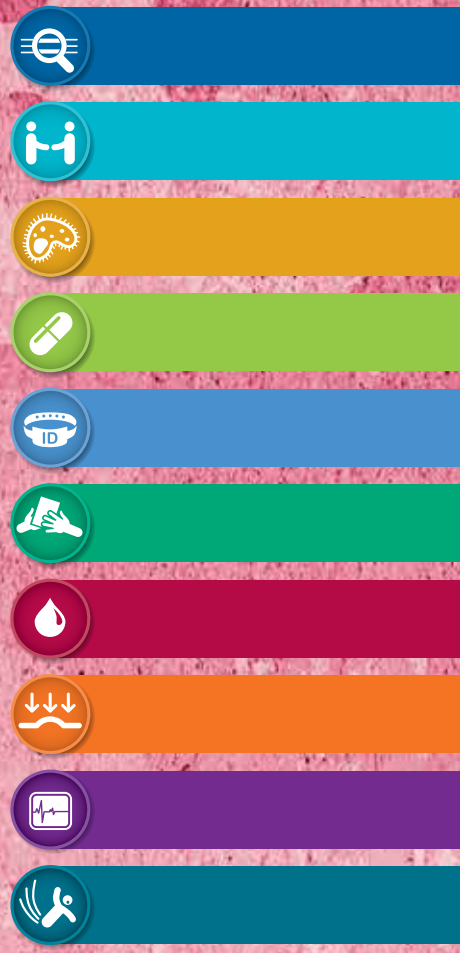
Accreditation Workbook for Mental Health Services

March 2014



AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

National Standards for Mental Health Services

Accreditation Workbook for Mental Health Services, 2014
ISBN Print: 978-1-921983-66-5
ISBN Online: 978-1-921983-60-3

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Suggested citation

Australian Commission on Safety and Quality in Health Care (2014) *Accreditation Workbook for Mental Health Services*, Sydney, ACSQHC.

Acknowledgements

This workbook was prepared by the Australian Commission on Safety and Quality in Health Care, in collaboration with the Department of Health and the Safety and Quality Partnership Standing Committee of the Mental Health and Drug and Alcohol Principal Committee of the Australian Health Ministers' Advisory Council. The Commission wishes to acknowledge the work of its staff in the development of this document.

This document can be downloaded from the ACSQHC website: www.safetyandquality.gov.au

Foreword

The Australian Commission on Safety and Quality in Health Care (the Commission) is pleased to provide health services with the *Accreditation Workbook for Mental Health Services*.

This workbook has been developed through collaborative work between the Commission, the Department of Health, and the Safety and Quality Partnership Standing Committee. This workbook contributes to the ongoing processes of collaboration which aim to ensure the provision of safe, high quality health care to people with mental health conditions.

In 2010, Health Ministers endorsed the *National Standards for Mental Health Services (NSMHS)*. The *NSMHS* present safety standards and best practice guidelines for service delivery to be applied across the broad range of mental health services.

In September 2011, Health Ministers took a significant step towards improving Australia's health system by mandating the *National Safety and Quality Health Service (NSQHS) Standards* and the national accreditation scheme. The new system will, for the first time, create a nationally coordinated safety and quality accreditation scheme for health service organisations.

Accreditation to the *NSQHS Standards* commenced on 1 January 2013. This workbook is intended as a tool for health services implementing and being accredited to both the *NSQHS Standards* and the *NSMHS*.

The workbook maps both sets of standards. The mapping work has shown that there is a significant overlap on the safety aspects of the two standards. It has also provided valuable lessons that have highlighted a number of important aspects of safety in mental health, including advocacy, consent, collaborative care planning to reduce self-harm, and the use of restraint and seclusion. There is a need to continue to work toward embedding these safety and quality aspects into the future revisions of the *NSQHS Standards*.

Professor Debora Picone AM
Chief Executive Officer
Australian Commission on Safety and Quality in Health Care

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Introduction

The Australian Commission on Safety and Quality in Health Care (the Commission) has developed this Accreditation Workbook to assist mental health services to understand and determine if they meet the requirements of the *National Safety and Quality Health Service (NSQHS) Standards*[1] and the *National Standards for Mental Health Services (NSMHS)*[2]. This work was done in collaboration with the Department of Health and the Safety and Quality Partnership Standing Committee (SQPSC) of the Mental Health, Drug and Alcohol Principal Committee of the Australian Health Ministers' Advisory Council.

The *NSQHS Standards* were mandated by Australian Health Ministers in 2011 and provide a clear statement about the level of care consumers can expect from health service organisations. The primary aims of the *NSQHS Standards* are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure minimum standards of safety and quality are met, and a quality improvement mechanism that allows health services to realise aspirational or developmental goals. All Australian public and private hospitals are required to be accredited to the *NSQHS Standards* commencing 2013.

The *National Standards for Mental Health Services (NSMHS)* were endorsed by Australian Health Ministers in 2010. They have been developed to be applied across the broad range of mental health services. They are designed to represent one component of the environment of different quality, safety and performance frameworks that influence service delivery[2].

This Workbook focuses on the process of accreditation, and:

- outlines the key steps in an accreditation process for the *NSQHS Standards*
- provides information about the areas of match and no match between the *NSQHS Standards* and the *NSMHS*
- provides examples of evidence that could be used to demonstrate that the *NSQHS Standards* and the *NSMHS* have been met.

Mapping the two sets of standards

The Commission worked with the Department of Health and the Safety and Quality Partnership Standing Committee to map the *NSQHS Standards* and the *NSMHS*. The aim was to identify areas where a substantial match, in terms of scope and intent, exists between the two sets of standards. The exercise also highlighted differences between the two standards and areas where separate evidence is needed to meet both sets of standards.

Purpose of this Workbook

This Workbook is designed to guide services through the accreditation process for the *NSQHS Standards*, and highlight areas where mental health services will also have substantively achieved relevant *NSMHS* criteria. Our intention is to assist mental health services to ensure efforts to establish evidence to meet either set of standards are not duplicated.

In addition to using criteria to guide accreditation requirements, the *NSQHS Standards* specify actions that should be taken to ensure that criteria are met.

Tables are provided to demonstrate where the standards overlap. *Table 5: Map of NSQHS against NSMHS Standards* highlights the overlap of the *NSQHS Standards* to the *NSMHS*. *Table 6: Map of NSMHS against NSQHS Standards* is a reverse map, from the *NSMHS* to the *NSQHS Standards*.

Across the two sets of standards there are some areas in which no match or overlap exists. Additional evidence may be required to meet the *NSHMS* criteria. Section B of this workbook outlines criteria in the *NSHMS* where no overlap or matching action occurs in the *NSQHS Standards*. This section contains reflective questions and examples of evidence drawn from the *Implementation Guidelines for Public Mental Health Services and Private Hospitals*.[3]

It is important that each mental health service check with their accrediting agency and regulatory authority to confirm the requirements for meeting the *NSMHS*.

Accreditation to the National Safety and Quality Health Service Standards

The following section describes the process of accreditation to the *NSQHS Standards*. The *NSQHS Standards* were developed to establish a common set of standards for hospitals, day procedure centres and dental services. This means that, for the first time, the same standards for safety and quality are being used in these different settings across Australia. The *NSQHS Standards* focus on the areas of care where we know that too many people are harmed from their health care, and where there is good evidence about how to provide better care.

They also play an essential part in new accreditation arrangement under the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme. The AHSSQA builds on the strengths of the current accreditation arrangements and provides for the nation coordination of accreditation processes.

Under this accreditation model, state and territory health departments have agreed that hospitals, day procedure services and public dental clinics are required to be accredited to the *NSQHS Standards*. Other health service organisations may also be required to be accredited to the *NSQHS Standards*. Health services should contact relevant state or territory health departments for information applicable to them.

Accreditation is one tool, in a range of strategies, which can be used to improve safety and quality. It is a way of verifying:

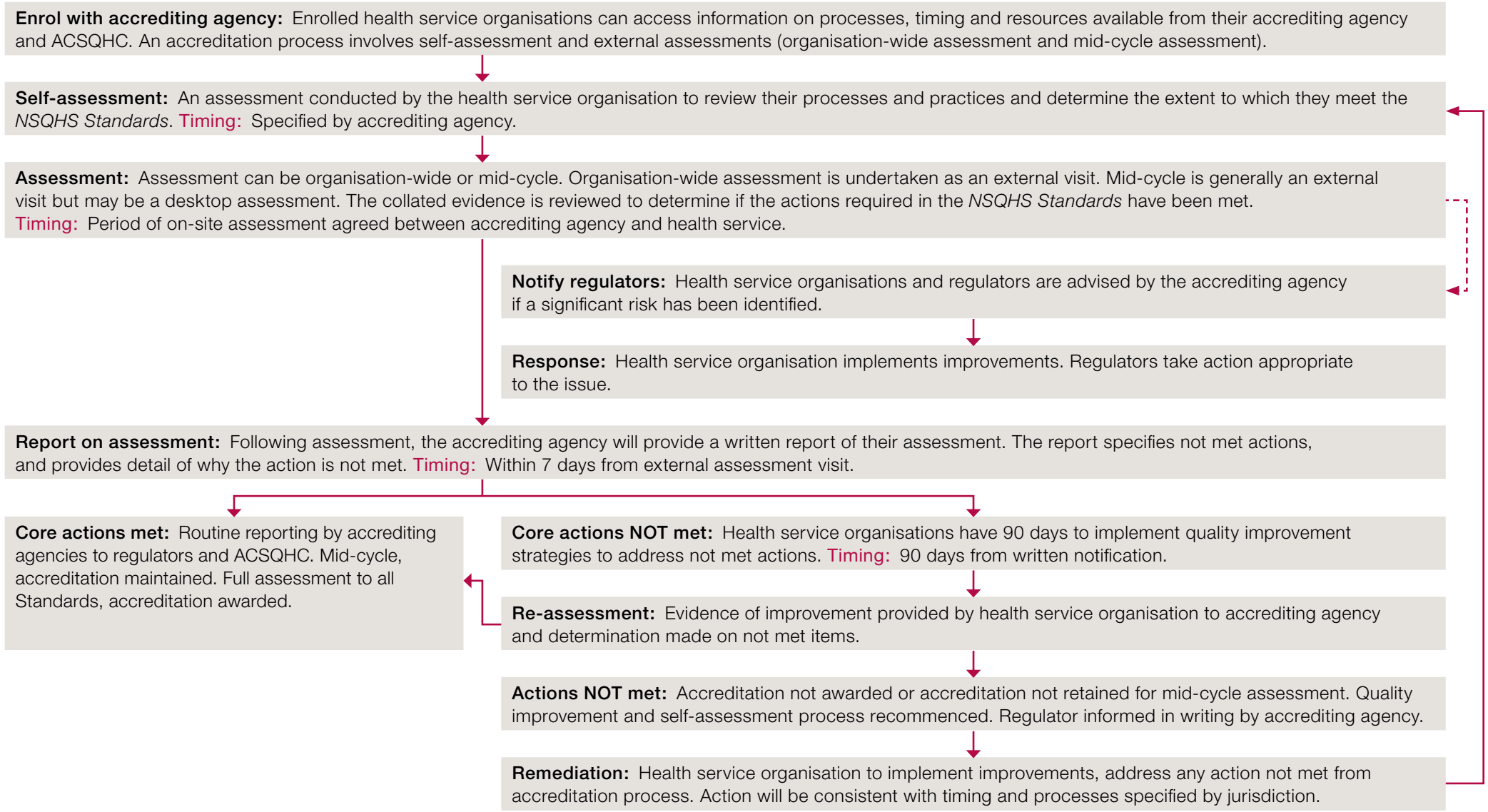
- actions are being taken
- system data is being used to inform activity
- improvements are made in safety and quality.

To be eligible for an accreditation award, a mental health service may undergo:

- periods of self-assessment
- comprehensive assessment to the *NSQHS Standards*
- interim or mid-cycle assessment to some *NSQHS Standards*.

You can find further details in **Figure 1**.

Figure 1: The NSQHS Standards accreditation process



Enrolling in an accreditation program

By selecting an approved accrediting agency, a mental health service will be selecting the style and timing of assessment to the *NSQHS Standards*. Not all accrediting agencies will take the same approach. The accreditation cycle ranges from 3-4 years, and the frequency and style of the mid-cycle assessment, periodic review or surveillance audit may vary between agencies.

Approved accrediting agencies

The Commission approves accrediting agencies to assess health service organisations to the *NSQHS Standards*. In order to be able to accredit to the *NSQHS Standards*, the Commission requires accrediting agencies to:

- be accredited by an internationally recognised body
- work with the Commission to ensure the consistent application of the *NSQHS Standards*
- provide data on accreditation outcomes to state and territory health departments and the Commission.

A list of all approved accrediting agencies is available on the Commission's website[4] at www.safetyandquality.gov.au .

Timeframe

Accreditation to the *NSQHS Standards* commenced in January 2013. This means that the next scheduled recertification audit or organisational-wide accreditation visit will involve assessment to all 10 *NSQHS Standards*.

For a mid-cycle assessment, periodic review or surveillance audit, hospitals will not need to be assessed against all 10 *NSQHS Standards*. Any mid-cycle assessment will, at a minimum, involve:

1. Standards 1, 2 and 3
2. the organisational quality improvement plan
3. recommendations from previous accreditation assessments.

Health services may agree to additional assessment requirements for the mid-cycle assessment.

Core and developmental actions for NSQHS Standards

The *NSQHS Standards* apply in a wide variety of health settings. Because of the variation in size, structure and complexity of health service delivery models a degree of flexibility is required in the application of the *NSQHS Standards*.

To achieve this flexibility, each action within a Standard is designated as either:

- **Core** – actions must be met before a mental health service can achieve an accreditation award to the *NSQHS Standards*. All core actions are critical for safety and quality; or
- **Developmental** – activity in these areas is still required, but the actions do not need to be fully met in order to achieve accreditation. Developmental actions are in areas where services should focus their future efforts and resources to improve patient safety and quality.

A list of core and developmental actions for different types of health settings can be found on the Commission's website at www.safetyandquality.gov.au . The Commission will review the classification of core and developmental actions in 2015.

Non-applicable criteria or actions

In some circumstances a Standard, criterion or action may be considered non-applicable. Non-applicable actions are those that are inappropriate in a specific service context or for which assessment would be meaningless.

There are two ways in which a criterion or action can be classified as non-applicable:

1. The Commission has designated non-applicable actions for various mental health services by category. **Table 1** summarises non-applicable actions by service type.
2. During the accreditation process, there may be instances where an individual mental health service decides that a criterion or action is non-applicable. A service can apply to their accrediting agency to have either core or developmental actions considered non-applicable. The process for applying for non-applicable actions is outlined in **Table 2**.

Table 1: Applicable NSQHS Standard actions for mental health services

Health service type	Definition	National Safety and Quality Standards for Health Services									
		1	2	3	4	5	6	7	8	9	10
Psychiatric inpatient services – public or privately funded											
Public psychiatric hospital	An establishment devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders that is controlled by a state or territory health authority and offers free diagnostic services, treatment, care and accommodation to all eligible patients.	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	May not be applicable if blood and blood products are not held or administered	All Items applicable	All Items applicable	All Items applicable
Private psychiatric hospital	An establishment devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders that is licensed or approved by a state or territory health authority.	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	May not be applicable if blood and blood products are not held or administered	All Items applicable	All Items applicable	All Items applicable

Table 1: Applicable NSQHS Standard actions for mental health services (continued)

Health service type	Definition	National Safety and Quality Standards for Health Services									
		1	2	3	4	5	6	7	8	9	10
Public acute hospital	An establishment that provides at least minimal medical, surgical or obstetric services for admitted patient treatment and/or care and provides round-the-clock comprehensive qualified nursing services as well as other necessary professional services. They must be licensed by the state or territory health department or be controlled by government departments.	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable
Psychiatric units or wards	Specialised units or wards, within public acute hospitals, that are dedicated to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders.	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	May not be applicable if blood and blood products are not held or administered	All Items applicable	All Items applicable	All Items applicable

Table 1: Applicable NSQHS Standard actions for mental health services (continued)

Health service type	Definition	National Safety and Quality Standards for Health Services									
		1	2	3	4	5	6	7	8	9	10
Forensic inpatient units	Specialist mental health units providing care for mentally ill patients who have been in contact with the criminal justice system and high-risk civil patients. The patient demographic consists of those found not guilty by reason of mental illness, those unfit to plead, mentally disordered offenders or those at risk of offending.	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable
Community-based psychiatric services – public or privately funded											
Community mental healthcare services	Include hospital outpatient clinics and non-hospital community mental healthcare services, such as crisis or mobile assessment and treatment services, day programs, outreach services, and consultation and liaison services.	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	Not applicable	Not applicable	Not applicable (ref. Criteria 1.8)	All Items applicable

Table 1: Applicable NSQHS Standard actions for mental health services (continued)

Health service type	Definition	National Safety and Quality Standards for Health Services									
		1	2	3	4	5	6	7	8	9	10
Government-operated residential mental health services	Specialised residential mental health services that are operated by a state or territory government and provide rehabilitation, treatment or extended care to residents for whom the care is intended to be on an overnight basis and in a domestic-like environment.	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	Not applicable	Not applicable	Not applicable (ref. Criteria 1.8)	All Items applicable
Forensic mental health services	These services provide comprehensive mental health care to people who come into contact with the criminal justice system or are at an increased risk of such contact.	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	All Items applicable	Not applicable	Not applicable	Not applicable (ref. Criteria 1.8)	All Items applicable
Non-Government Organisation (NGO) sector											
Non-government-operated residential mental health services	Specialised residential mental health services that meet the same criteria as government-operated residential mental health services that are operated by non-government agencies.	All Items applicable *but not mandatory	All Items applicable *but not mandatory	All Items applicable *but not mandatory	All Items applicable *but not mandatory	All Items applicable *but not mandatory	All Items applicable *but not mandatory	Not applicable	All Items applicable *but not mandatory	Not applicable (ref. Criteria 1.8)	All Items applicable *but not mandatory

Table 2: Steps in applying for NSQHS Standards non-applicable actions

Application

A mental health service organisation assesses an action as non-applicable and applies to the accrediting agency by providing evidence or arguments for the action to be rated as non-applicable.

Assessment

Assessment of submissions for non-applicable actions by the accrediting agency will be against the following criteria:

- The mental health service organisation demonstrates that an action, criteria or standard is non-applicable because a particular service or product is not provided by the health service organisation, for example, blood and blood products.
- The mental health service organisation demonstrates that an action, criteria or standard has limited applicability to the services it provides. For example, *Standard 9: Recognising and Responding to Clinical Deterioration* is non-applicable in a non-acute healthcare setting.
- If a mental health service organisation changes the types of services offered and an action, criterion or standard that was previously assessed is no longer applicable.

Confirmation

The accrediting agency confirms with the mental health service organisation, surveyor and regulator that an action is non-applicable for the purpose of accreditation of that facility based on the evidence, context and precedence. A mental health service can appeal any decision with their accrediting agency, which will have their own appeals process.

Notification

All actions that are confirmed as non-applicable and the basis for the decision is provided to the Commission, as the national coordinator, to determine national trends with a view to:

- clarifying the requirements of the action
- providing additional tools and resources for health services to meet a Standard
- making amendments to the Workbooks
- considering amendments to the *NSQHS Standards*.

Assessment and rating scale

Accrediting agencies may use their own rating scales when assessing services, but will be required to use the following three point rating scale to report accreditation outcomes to state and territory health departments and the Commission:

- **Not met** – the actions required have not been achieved
- **Satisfactorily met** – the actions required have been achieved
- **Met with merit** – in addition to achieving the actions required, measures of good quality and a higher level of achievement are evident. This would mean a culture of safety, evaluation and improvement is evident throughout the organisation, and that the level of performance is sustainable.

This rating system can be used to rate individual actions within a *NSQHS Standard* and to rate the Standard overall.

A decision support tool is provided in **Table 3**. This can be used as a guide in making an assessment of evidence against each action.

Table 3: Decision support tool for determining the level of performance to meet the NSQHS Standards

This decision support tool has been developed as general guidance for health services undertaking self-assessment. It is designed to be read in conjunction with the 10 Standard-specific Safety and Quality Improvement Guides[5-14] developed by the Commission.

Issue	Satisfactory performance	Unsatisfactory performance
Policies, procedures and/or protocols are in use	• Documents detail the date they become effective and the date of the next revision • Source documents are referenced, particularly where they are represented as best practice • Documents may reference the consultation processes undertaken or collaborative group involved in their development • The documents are adapted to the specific context and setting in which they are used by the health service • The workforce knows the documents exist, can access them, and knows and uses the contents	Documentation is: • Outdated • Incomplete • Either overly complex and detailed or lacking in specificity • Not related to the organisation, for example policy developed by another organisation or body and not adapted for use by the health services, and/or • Not accessible or unknown to users
Monitor and report	• Data sampling or collection occurs across the health service organisation • Quality of data is known • Processes exist to test and improve the quality of the data • Feedback is provided to targeted areas and/or available across the health service organisation • Data presented in reports is meaningful and relevant • Data collection and reporting informs a problem area or an area of specific risk • Timeliness of the collection and review of the data is consistent with the issue being examined	• Data is not sufficiently proximal to the issue being examined to provide meaningful information • No feedback is provided or the feedback provided is not sufficiently specific to be of use • Feedback is not available to individuals, the workforce, units, governance committees or areas that can make improvements, and/or • Data is not sufficiently recent to be relevant to the current provisioning of service

Table 3: Decision support tool for determining the level of performance to meet the NSQHS Standards (continued)

This decision support tool has been developed as general guidance for health services undertaking self-assessment. It is designed to be read in conjunction with the 10 Standard-specific Safety and Quality Improvement Guides[5-14] developed by the Commission.

Issue	Satisfactory performance	Unsatisfactory performance
Action is taken to improve	• The action being taken: – is applicable broadly across the health service, and/or – is readily transferable across the organisation, and/or – focuses on key risks or priority areas identified by the health service organisation • Action outcomes will inform future improvement plans across the health service or target specific risks • Action outcomes are, or will be, communicated to the workforce, patients and carers, and governance committees • Action is timely and responsive to issues as they arise, and/or • Action is coordinated	• Action claims to be organisation-wide, but relates to a localised issue, process or situation and there is no clear outcome with the transfer of lessons learned across the health service • Action is limited to an area of interest rather than an organisational priority or risk • Significant delays exist between the identification of an issue and action being taken, and/or • Action is disparate and not coordinated, or duplicated across the organisation
Training	• Training provided or accessed is matched to workforce training needs • A system, such as a register, is in place to track workforce participation in training and qualifications, and/or • Training programs are evaluated	• Training does not address safety and quality of care needs, or workforce training needs • The workforce are not aware of training • The workforce are not able to access training, and/or • The workforce are not given the opportunity to provide feedback on training
Risk assessment	• Clear and agreed processes exist to identify risks for the organisation and for individual service areas • A scale to rate risk is consistently applied • The risks are reviewed on a regular basis, and/or • Risks are assessed at all levels of an organisation	• There is no formal process for identifying and rating of risk, or where risk exists, the formal process is not applied, and/or • Risks are identified and rated at an organisational level, not at an individual service level

Table 3: Decision support tool for determining the level of performance to meet the NSQHS Standards (continued)

This decision support tool has been developed as general guidance for health services undertaking self-assessment. It is designed to be read in conjunction with the 10 Standard-specific Safety and Quality Improvement Guides[5-14] developed by the Commission.

Issue	Satisfactory performance	Unsatisfactory performance
Regular review	• Review occurs across the relevant organisation or a representative sample that is appropriate for the issue under review • Risk assessment is used as the basis to determine the location and size of the sample, and/or • Frequency and timing of the review is both organisationally appropriate and consistent with the level of risk of the issue	• Frequency of review is insufficient in providing information that can be used to introduce change • Size of the review is too small or limited to provide meaningful information • Data collected is not current • Reviewed data is not representative of all areas where the issue occurs • The review inappropriately excludes consumers
Evidence base or best practice	• Reference is current and source is accepted as reputable and authoritative, and may include professional body, published articles, published research • May be peer reviewed, and/or • Where possible or appropriate, are consistent with national specifications or standards	• Material or resources are not referenced, or source is not clear • Reference material is out of date, and/or • Inconsistencies are apparent in the material or resources
Processes and/or systems are in place	• Processes/systems: – are responsive in their ability to address issues – clearly delineate roles and responsibilities – interface with risk management, governance, operational processes and procedures for each Standard	• The workforce are not aware of the processes/systems, and/or • Processes/systems are cumbersome and/or not adhered to

Table 3: Decision support tool for determining the level of performance to meet the NSQHS Standards (continued)

This decision support tool has been developed as general guidance for health services undertaking self-assessment. It is designed to be read in conjunction with the 10 Standard-specific Safety and Quality Improvement Guides[5-14] developed by the Commission.

Issue	Satisfactory performance	Unsatisfactory performance
Communication	• Format of communication (for example email, posters or website updates) is appropriate to the purpose • Language is clear and concise • Workforce are aware of the communication • Processes are in place for routinely distributing relevant communication materials • The effectiveness of the communication strategy is evaluated • The needs of culturally and linguistically diverse populations are taken into consideration and/or • Communication strategies are evaluated and modified accordingly	• Format is inappropriate for purpose • Communication is not adapted for the target audience • Key pieces of communication do not reach the target audience and/or • Communication strategies are rarely or not evaluated
Equipment	• Workforce are trained in use of equipment and/or • Records are kept of equipment maintenance	• Workforce do not know how to use the available equipment appropriately • Equipment is not available and/or • Equipment is not maintained

Actions that are not met

When an accrediting agency finds a mental health service does not meet the requirements of the *NSQHS Standards*, the accrediting agency will inform the service to provide the opportunity for remedial action.

Following an assessment to the *NSQHS Standards*, mental health services will have 90 days from the receipt of their written report to address any 'not met' actions before a final determination on accreditation is made. Where improvements are not implemented or patient risks not addressed, accrediting agencies will notify the relevant health department and an accreditation award will not be issued.

When a significant risk to patient safety is identified, accrediting agencies will notify the relevant health department immediately. The health department will then verify the scope, scale and implications of the reported non-compliance and will take further action if the service does not rectify the patient safety risk. State and territory health departments can be contacted for further information about their regulatory response process.

Appeals process

All accrediting agencies have an appeals process by which services can appeal assessment decisions. Information on these processes should be accessed via your approved accrediting agency.

Accreditation award

Mental health services that meet the requirements of the *NSQHS Standards* will be issued an award by their accrediting agency specifying that it is:

'Accredited to the National Safety and Quality Health Service Standards'.

In addition, awards will include:

- the period of accreditation (date awarded and expiry date)
- the name of the facility
- a description of the services covered by the award.

Where an application for 'non-applicable' actions has been supported by the accrediting agency, the award will indicate that there are exclusions. These exclusions will also be detailed on the accrediting agency's website, along with details of the accreditation status of the service.

Data and reporting

The accreditation model allows state and territory health departments and the Commission to receive information from accrediting agencies on the accreditation outcomes of mental health services.

The Commission will use this information to review and maintain the *NSQHS Standards* and report to Health Ministers on the safety and quality of healthcare services across Australia.

The following data will be submitted to state and territory health departments and the Commission:

- name and description of the mental health service
- any non-applicable *Standards, criteria or actions* excluded from the assessment process
- ratings for core and development actions not met, satisfactorily met and met with merit
- any high priority recommendations.

Accreditation to the National Standards for Mental Health Services

The *NSMHS* set out the minimum requirements for all service providers in the mental health service system. The *NSMHS* will be most effective if they are seen as an integral part of each service provider's quality assurance system, rather than as a stand-alone obligation.

Accreditation is one means of providing an independent assessment of performance against standards. A formal accreditation process supports continuous quality improvement in service provision.

All states already have a strong emphasis on accreditation for state- and territory-funded public mental health services. These services have chosen to become accredited with an external accreditation provider. While it is anticipated that the *NSMHS* will be incorporated into relevant accreditation programs, states and territories will make their own decisions on whether accreditation will be mandatory for non-government community mental health service providers.[15]

Timeframe

The Australian Health Ministers' Conference endorsed the revised standards in September 2010.

Enrolling in an accreditation program/ Approved accreditation agencies

It is anticipated that the *NSMHS* will be incorporated into the relevant service accreditation programs.[2] All service providers need to check with their local jurisdiction/ regulatory authority/funding body regarding the approved accreditation agencies for their particular service.

Core and developmental actions for NSMHS

As services are at different stages, some criteria will be routine practice for some and aspirational for others. In considering implementation attainment and maintenance of the Standards, services will need to be cognisant of their stage of development and model of service delivery, and therefore which standards and criteria are most relevant, and which should be addressed most urgently. It is expected that consumers and carers will be involved in these deliberations.[2]

Some standards and the criteria that support them must always be met in full. *Standard 2 (Safety)* is in this category. All service providers must be able to demonstrate that their services are safe. While continuous improvement should still be a goal, safety requirements must be met. There is no scope for service providers to be at a 'minimal' level of achievement and 'working towards' achieving Standard 2. Similarly, if standards have criteria that relate to meeting legislative requirements (for example, *Standard 8 Governance, Leadership and Management*, Criteria 8.4 and 8.9) service providers must demonstrate from year one that these criteria are met.[15]

All of the *NSMHS*, except the consumer standard, are designed to be assessed. In contrast, the consumer standard is designed to inform consumers about their rights and responsibilities and the key elements underpinning the provision of quality service that consumers can expect to receive from mental health service providers throughout the continuum of care. The consumer standard is therefore not intended to be assessed, as it contains criteria that are all assessable within the other standards.[2]

NSMHS Non-applicable criteria or actions

Each organisation will need to carefully consider each standard and its associated criteria and make decisions about which apply to them. Check with your accreditation agency and regulatory body to confirm if a standard is not applicable to your service.

Table 4: Applicable NSMHS criteria for mental health services

Health service type	Definition	National Standards for Mental Health Services									
		1	2	3	4	5	6	7	8	9	10
Psychiatric inpatient services – public or privately funded											
Public acute hospital	An establishment that provides at least minimal medical, surgical or obstetric services for admitted patient treatment and/or care and provides round-the-clock comprehensive qualified nursing services as well as other necessary professional services. They must be licensed by the state or territory health department or be controlled by government departments.	All items applicable	All items applicable	All items applicable	All items applicable	All items applicable	All items applicable, assessment incorporated in other Standards	All items applicable	All items applicable	All items applicable	All items applicable
Private psychiatric hospital	An establishment devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders that is licensed or approved by a state or territory health authority.	All items applicable	All items applicable	All items applicable	All items applicable	All items applicable	All items applicable, assessment incorporated in other Standards	All items applicable	All items applicable	All items applicable	All items applicable

Table 4: Applicable NSMHS criteria for mental health services (continued)

Health service type	Definition	National Standards for Mental Health Services									
		1	2	3	4	5	6	7	8	9	10
Public acute hospital	An establishment that provides at least minimal medical, surgical or obstetric services for admitted patient treatment and/or care and provides round-the-clock comprehensive qualified nursing services as well as other necessary professional services. They must be licensed by the state or territory health department or be controlled by government departments.	All items applicable	All items applicable	All items applicable	All items applicable	All items applicable	All items applicable, assessment incorporated in other Standards	All items applicable	All items applicable	All items applicable	All items applicable
Psychiatric units or wards	Specialised units or wards, within public acute hospitals, that are dedicated to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders.	All items applicable	All items applicable	All items applicable	All items applicable	All items applicable	All items applicable, assessment incorporated in other Standards	All items applicable	All items applicable	All items applicable	All items applicable

Table 4: Applicable NSMHS criteria for mental health services (continued)

Health service type	Definition	National Standards for Mental Health Services									
		1	2	3	4	5	6	7	8	9	10
Forensic inpatient units	Specialist mental health units providing care for mentally ill patients who have been in contact with the criminal justice system and high-risk civil patients. The patient demographic consists of those found not guilty by reason of mental illness, those unfit to plead, mentally disordered offenders or those at risk of offending.	All items applicable	All items applicable	All items applicable	All items applicable	All items applicable	All items applicable, assessment incorporated in other Standards	All items applicable	All items applicable	All items applicable	All items applicable
Community-based psychiatric services – public or privately funded											
Community mental healthcare services	Include hospital outpatient clinics and non-hospital community mental healthcare services such as crisis or mobile assessment and treatment services, day programs, outreach services, and consultation and liaison services.	All items applicable	All items applicable	All items applicable	All items applicable	All items applicable	All items applicable, assessment incorporated in other Standards	All items applicable	All items applicable	All items applicable	All items applicable

Table 4: Applicable NSMHS criteria for mental health services (continued)

Health service type	Definition	National Standards for Mental Health Services									
		1	2	3	4	5	6	7	8	9	10
Government-operated residential mental health services	Specialised residential mental health services that are operated by a state or territory government and provide rehabilitation, treatment or extended care to residents for whom the care is intended to be on an overnight basis and in a domestic-like environment.	All items applicable	All items applicable	All items applicable	All items applicable	All items applicable	All items applicable, assessment incorporated in other Standards	All items applicable	All items applicable	All items applicable	All items applicable
Forensic mental health services	These services provide comprehensive mental health care to people who come into contact with the criminal justice system or are at an increased risk of such contact.	All items applicable	All items applicable	All items applicable	All items applicable	All items applicable	All items applicable, assessment incorporated in other Standards	All items applicable	All items applicable	All items applicable	All items applicable
Non-Government Organisation (NGO) sector											
Non-government-operated residential mental health services	Specialised residential mental health services that meet the same criteria as government-operated residential mental health services that are operated by non-government agencies.	All items applicable	All items applicable	All items applicable	All items applicable	All items applicable	All items applicable, assessment incorporated in other Standards	All items applicable	All items applicable	All items applicable	All items applicable

Assessment and rating scale

Accrediting agencies use their own scales when surveying, but summarise these in standardised ways for the purposes of reporting to relevant bodies.

Actions that are not met

Check with local jurisdiction/regulatory authority/funding body.

Appeals process

All accrediting agencies have a well-established appeals process by which services can appeal assessment decisions. Information on these processes should be accessed via your approved accrediting agency.

Accreditation award

Accrediting agencies issue certification detailing which standards a health service has been accredited to. Agencies have worked on standardising the language of these certificates for reporting to relevant bodies.

How to use this Workbook

Mental Health Services can use this Workbook to prepare for accreditation to the *NSQHS Standards* and to determine if there is sufficient evidence available to demonstrate that systems and processes meet these requirements. At the same time, the Workbook can be used to determine if the evidence available to meet the *NSQHS Standard* also substantively fulfils the requirements for an identified match with the *NSMHS Standard*.

National Safety and Quality Health Service Standards

Section A of the Workbook presents the *NSQHS Standards* at 'Actions Required' level with matching *NSMHS* at 'Criterion' level.

Figure 2 illustrates how each *NSQHS Standard* is presented in this Workbook. For each *NSQHS Standard* the Workbook includes:

- a description of the **Standard**
- a **statement of intent** or the desired outcome for the Standard
- the **context** in which the Standard must be applied
- key **criteria** of the Standard
- a series of **actions** relevant to each criterion
- where a match has been identified, the relevant ***NSMHS* criterion** is listed in an adjoining column.
- **reflective questions** to clarify the intent of each criterion
- **examples of evidence**
- a column to assist health services identify if **further action** is required.

Note: There are four *NSQHS Standards* where no matching *NSMHS* criteria were identified:

- Standard 5: Patient Identification and Procedure Matching,
- Standard 7: Blood and Blood Products,
- Standard 8: Preventing and Managing Pressure Injuries; and
- Standard 10: Preventing Falls and Harm from Falls.

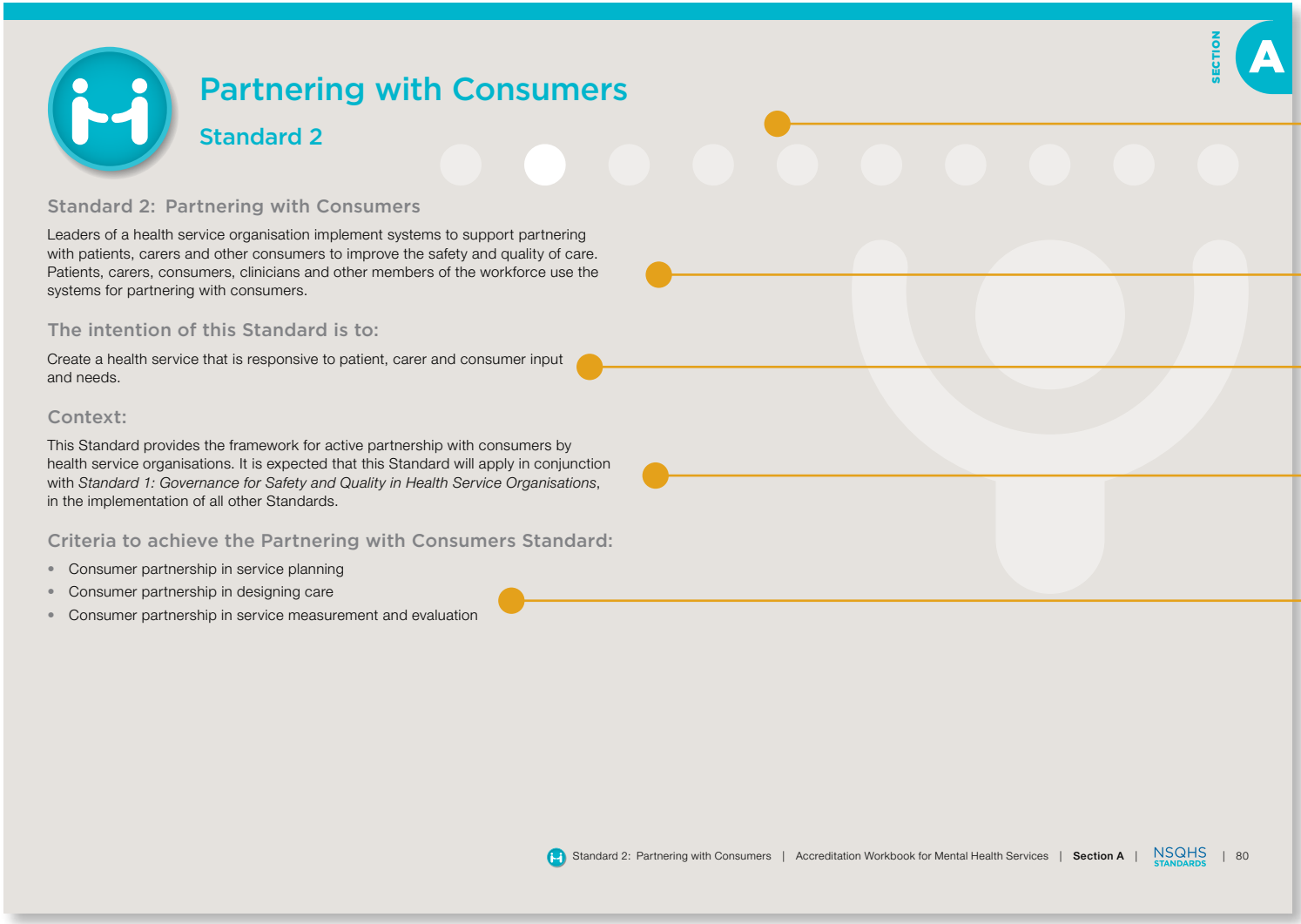
These Standards are not specifically addressed within the *NSMHS*. This does not imply that these are not important issues in mental health services. A column for the *NSMHS* is not included in the tables for these four *NSQHS Standards*.

National Standards for Mental Health Services

Section B of the Workbook outlines criteria in the *NSHMS* for which there has been no match with the *NSQHS Standards* identified. This table contains reflective questions and examples of evidence. The examples of evidence are drawn from the *Implementation Guidelines for Public Mental Health Services and Private Hospitals*.[3] In many cases, the examples of evidence required to meet criteria for each set of standards is similar, e.g. surveyors will be looking for policies, procedures and protocols for some items, and results of consumer and carer feedback for others. In some cases, **examples of evidence** specific to the *NSMHS* have been added, many of these taken directly from the *Implementation Guidelines for Public Mental Health Services and Private Hospitals*.

It is worth noting that the two sets of Standards are set out in different ways. Each set comprises 10 Standards, which are divided into a number of criteria. The *NSQHS Standards* are divided into 'Actions Required', but the *NSMHS* are considered at a 'Criterion' level. The levels used to map these Standards consider the 'Actions Required' component of the *NSQHS Standards* and the 'Criterion' level of the *NSMHS*. As a result, the language in the *NSQHS Standards* is at times more specific, while the *NSMHS* seem to cover a broader scope. It is in drilling down via reflective questions, to the examples of evidence required to meet each Standard, that the match becomes more obvious.

Figure 2: How the NSQHS Standards with matched NSMHS are presented in this Workbook



SECTION A

Partnering with Consumers

Standard 2

Standard 2: Partnering with Consumers

Leaders of a health service organisation implement systems to support partnering with patients, carers and other consumers to improve the safety and quality of care. Patients, carers, consumers, clinicians and other members of the workforce use the systems for partnering with consumers.

The intention of this Standard is to:

Create a health service that is responsive to patient, carer and consumer input and needs.

Context:

This Standard provides the framework for active partnership with consumers by health service organisations. It is expected that this Standard will apply in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations*, in the implementation of all other Standards.

Criteria to achieve the Partnering with Consumers Standard:

- Consumer partnership in service planning
- Consumer partnership in designing care
- Consumer partnership in service measurement and evaluation

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Each Standard is represented by an **icon and colour scheme** for easy recognition. Tools and resources developed by the Commission that relate to a specific Standard will also display this logo.

The **Standard** describes the minimum performance expectations, processes or structures that should be in place to ensure safe and high quality services.

The **intention** describes the desired outcome of each Standard.

The **context** highlights the link between Standard 1, Standard 2 and each of the eight clinical Standards.

Each **criterion** groups similar items together and sets out the areas the Standard addresses.

Figure 2: How the NSQHS Standards with matched NSMHS are presented in this Workbook (continued)

The **criterion**

***NSMHS*:** These are the *NSMHS* criteria which closely match the *NSQHS Standards* Actions Required

Reflective questions help health service organisations consider the intent of the action.

Items describe how a criterion is to be met.

- Services **do not** need to meet **all the evidence listed**. This is only a guide.
- **Other examples of evidence** may be applicable. When used, it is recommended that other evidence be documented here.

Consumer partnership in designing care

Consumers and/or carers are supported by the health service organisation to actively participate in the improvement of the patient experience and patient health outcomes.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
2.6 Implementing training for clinical leaders, senior management and the workforce on the value of and ways to facilitate consumer engagement and how to create and sustain partnerships				
2.6.1 Clinical leaders, senior managers and the workforce access training on patient-centred care and the engagement of individuals in their care	**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 **7.16** The MHS provides training to staff to develop skills and competencies for working with carers	How do we provide the executive and senior clinicians with training on patient-centred care?	☐ Training curricula, resources or materials that include sections on consumer-centred care, implementation of a personally controlled electronic health record, partnerships and consumer perspectives are utilised for orientation and ongoing training ☐ Scheduled training dates include sections on consumer-centred care, partnerships and consumer perspectives ☐ Resources on consumer-centred care, partnerships and consumer perspectives are developed and disseminated ☐ Evaluation and feedback from participants on training that includes sections on consumer-centred care, partnerships and consumer perspectives is analysed and used to refine training ☐ Feedback from consumers and carers involved in developing training and resources is analysed and used to refine training ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
2.6.2 Consumers and/or carers are involved in training the clinical workforce	No match to the *NSMHS*	How do we involve consumers and carers in training the clinical workforce?	☐ Agenda items, minutes or other records of meetings involving consumers indicating that training curricula were discussed and feedback provided by consumers ☐ Records of focus groups, community meetings or discussions involving consumers and carers where feedback on training curricula and materials has been sought ☐ Project plans, communication strategies or consultation plans detailing involvement of consumers in the development of training curricula and materials ☐ Feedback from consumers and carers involved in developing training and resources ☐ Records of training provided by consumers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

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A health service organisation assesses the quality of the evidence in demonstrating the action is met. If there is insufficient evidence, the 'No' box is there to **prompt further action**.

Actions Required that are:

- unshaded are **core** and therefore must be met
- shaded are **developmental** and services need to demonstrate they are working towards implementation.

Actions Required describe what must be done to fulfil the ***NSQHS Standard***.

Examples of evidence

This Workbook includes examples of the kind of evidence a mental health service may use to demonstrate that it meets each of the actions required for the *NSQHS Standards*.

The evidence list is designed to assist a service to show that:

- safety and quality processes and systems are in place
- they are reviewed and evaluated
- practices are changed when necessary.

The list can be used as a checklist, but remember that this Workbook does not cover all possible sources of evidence that could be used by a service. You may want to use additional examples of evidence that are not included in the list and you can indicate this by ticking the 'Other' box. It is not expected that a service will have in place all the examples of evidence listed. This is because services vary in size and structure, and will have different ways of developing and presenting the evidence. For example, a large organisation is more likely to have formal committees and processes in place, and therefore have formal meeting agendas, minutes and reports. In contrast, a smaller organisation may have structured meetings rather than committees and therefore uses different types of records such as meeting notes, workforce message books and issues logs.

Quality improvement is an ongoing process. That means activities aimed at minimising risks to patients, employees, visitors and the organisation will be in various stages of review and implementation. Not all strategies and actions will be applicable or a priority in all parts of the health service organisation. You do not need to demonstrate implementation of strategies in all parts of an organisation for an action to be met, particularly if they are areas of low risk or where the strategies may have limited application.

Each mental health service should interpret the evidence listed with regard to its own model of service delivery. If a service finds there is insufficient evidence available to demonstrate an action has been met, select the 'No' box in the last column of the Workbook tables (see Figure 2) to prompt further action to address identified gaps.

It is not expected that mental health services will have every form of evidence provided in the list of examples. You are strongly encouraged to provide only enough evidence to show actions are being addressed. The evidence used would typically come from the usual business process improvement strategies you have in place, rather than strategies developed specifically for accreditation.

Workbook resources

A major focus of the Commission's work is to support health service organisations to implement the *NSQHS Standards*. This Workbook contains a number of tools to assist services to prepare for accreditation. These include:

- **Map of *NSQHS Standards*** at Actions Required level with **matching *NSMHS*** at Criterion level. A summary of codes, with matches highlighted in blue font, is listed in **Table 5** on page 31
- **Reverse map of *NSMHS*** at Criterion level with **matching *NSQHS Standard*** at Actions Required level, with matches highlighted in blue font, is listed in **Table 6** on page 32
- **Terms and definitions** – an explanation of key terms which are referred to throughout this Workbook.

Tip: it may be worthwhile to print A3 copies of Tables 5 and 6, and have these as a ready reference while working through the larger tables. PDFs of these tables are available on the Commission website at www.safetyandquality.gov.au

Additional resources

This Workbook should be read in conjunction with a range of other materials developed by the Commission and other agencies to assist health service organisations engage in continuous quality improvement activities. These additional resources include:

- a set of 10 *Safety and Quality Improvement Guides*[5-14], one for each of the *NSQHS Standards*. Each Guide provides information and resources that can be used to implement quality improvement programs in line with the *NSQHS Standards*. They include key tasks, suggested improvement strategies, possible outputs, links to resources and tools relevant to each of the *NSQHS Standards*
- reports, guidelines, evidence-based resource documents and tools developed by the Commission that address specific clinical areas of patient care.

These resources are available at the Commission's website[4] www.safetyandquality.gov.au .

- three sector-specific Implementation Guidelines, developed by the Department of Health and Ageing, that accompany the *NSMHS*. These guidelines provide more detail to inform the implementation of the Standards, and clear directions for mental health services on how the criteria of the Standards apply to different services. The guidelines are aimed at the following service sector groups:
  - Public mental health services and private hospitals[3]
  - Non-government community services[15]
  - Private office-based mental health services[17]

NSMHS implementation guidelines can be accessed at http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-servst10

Table 5: Map of NSQHS Standards with matching NSMHS

SQ1 C	SQ1 AR	MH C
1.1	1.1.1	1.2
		1.6
		1.13
		1.14
		7.7
		8.4
		10.3.6
	1.1.2	8.3
1.2	1.2.1	8.10
	1.2.2	2.8
		2.13
		8.11
1.3	1.3.1	8.7
	1.3.2	8.7
	1.3.3	
1.4	1.4.1	8.7
	1.4.2	2.10
	1.4.3	
	1.4.4	8.7
1.5	1.5.1	8.10
	1.5.2	8.10
1.6	1.6.1	8.11
	1.6.2	8.11
1.7	1.7.1	10.4.1
		10.5.1
	1.7.2	10.5.7
1.8	1.8.1	2.3
		2.11
	1.8.2	10.5.2
	1.8.3	10.4.5
1.9	1.9.1	9.3
	1.9.2	8.9
1.10	1.10.1	
	1.10.2	8.6
	1.10.3	8.5
	1.10.4	
	1.10.5	8.7
1.11	1.11.1	8.7
	1.11.2	8.7
1.12	1.12.1	8.7
1.13	1.13.1	
	1.13.2	
1.14	1.14.1	2.13
	1.14.2	2.13
	1.14.3	2.13
	1.14.4	2.13
	1.14.5	2.13
1.15	1.15.1	1.16
	1.15.2	1.16
	1.15.3	1.16
	1.15.4	1.16

SQ1 C	SQ1 AR	MH C
(continued)		
1.16	1.16.1	8.8
	1.16.2	8.8
1.17	1.17.1	1.1
		1.5
		10.1.2
	1.17.2	1.4
		7.4
	1.17.3	1.7
1.18	1.18.1	1.10
		1.11
		1.12
		10.4.3
		10.5.8
		10.5.11
	1.18.2	1.3
	1.18.3	10.5.3
	1.18.4	10.1.6
1.19	1.19.1	
	1.19.2	1.8
1.20	1.20.1	3.2

SQ2 C	SQ2 AR	MH C
2.1	2.1.1	3.1
		3.7
	2.1.2	4.3
		7.5
2.2	2.2.1	3.1
		7.14
		7.17
		10.1.8
	2.2.2	3.1
2.3	2.3.1	3.3
		3.5
		3.6
		7.15
2.4	2.4.1	3.1
	2.4.2	
2.5	2.5.1	3.1
		3.2
2.6	2.6.1	3.3
		7.16
	2.6.2	
2.7	2.7.1	
2.8	2.8.1	
	2.8.2	
2.9	2.9.1	3.2
	2.9.2	

SQ3 C	SQ3 AR	MH C
3.1	3.1.1	2.7
	3.1.2	2.7
	3.1.3	2.7
	3.1.4	2.7
3.2	3.2.1	
	3.2.2	
3.3	3.3.1	2.13
	3.3.2	2.13
3.4	3.4.1	
	3.4.2	
	3.4.3	
3.5	3.5.1	2.7
	3.5.2	2.7
	3.5.3	2.7
3.6	3.6.1	
3.7	3.7.1	2.6
		2.9
3.8	3.8.1	
3.9	3.9.1	
3.10	3.10.1	
	3.10.2	
	3.10.3	
3.11	3.11.1	
	3.11.2	
	3.11.3	
	3.11.4	
	3.11.5	
3.12	3.12.1	
3.13	3.13.1	
	3.13.2	
3.14	3.14.1	
	3.14.2	
	3.14.3	
	3.14.4	
3.15	3.15.1	2.12
	3.15.2	2.12
	3.15.3	2.12
3.16	3.16.1	
3.17	3.17.1	
3.18	3.18.1	
3.19	3.19.1	
	3.19.2	

SQ4 C	SQ4 AR	MH C
4.1	4.1.1	10.5.6
	4.1.2	10.5.6
4.2	4.2.1	2.4
	4.2.2	2.4
4.3	4.3.1	
	4.3.2	
	4.3.3	
4.4	4.4.1	
	4.4.2	
4.5	4.5.1	
	4.5.2	
4.6	4.6.1	10.5.8
	4.6.2	
4.7	4.7.1	
	4.7.2	
	4.7.3	
4.8	4.8.1	
4.9	4.9.1	
	4.9.2	
	4.9.3	
4.10	4.10.1	10.5.6
	4.10.2	10.5.6
	4.10.3	10.5.6
	4.10.4	10.5.6
	4.10.5	10.5.6
	4.10.6	10.5.6
4.11	4.11.1	
	4.11.2	
4.12	4.12.1	9.3
	4.12.2	9.3
	4.12.3	9.3
	4.12.4	9.3
4.13	4.13.1	10.5.3
	4.13.2	
4.14	4.14.1	10.5.8
		10.5.10
4.15	4.15.1	10.5.7
	4.15.2	10.5.7

SQ5 C	SQ5 AR	MH C
5.1	5.1.1	
	5.1.2	
5.2	5.2.1	
	5.2.2	
5.3	5.3.1	
5.4	5.4.1	
5.5	5.5.1	
	5.5.2	
	5.5.3	

SQ6 C	SQ6 AR	MH C
6.1	6.1.1	8.1
		9.4
		10.5.9
	6.1.2	9.3
	6.1.3	
6.2	6.2.1	
6.3	6.3.1	
	6.3.2	
	6.3.3	
	6.3.4	
6.4	6.4.1	
	6.4.2	
6.5	6.5.1	7.10
		7.12
		10.6.4

SQ7 C	SQ7 AR	MH C
7.1	7.1.1	
	7.1.2	
	7.1.3	
7.2	7.2.1	
	7.2.2	
7.3	7.3.1	
	7.3.2	
	7.3.3	
7.4	7.4.1	
7.5	7.5.1	
	7.5.2	
	7.5.3	
7.6	7.6.1	
	7.6.2	
	7.6.3	
7.7	7.7.1	
	7.7.2	
7.8	7.8.1	
	7.8.2	
7.9	7.9.1	
	7.9.2	
7.10	7.10.1	
7.11	7.11.1	

SQ8 C	SQ8 AR	MH C
8.1	8.1.1	
	8.1.2	
8.2	8.2.1	
	8.2.2	
	8.2.3	
	8.2.4	
8.3	8.3.1	
8.4	8.4.1	
8.5	8.5.1	
	8.5.2	
	8.5.3	
8.6	8.6.1	
	8.6.2	
	8.6.3	
8.7	8.7.1	
	8.7.2	
	8.7.3	
	8.7.4	
8.8	8.8.1	
	8.8.2	
	8.8.3	
	8.8.4	
8.9	8.9.1	
8.10	8.10.1	

SQ9 C	SQ9 AR	MH C
9.1	9.1.1	
	9.1.2	
9.2	9.2.1	
	9.2.2	
	9.2.3	
	9.2.4	
9.3	9.3.1	
	9.3.2	
	9.3.3	
9.4	9.4.1	
	9.4.2	
	9.4.3	
9.5	9.5.1	
	9.5.2	
9.6	9.6.1	
	9.6.2	
9.7	9.7.1	
9.8	9.8.1	10.1.6
	9.8.2	
9.9	9.9.1	10.4.5
	9.9.2	
	9.9.3	
	9.9.4	

SQ10 C	SQ10 AR	MH C
10.1	10.1.1	
	10.1.2	
10.2	10.2.1	
	10.2.2	
	10.2.3	
	10.2.4	
10.3	10.3.1	
10.4	10.4.1	
10.5	10.5.1	
	10.5.2	
	10.5.3	
10.6	10.6.1	
	10.6.2	
	10.6.3	
10.7	10.7.1	
	10.7.2	
	10.7.3	
10.8	10.8.1	
10.9	10.9.1	
10.10	10.10.1	

Legend:

- **SQ1** Governance for Safety and Quality In Health Service Organisations
- **SQ2** Partnering with Consumers
- **SQ3** Preventing and Controlling Healthcare Associated Infections
- **SQ4** Medication Safety
- **SQ5** Patient Identification and Procedure Matching
- **SQ6** Clinical Handover
- **SQ7** Blood and Blood Products
- **SQ8** Preventing and Managing Pressure Injuries
- **SQ9** Recognising and Responding to Clinical Deterioration
- **SQ10** Preventing Falls and Harm from Falls

MH = National Standards for Mental Health Services

C = Criteria

AR = Action Required

Note:

Grey shading indicates actions currently considered developmental

Blue font indicates a match between *NSQHS Standards* Actions and *NSMHS*

Table 6: Map of NSMHS with matching NSQHS Standards

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
	6.1	6.1.2
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		
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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

Terms and definitions

Accreditation: A status that is conferred on an organisation or an individual when they have been assessed as having met particular standards. The two conditions for accreditation are an explicit definition of quality (i.e. standards) and an independent review process aimed at identifying the level of congruence between practices and quality standards.[18]

Acute healthcare facility: A hospital or other healthcare facility providing healthcare services to patients for short periods of acute illness, injury or recovery.[19]

ACSQHC: Australian Commission on Safety and Quality in Health Care (the Commission).

Advance care directive: Instructions that consent to, or refuse the future use of, specified medical treatments (also known as a healthcare directive, advance plan or another similar term).[19]

Advanced life support: The preservation or restoration of life by the establishment and/or maintenance of airway, breathing and circulation using invasive techniques such as defibrillation, advanced airway management, intravenous access and drug therapy.[19]

Adverse drug reaction: A drug response that is noxious and unintended, and which occurs at doses normally used or tested in humans for the prophylaxis, diagnosis or therapy of disease, or for the modification of physiological function.[20]

Adverse event: An incident in which harm resulted to a person receiving health care.

Adverse medicines event: An adverse event due to a medicine. This includes the harm that results from the medicine itself (an adverse drug reaction) and the potential or actual patient harm that comes from errors or system failures associated with the preparation, prescribing, dispensing, distribution or administration of medicines (medication incident).[21]

Advocacy: Representing the concerns and interests of consumers and carers, speaking on their behalf, and providing training and support so they can represent themselves.[2]

Agreed tool: An instrument that has been approved for use within a health service organisation.

Antibiotic: A substance that kills or inhibits the growth of bacteria.[22]

Antimicrobial: A chemical substance that inhibits or destroys bacteria, viruses and fungi, including yeasts or moulds.[22]

Antimicrobial stewardship: A program implemented in a health service organisation to reduce the risks associated with increasing microbial resistance and to extend the effectiveness of antimicrobial treatments. Antimicrobial stewardship may incorporate a broad range of strategies including the monitoring and reviews of antimicrobial use.[22]

Approved patient identifiers: Items of information accepted for use in patient identification, including patient name (family and given names), date of birth, gender, address, medical record number and/or Individual Healthcare Identifier. Health service organisations and clinicians are responsible for specifying the approved items for patient identification. Identifiers such as room or bed number are not to be used.

Assessment: Process by which the characteristics and needs of consumers, groups or situations are evaluated or determined so they can be addressed. The assessment forms the basis of a plan for services or action.[2]

Audit: A systematic review of clinical care against a pre-determined set of criteria.[13]

Basic life support: The preservation of life by the initial establishment of, and/or maintenance of, airway, breathing, circulation and related emergency care, including use of an automated external defibrillator.[23]

Blood: Includes homologous and autologous whole blood. Blood includes red blood cells, platelets, fresh frozen plasma, cryoprecipitate and cryodepleted plasma.[24]

Blood products: Plasma derivatives and recombinant products excluding medication products.[24]

CALD: Cultural and linguistic diversity.

Care management: A cyclical process, in which needs are assessed, services are delivered in response, and needs are re-assessed, leading to a changed service response.[2]

Carers: People who provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness or general frailty.[25] Carers include parents and guardians caring for children.

Clinical audit: Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.[26]

Clinical communication: An exchange of information that occurs between treating clinicians. Communication can be formal (when a message conforms to a predetermined structure, for example, in a health record or stored electronic data) or informal (when the structure of the message is determined solely by the relevant parties; for example, a face-to-face or telephone conversation).[27]

Clinical governance: A system through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. This is achieved by creating an environment in which there is transparent responsibility and accountability for maintaining standards and by allowing excellence in clinical care to flourish.[28]

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

Clinical indicators: Describes a measurable component of the standard, with explicit criteria for inclusion, exclusion, time frame and setting.[30]

Clinical workforce: The nursing, medical and allied health workforce who provide patient care and students who provide patient care under supervision. This may also include laboratory scientists.[31]

Clinician: A healthcare provider, trained as a health professional. Clinicians include registered and non-registered practitioners, or a team of health professionals providing health care who spend the majority of their time providing direct clinical care.

Communication material: For consumers this may include brochures, fact sheets, letters, newsletters, presentations, posters, social media, trusted websites and videos. For the workforce this may include agenda papers, letters, meeting papers, memos, minutes and action items, Terms of Reference and reports.

Competency-based training: An approach to training that places emphasis on what a person can do in the workplace as a result of training completion.

Complementary healthcare products: Vitamin, mineral, herbal, aromatherapy and homeopathic products, also known as 'traditional' or 'alternative' medicines.[32]

Consumer (health): Patients and potential patients, carers and organisations representing consumers' interests.[33]

Consumer advocate: People who have been given the power by consumers to speak on their behalf, who represent the concerns and interest of the consumer as directed by the consumer, and seek the outcomes desired by the consumer. Although government and others may give power to advocates, such advocacy is token unless it is directly accountable to the consumer.[2]

Consumer engagement: This involves different types and levels of engagement with consumers that reflect the different goals, audiences and purposes for seeking engagement. Different types of consumer engagement range from processes to inform or disseminate information, which have a low level of engagement, to formal partnerships with a high level of public involvement and influence. Aiming to have active and informed consumers as equal partners in decision-making processes at all levels of the healthcare system is therefore the central concept for both consumer engagement and patient-centred care. Examples of different strategies that can be used to engage consumers are included in the *Safety and Quality Improvement Guide for Standard 2: Partnering with Consumers*.[6]

Consumer medicines information: Brand-specific leaflets produced by a pharmaceutical company, in accordance with the Therapeutic Goods Regulations *(Therapeutic Goods Act 1989)*, to inform patients about prescription and pharmacist-only medicines. These are available from a variety of sources: for example, a leaflet enclosed within the medication package or supplied by a pharmacist; or a computer printout, provided by a doctor, nurse or hospital, and obtained from the pharmaceutical manufacturer or from the internet.[20]

Continuity of care: Linkage of components of individualised treatment and care across health service agencies according to individual needs.[2]

Continuous improvement: A systematic, ongoing effort to raise an organisation's performance as measured against a set of standards or indicators.[34]

Credentialling: Refers to the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of a practitioner for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality healthcare services within specific organisational environments.[35]

Discharge/Exit planning: A process for ensuring transfer of care of a consumer between service providers. Discharge planning results in a formal written discharge plan, the aim of which is to ensure continuity of services that are necessary for successful community living. The discharge plan is a negotiated enterprise between the consumer, carer or family, referring doctor, community mental health team and the inpatient unit. It includes medical information, follow-up appointments and the desired outcomes of treatment.

The process of discharge planning begins at the time of admission. Barriers to discharge are identified at the time of admission and specific planning initiated to address these barriers, for example, anticipated difficulties in finding suitable accommodation. The relevant stakeholders who are not directly involved in the discharge planning should also be notified of the anticipated discharge date, for example general practitioner and supported accommodation provider.[2]

Disease surveillance: An epidemiological practice that involves monitoring the spread of disease to establish progression patterns. The main role of surveillance is to predict, observe and provide a measure for strategies that may minimise the harm caused by outbreak, epidemic and pandemic situations, as well as to increase knowledge of the factors that might contribute to such circumstances.[22]

Diversity: A broad concept that includes age, personal and corporate background, education, function and personality. Includes lifestyle, sexual orientation, ethnicity and status within the general community.[2]

Early intervention: Interventions targeting people displaying the early signs and symptoms of a mental health problem or mental disorder.[2]

Emergency assistance: Clinical advice or assistance provided when a patient's condition has deteriorated severely. This assistance is provided as part of the rapid response system, and is additional to the care provided by the attending medical officer or team.[19]

Environment: The overall surroundings where health care is being delivered, including the building, fixtures, fittings and services such as air and water supply. Environment can also include other patients, visitors and the workforce.

Escalation protocol: The protocol that sets out the organisational response required for different levels of abnormal physiological measurements or other observed deterioration. The protocol applies to the care of all patients at all times.[19]

Evaluation: A systematic analysis of the merit, worth or significance of an object, system or program.[13]

Evidence-based practice: Care where experience, judgement and expertise is integrated with knowledge about effectiveness gained from a systematic overview of all relevant high quality research evidence.

Exit: When the consumer no longer requires treatment, support, or any other service from the mental health service, and there has been a last review of the case with peers and the case is closed. Exit is prepared for in a collaborative manner with the consumer. This may be referred to as discharge in some services.[2]

Fall: An event that results in a person coming to rest inadvertently on the ground or floor or another lower level.[36]

Guidelines: Clinical practice guidelines are 'systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific circumstances'.[37]

Governance: The set of relationships and responsibilities established by a health service organisation between its executive, workforce and stakeholders (including consumers). Governance incorporates the set of processes, customs, policy directives, laws and conventions affecting the way an organisation is directed, administered or controlled. Governance arrangements provide the structure through which the corporate objectives (social, fiscal, legal, human resources) of the organisation are set and the means by which the objectives are to be achieved. They also specify the mechanisms for monitoring performance. Effective governance provides a clear statement of individual accountabilities within the organisation to help in aligning the roles, interests and actions of different participants in the organisation to achieve the organisation's objectives. In these Standards, governance includes both corporate and clinical governance.[1]

Hand hygiene: A general term referring to any action of hand cleansing.

Healthcare associated infections: Infections that are acquired in healthcare facilities (nosocomial infections) or that occur as a result of healthcare interventions (iatrogenic infections). Healthcare associated infections may manifest after people leave the healthcare facility.[38]

Healthcare Provider Identifier: Allocated to healthcare providers involved in providing patient care.[39]

Healthcare Provider Identifier – Organisation: Allocated to organisations (such as a hospital or medical clinic) where health care is provided.[39]

Health outcome: The health status of an individual, a group of people or a population that is wholly or partially attributable to an action, agent or circumstance.

Health service organisation: A separately constituted health service that is responsible for the clinical governance, administration and financial management of a service unit(s) providing health care. A service unit involves a grouping of clinicians and others working in a systematic way to deliver health care to patients and can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.

Health service record: Information about a patient held in hard or soft copy. The health service record may comprise of clinical records (such as medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records, medication charts), administrative records (such as contact and demographic information, legal and occupational health and safety reports) and financial records (such as invoices, payments and insurance information). See **Patient clinical record**.

High-risk medicines: Medicines that have a high risk of causing serious injury or death to a patient if they are misused. Errors with these products are not necessarily more common, but the effects can be more devastating. Examples of high-risk medicines include anticoagulants, opioids and chemotherapy.[40]

Hospital: A healthcare facility licensed by the respective regulator as a hospital or declared as a hospital.

Human factors: Study of the interactions between humans and other elements of a system, and the profession that applies theory, principles, data and methods to design in order to optimise human wellbeing and overall system performance.[41]

Incident: An event or circumstance that resulted, or could have resulted, in unintended and/or unnecessary harm to a person and/or a complaint, loss or damage.

Individual Healthcare Identifier: Allocated to all individuals enrolled in the Medicare program or those who are issued with a Department of Veterans' Affairs treatment card, and others who seek health care in Australia.[39]

Infection: The invasion and reproduction of pathogenic or disease causing organisms inside the body. This may cause tissue injury and disease.[22]

Infection control or **infection control measures:** Actions to prevent the spread of pathogens between people in a healthcare setting. Examples of infection control measures include targeted healthcare associated infection surveillance, infectious disease monitoring, hand hygiene and personal protective equipment.[22]

Informed consent: A process of communication between a patient and their medical officer that results in the patient's authorisation or agreement to undergo a specific medical intervention.[42] This communication should ensure the patient has an understanding of all the available options and the expected outcomes such as the success rates and/or side effects for each option.[43] Consent obtained freely, without coercion, threats or improper inducements, after questions asked by the consumer have been answered, after appropriate disclosure to the patient, adequate and understandable information in a form and language demonstrably understood by the patient.[2]

Integration: The process whereby inpatient and community components of a mental health service become coordinated as a single, specialist network and include mechanisms which link intake, assessment, crisis intervention, and acute, extended and ongoing treatment using a case management approach to ensure continuity of care.[2]

Interventional procedures: Any procedure used for diagnosis or treatment that penetrates the body. These procedures involve incision, puncture, or entry into a body cavity.

Invasive devices: Devices inserted through skin, mucosal barrier or internal cavity, including central lines, peripheral lines, urinary catheters, chest drains, peripherally inserted central catheters and endotracheal tubes.[44-45]

Involuntary: Where persons are detained in hospital or compulsorily treated in the community under mental health legislation for the purpose of assessment or provision of appropriate treatment or care.[2]

Mandatory training: Compulsory training designed to ensure healthcare workers have the required knowledge and skills to practice safely in areas.

Medication: The use of medicine for therapy or for diagnosis, its interaction with the patient and its effect.

Medication authorities: An organisation's formal authorisation of an individual, or group of individuals, to prescribe, dispense or administer medicines or categories of medicine consistent with their scope of practice.

Medication error: Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient or consumer.[46]

Medication history: An accurate recording of a patient's medicines. It comprises a list of all current medicines including all current prescription and non-prescription medicines, complementary healthcare products and medicines used intermittently; recent changes to medicines; past history of adverse drug reactions including allergies; and recreational drug use.[47]

Medication incident: See **Adverse medicines event**.

Medication Management Plan (MMP): A form that contains a comprehensive medication history form with space for recording information, prompts for obtaining patient information, dedicated space for documenting medication issues during the care episode and a medication discharge checklist.

Medication management system: The system used to manage the provision of medicines to patients. This system includes dispensing, prescribing, storing, administering, manufacturing, compounding and monitoring the effects of medicines as well as the rules, guidelines, decision-making and support tools, policies and procedures in place to direct the use of medicines. These are specific to a healthcare setting.

Medications reconciliation: The process of obtaining, verifying and documenting an accurate list of a patient's current medications on admission and comparing this list to the admission, transfer, and/or discharge medication orders to identify and resolve discrepancies. At the end of the episode of care the verified information is transferred to the next care provider.

Medicine: A chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental welfare of people. Prescription, non-prescription and complementary medicines, irrespective of their administration route, are included.[48]

Mental health: The capacity of individuals within the groups and the environment to interact with one another in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice.[2]

Mental health problems: A disruption in the interaction between the individual, the group and the environment, producing a diminished state of mental health.[2]

Mental health professional: A person who offers services for the purpose of improving an individual's mental health or to treat mental illness. These professionals include psychiatrists, clinical psychologists, clinical social workers, occupational therapists, psychiatric nurses as well as other professionals.[2]

Mental health promotion: Action to maximise mental health and wellbeing among populations and individuals. Mental health promotion is concerned with promoting wellbeing across entire population groups for people who are currently well, for those at-risk, and for those experiencing illness.[2]

Mental health service (MHS): Specialised mental health services are those with the primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental illness or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental healthcare function.[2]

Mental illness: A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities.

The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM-IV-TR) or the International Classification of Diseases, Tenth Edition (ICD-10). These classification systems apply to a wide range of mental disorders (for the DSM-IV) and mental and physical disorders (for the ICD-10). Not all the DSM-IV mental disorders are within the ambit of the National Mental Health Plan 2003–2008.

In Australia, drug and alcohol problems are primarily the responsibility of the drug and alcohol service system and there is a separate, but linked, national strategy. Similarly, dementia is treated primarily in aged care settings. Both are considered important in terms of their co-morbidity with mental illness.[2]

Monitoring plan: A written plan that documents the type and frequency of observations to be recorded as referred to in *Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care*.[13]

Near miss: An incident that did not cause harm but had the potential to do so.[49]

Non-clinical workforce: The workforce engaged in a health service organisation who do not provide direct clinical care but support the business of health service delivery through administration, hotel service and corporate record management, management support or volunteering.

Non-prescription medicines: Medicines available without a prescription. Some non-prescription medicines can be sold only by pharmacists or in a pharmacy; others can be sold through non-pharmacy outlets. Examples of non-prescription medicines include simple analgesics, cough medicines and antacids.[48]

Open disclosure: An open discussion with a patient about an incident(s) that resulted in harm to that patient while receiving health care. The criteria of open disclosure are an expression of regret and a factual explanation of what happened, the potential consequences and the steps taken to manage the event and prevent recurrence.[50]

Orientation: A formal process of informing and training workforce upon entry into a position or organisation, which covers the policies, processes and procedures applicable to the organisation.

Patient: A person receiving health care. Synonyms for 'patient' include consumer and client.

Patient-care mismatching events: Events where a patient receives the incorrect procedure, therapy, medication, implant, device or diagnostic test. This may be as a result of the wrong patient receiving the correct treatment (such as the wrong patient receiving an X-ray) or as a result of the correct patient receiving the wrong care (such as a surgical procedure performed on the wrong side of the body or the provision of an incorrect meal, resulting in an adverse event). Organisations may elect to include other forms of patient care mismatching (for example, provision of an incorrect meal resulting in an adverse event) in their reporting however these should be recorded separately.[9]

Patient-centred care: The delivery of health care that is responsive to the needs and preferences of patients. Patient-centred care is a dimension of safety and quality.

Patient clinical record: Consists of, but is not limited to, a record of the patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care. See **Health service record**.

Patient information: Formal information that is provided by health services to a patient. Patient information ensures the patient is informed before making decisions about their health care.

Patient blood management: Involves a precautionary approach and aims to improve clinical outcomes by avoiding unnecessary exposure to blood components. It includes the three pillars of blood management:

- optimisation of blood volume and red cell mass
- minimisation of blood loss
- optimisation of the patient's tolerance of anaemia.[51]

Patient master index: An organisation's permanent listing or register of health information on patients who have received or are scheduled to receive services.[52]

Patient procedure matching protocols: Protocols that provide guidance regarding the steps that should be taken to correctly match patients to their intended care.[9]

Performance review: A form of appraisal and evaluation of an employee's performance of assigned duties and responsibilities. It is any form of activity that provides a way to help identify areas for performance enhancement and to help promote professional growth. It can be formal or informal, through discussion or in writing. Evidence may include: reports on compliance with a structured performance management system; records of individual performance improvement discussions and plans; records of training undertaken to address identified gaps in skills and knowledge; use of probation programs, or records of regular feedback sessions between a supervisor and their team member(s) such as diary records.

Periodic review: Infrequent review, the frequency of which is determined by the subject, risk, scale and nature of the review.

Point of care: The time and location where an interaction between a patient and clinician occurs for the purpose of delivering care.

Policy: A set of principles that reflect the organisation's mission and direction. All procedures and protocols are linked to a policy statement.

Prescription medicine: A prescription medicine is any medicine that requires a prescription before it can be supplied. A prescription must be authorised by an appropriately registered practitioner.[53]

Pressure injuries: These are localised to the skin and/or underlying tissue, usually over a bony prominence and caused by unrelieved pressure, friction or shearing. Pressure injuries occur most commonly on the sacrum and heel but can develop anywhere on the body. Pressure injury is a synonymous term for pressure ulcer.

Prevention: Interventions that occur before the initial onset of a disorder.[2]

Procedure: The set of instructions to make policies and protocols operational and are specific to an organisation.

Protocol: An established set of rules used for the completion of tasks or a set of tasks.

Rapid response system: The system for providing emergency assistance to patients whose condition is deteriorating. The system includes the clinical team or individual providing emergency assistance, and may include on-site and off-site personnel.[19]

Recognition and response systems: Formal systems that help workforce promptly and reliably recognise patients who are clinically deteriorating, and appropriately respond to stabilise the patient.[19]

Recovery: A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability.[2]

Referral processes/pathways: Systems and protocols that ensure linkages between services to support continuity of care and ensure that consumers of services are able to negotiate the system in a seamless and timely manner.[2]

Regular: Performed at recurring intervals. The specific interval for regular review, evaluation, audit or monitoring and so on needs to be determined for each case. In these Standards, the time period should be consistent with best practice, be risk-based, and be determined by the subject and nature of the review.

Relapse: A subsequent episode of mental illness. It is a recurrence of symptoms of mental illness similar to those that have previously been experienced. The threshold of symptoms required to identify a relapse varies according to the differing perspectives of the person experiencing the symptoms, their family and carers, and service providers.

Relapse is generally agreed to have occurred when the person experiencing the symptoms is not able to cope using their usual supports and requires a greater intensity of intervention. The word 'relapse' is viewed by many as a negative and medicalised term, and the words 'episode' or 'being unwell' may be preferred.[2]

Relevant documentation: This may include emails, file notes, information posted on workforce notice boards, message books, notes, memos, minutes, records of workforce meetings, reports, workforce emails, written notes of ad hoc meetings. See **Communication material**.

Restraint: A restrictive intervention that relies on external controls to limit the movement or response of a person.[2]

Rights: Something that can be claimed as justly, fairly, legally or morally one's own. A formal description of the services that consumers can expect and demand from an organisation.[2]

Risk: The chance of something happening that will have a negative impact. It is measured by consequences and likelihood.

Risk management: The design and implementation of a program to identify and avoid or minimise risks to patients, employees, volunteers, visitors and the institution.

Scope of clinical practice: The extent of an individual practitioner's approved clinical practice within a particular health service organisation based on the individual's credentials, competence, performance and professional suitability and the needs and capability of the health service organisation.[35]

Seclusion: The act of confining a patient in a room when it is not within their control to leave. It should not be confused with the practice of time out, where a patient is requested to seek voluntary social isolation for a minimum period of time.[2]

Senior level of governance: The most senior committee or individual with the delegated authority to act or influence change to bring about improvement in care or processes.

Sentinel event: Events in which death or serious harm to a patient has occurred. They signal catastrophic system failure and have the potential to seriously undermine public confidence in the healthcare system.[2]

Single use: Single use means the medical device is intended to be used on an individual patient during a single procedure and then discarded. It is not intended to be reprocessed and used on another patient. Some single-use devices are marketed as non-sterile which require processing to make them sterile and ready for use. The manufacture of the device will include appropriate processing instructions to make it ready for use.[38]

Spaulding classification: strategy for reprocessing contaminated medical devices. The system classifies a medical device as critical, semi-critical, or non-critical on the basis of risk to patient safety from contamination on a device. The system also established three levels of germicidal activity (sterilisation, high-level disinfection, and low-level disinfection) for strategies with the three classes of medical devices (critical, semi-critical, and non-critical).[54]

Stakeholder: Individuals, organisations or groups that have an interest or share in services.[2]

Support services: Direct services and interventions provided for a person with a mental health problem and/or mental illness and associated disability aimed at reducing handicap and promoting community tenure, for example, assistance with cooking and cleaning. Support services do not necessarily have a treatment or rehabilitation focus.[2]

System: The resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish the objective of the Standard. The system:

- interfaces risk management, governance, operational processes and procedures, including education, training and orientation
- deploys an active implementation plan and feedback mechanisms
- includes agreed protocols and guidelines, decision support tools and other resource material
- employs a range of incentives and sanctions to influence behaviours and encourage compliance with policy, protocol, regulation and procedures.

Tall Man Lettering: Enhancement of unique letter characters of medicines names by use of upper case characters to improve differentiation of look-alike medicines names. Australia has nationally standardised application of Tall Man Lettering to medicines names pairs and groups which are at high risk of confusion and are likely to cause serious or catastrophic patient harm if confused.[8]

Training: The development of knowledge and skills.

Transfer of care: Any instance where the responsibility for care of a patient passes from one individual or team to another. This includes nursing and medical change of shift, transfer of to another medical officer or primary care practitioner and transfer of a patient to another health facility.[9]

Transmission-based precautions: Extra work practices in situations where standard precautions alone may be insufficient to prevent infection (for example, for patients known or suspected to be infected or colonised with infectious agents that may not be contained with standard precautions along).[38]

Treatment: Specific physical, psychological and social interventions provided by health professionals aimed at the reduction of impairment and disability and/or the maintenance of current level of functioning.[2]

Treatment-limiting orders: Orders, instructions or decisions that involve the reduction, withdrawal or withholding of life-sustaining treatment. These may include 'no cardiopulmonary resuscitation' or 'not for resuscitation'.[19]

Triage: A system for determining the relative priority of new referrals. Might also be called intake or engagement.[2]

Voluntary admission: Admission to a mental health unit for treatment that results from the client making the decision for admission and signing the necessary agreement for inpatient treatment.[2]

Wellbeing: The state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or economic and social condition.[2]

Workforce: All those people employed by a health service organisation.

Section A

NSQHS STANDARDS

A

National Safety and Quality Health Service Standards

Section A of the Workbook presents the *NSQHS Standards* at 'Actions Required' level with matching *NSMHS* at 'Criterion' level. The tables contain reflective questions and examples of evidence drawn from the *Hospital Accreditation Workbook* and the *Implementation Guidelines for Public Mental Health Services and Private Hospitals*.[3]

Governance for Safety and Quality in Health Service Organisations

Standard 1

Standard 1: Governance for Safety and Quality in Health Service Organisations

Health service organisation leaders implement governance systems to set, monitor and improve the performance of the organisation and communicate the importance of the patient experience and quality management to all members of the workforce. Clinicians and other members of the workforce use the governance systems.

The intention of this Standard is to:

Create integrated governance systems that maintain and improve the reliability and quality of patient care, as well as improve patient outcomes.

Context:

This Standard provides the safety and quality governance framework for health service organisations. It is expected that this Standard will apply to the implementation of all other Standards in conjunction with *Standard 2: Partnering with Consumers*.

Criteria to achieve the Governance for Safety and Quality in Health Service Organisations Standard:

- Governance and quality improvement systems
- Clinical practice
- Performance and skills management
- Incident and complaints management
- Patient rights and engagement

Governance and quality improvement systems

There are integrated systems of governance to actively manage patient safety and quality risks.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.1 Implementing a governance system that sets out the policies, procedures and/or protocols for: • establishing and maintaining a clinical governance framework • identifying safety and quality risks • collecting and reviewing performance data • implementing prevention strategies based on data analysis • analysing reported incidents • implementing performance management procedures • ensuring compliance with legislative requirements and relevant industry standards • communicating with and informing the clinical and non-clinical workforce • undertaking regular clinical audits				
1.1.1 An organisation-wide management system is in place for the development, implementation and regular review of policies, procedures and/or protocols	**1.2** All care is delivered in accordance with relevant Commonwealth, state/territory mental health legislation and related Acts **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 **1.13** The MHS upholds the right of consumers to have access to their own health records in accordance with relevant Commonwealth, state/territory legislation **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	How do we describe our decision-making and management processes? What documents do we use to check that we meet legislation, regulation, business and professional requirements? How do we describe what we have put in place in our MHS? How do we ensure these documents are updated and used by our workforce? How do we ensure policies, procedures and protocols are implemented?	☐ Policies, procedures and protocols that address the items listed in 1.1 ☐ Register of completed policy, procedure and protocol reviews, including dates of effect, dates policy documents were amended and a prioritised schedule for future reviews ☐ Policy documents that have been reviewed in response to identified risks ☐ Relevant documentation of committee structures and roles that oversee policy, procedure and protocol development ☐ Register of safety and quality risks and actions taken to address identified risks ☐ Register of legislative requirements, with routine process for review ☐ Communication of new or revised policy documents to the workforce ☐ Audit of clinical records detailing when consumers and carers provided with brochure outlining Rights and Responsibilities ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and quality improvement systems

There are integrated systems of governance to actively manage patient safety and quality risks.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.1 Implementing a governance system that sets out the policies, procedures and/or protocols for: • establishing and maintaining a clinical governance framework • identifying safety and quality risks • collecting and reviewing performance data • implementing prevention strategies based on data analysis • analysing reported incidents • implementing performance management procedures • ensuring compliance with legislative requirements and relevant industry standards • communicating with and informing the clinical and non-clinical workforce • undertaking regular clinical audits				
1.1.1 An organisation-wide management system is in place for the development, implementation and regular review of policies, procedures and/or protocols *(continued)*	**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 issue of sharing confidential information with carers **8.4** The MHS has processes in place to ensure compliance with relevant Commonwealth, state/territory mental health legislation and related Acts **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 their stay			

Governance and quality improvement systems

There are integrated systems of governance to actively manage patient safety and quality risks.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.1 Implementing a governance system that sets out the policies, procedures and/or protocols for: • establishing and maintaining a clinical governance framework • identifying safety and quality risks • collecting and reviewing performance data • implementing prevention strategies based on data analysis • analysing reported incidents • implementing performance management procedures • ensuring compliance with legislative requirements and relevant industry standards • communicating with and informing the clinical and non-clinical workforce • undertaking regular clinical audits (continued)				
1.1.2 The impact on patient safety and quality of care is considered in business decision-making	**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	How do we show that our business decisions take into account safe practice and quality of care for patients?	☐ Strategic and business plans that outline the potential impact on patient safety and quality of care ☐ Register of safety and quality risks that includes actions to address the identified risks ☐ Business proposal templates ☐ Relevant documentation from committees and meetings, such as finance and audit committees and strategic planning committees, that demonstrate safety and quality of care is considered in business decision-making ☐ Evidence that committees include consumer and carer representatives ☐ Policies, procedures and protocols for assessing risks associated with the introduction of new services, including changes to clinicians' scope of practice ☐ Results of audits of policy documents, patients clinical records and clinical practice ☐ The organisation's strategic and operational governance framework includes the organisational and committee structure ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Governance and quality improvement systems

There are integrated systems of governance to actively manage patient safety and quality risks.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.2 The board, chief executive officer and/or other higher level of governance within a health service organisation taking responsibility for patient safety and quality of care				
1.2.1 Regular reports on safety and quality indicators and other safety and quality performance data are monitored by the executive level of governance	**8.10** The MHS has an integrated risk management policy and practices to identify, evaluate, monitor, manage and communicate organisational and clinical risks	What information do we provide to our executive to review patient safety and quality? How do they feed back on changes to be implemented?	☐ Relevant documentation from committees and meetings that include information on safety and quality indicators and data ☐ Reporting templates and calendars ☐ Safety and quality information and data presented to the executive ☐ Annual report which includes information on safety and quality performance ☐ Communication to the workforce on safety and quality indicators and data ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.2.2 Action is taken to improve the safety and quality of patient care	**2.8** The MHS can demonstrate investment in adequate staffing and resources for the safe delivery of care **2.13** The MHS has a formal process for identification, mitigation, resolution (where possible) and review of any safety issues **8.11** The MHS has a formal quality improvement program incorporating evaluation of its services that result in changes to improve practice	What action has our executive endorsed to improve safe practice and quality of patient care? What evidence has been analysed to inform these actions?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Evidence of analysis of critical events, both collated data and trends, and individual cases ☐ Quality improvement plan that includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to improve the safety and quality of patient care ☐ Communication material developed for the workforce and patients ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and quality improvement systems

There are integrated systems of governance to actively manage patient safety and quality risks.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.3 Assigning workforce roles, responsibilities and accountabilities to individuals for: • **patient safety and quality in the delivery of health care** • **the management of safety and quality as specified in each of these Standards**				
1.3.1 Workforce are aware of their delegated safety and quality roles and responsibilities	**8.7** Staff are appropriately trained, developed and supported to safely perform the duties required of them	How do we inform the workforce about their roles and responsibilities for safety and quality of care?	☐ Position descriptions, duty statements and employment contracts that describe safety and quality roles, responsibilities and accountabilities ☐ Results of workforce surveys or feedback regarding their safety and quality roles and responsibilities ☐ Policies, procedures and protocols that outline the delegated safety and quality roles and responsibilities of the workforce ☐ Organisational chart and delegations policy demonstrating clinical governance reporting lines and relationships ☐ Education resources and records of attendance at training by the workforce on their safety and quality roles and responsibilities ☐ Communication to the workforce on their safety and quality roles and responsibilities ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and quality improvement systems

There are integrated systems of governance to actively manage patient safety and quality risks.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.3 Assigning workforce roles, responsibilities and accountabilities to individuals for: • **patient safety and quality in the delivery of health care** • **the management of safety and quality as specified in each of these Standards** (continued)				
1.3.2 Individuals with delegated responsibilities are supported to understand and perform their roles and responsibilities, in particular to meet the requirements of these Standards	**8.7** Staff are appropriately trained, developed and supported to safely perform the duties required of them	How do we support the workforce to perform their roles and responsibilities for safety and quality of care?	☐ Relevant regulations, legislation, guidelines and standards that are accessible to the workforce ☐ Education resources and records of attendance at training by the workforce, specifically for those with delegated responsibilities for safety and quality ☐ Performance appraisals that include feedback to the workforce on delegated roles and responsibilities ☐ Feedback from the workforce regarding their roles and responsibilities for safety and quality ☐ Succession plans for key clinical governance position ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.3.3 Agency or locum workforce are aware of their designated roles and responsibilities	No match to the *NSMHS*	How do we inform locum or agency workforce of their roles and responsibilities for safety and quality of care?	☐ Policies, procedures and protocols that address the roles and responsibilities of locum and agency workforce ☐ Contracts for locum and agency workforce that specify designated roles and responsibilities, including for safety and quality ☐ Position descriptions, duty statements and employment contracts for locum and agency workforce specify designated roles and responsibilities ☐ Induction checklists ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and quality improvement systems

There are integrated systems of governance to actively manage patient safety and quality risks.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.4 Implementing training in the assigned safety and quality roles and responsibilities				
1.4.1 Orientation and ongoing training programs provide the workforce with the skill and information needed to fulfil their safety and quality roles and responsibilities	**8.7** Staff are appropriately trained, developed and supported to safely perform the duties required of them	What training must new members of the workforce have to meet their roles and responsibilities for safety and quality? How do we provide the workforce with the skills and information necessary for their roles and responsibilities for safety and quality?	☐ Evidence of the assessment of training needs through review of incidents, performance data, workforce feedback, workforce reviews, system audits and policy ☐ Education resources and records of attendance at training by the workforce on safety and quality roles and responsibilities ☐ Review and evaluation reports of education and training ☐ Feedback from the workforce regarding their training needs ☐ Relevant guidelines, legislation and standards that are accessible to the workforce ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.4.2 Annual mandatory training programs to meet the requirements of these Standards	**2.10** Staff are regularly trained to, wherever possible, prevent, minimise and safely respond to aggressive and other difficult behaviours	What training does our organisation require each member of the workforce to complete annually in relation to the *NSQHS Standards* and the *NSMHS*?	☐ Schedule of annual mandatory training that includes the requirements of the *NSQHS Standards* ☐ Schedule of annual mandatory updates in staff aggression minimisation skills ☐ Education resources and records of attendance at mandatory training by the workforce ☐ Annual review of mandatory training needs and resources provided to support training requirements ☐ Evaluation survey or report on training programs on workforce safety and quality roles and responsibilities ☐ Communication to the workforce regarding annual mandatory training requirements ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and quality improvement systems

There are integrated systems of governance to actively manage patient safety and quality risks.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.4 Implementing training in the assigned safety and quality roles and responsibilities				(continued)
1.4.3 Locum and agency workforce have the necessary information, training and orientation to the workplace to fulfil their safety and quality roles and responsibilities	No match to the *NSMHS*	How do we ensure locum or agency workforce have the necessary skills and information to undertake their role and responsibilities?	☐ Policies, procedures and protocols for clinical supervision of locum and agency workforce ☐ Policies, procedures and protocols that are accessible to locum and agency workforce ☐ Orientation and education resources for locum and agency workforce ☐ Position descriptions, duty statements and employment contracts that detail the safety and quality roles and responsibilities for locum and agency workforce ☐ Register of locum and agency workforce credentials ☐ Skills appraisals and record of competencies for locum and agency workforce ☐ Communication to locum and agency workforce related to their safety and quality roles and responsibilities ☐ Feedback from locum and agency workforce regarding their safety and quality roles and responsibilities ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.4.4 Competency-based training is provided to the clinical workforce to improve safety and quality	**8.7** Staff are appropriately trained, developed and supported to safely perform the duties required of them	What training is provided to clinicians to improve their competency in patient safety and quality?	☐ Education resources and records of attendance at competency-based training by clinicians ☐ Schedule of clinical workforce education and competency-based training ☐ Documented assessment of competency-based training needs of clinicians ☐ Communication to clinicians regarding annual mandatory training requirements ☐ Evaluation of competency-based training courses ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and quality improvement systems

There are integrated systems of governance to actively manage patient safety and quality risks.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.5 Establishing an organisation-wide risk management system that incorporates identification, assessment, rating, controls and monitoring for patient safety and quality				
1.5.1 An organisation-wide risk register is used and regularly monitored	**8.10** The MHS has an integrated risk management policy and practices to identify, evaluate, monitor, manage and communicate organisational and clinical risks	How do we identify, record and implement changes to reduce the risks for safe practice and quality of care for our patients?	☐ Policies, procedures and protocols for implementing and monitoring the risk management system ☐ Risk register that includes actions to address identified risks ☐ Reports on safety and quality performance trends ☐ Feedback from workforce ☐ Relevant documentation from committees and meetings that oversee the risk management system ☐ Education resources and records of attendance at training by the workforce in relation to the organisation's risk management system ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.5.2 Actions are taken to minimise risks to patient safety and quality of care	**8.10** The MHS has an integrated risk management policy and practices to identify, evaluate, monitor, manage and communicate organisational and clinical risks	What action have we taken to reduce safety risks and improve the quality of care for our patients?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to minimise risks to patient safety and quality of care ☐ Communication material developed for the workforce, patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and quality improvement systems

There are integrated systems of governance to actively manage patient safety and quality risks.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.6 Establishing an organisation-wide quality management system that monitors and reports on the safety and quality of patient care and informs changes in practice				
1.6.1 An organisation-wide quality management system is used and regularly monitored	**8.11** The MHS has a formal quality improvement program incorporating evaluation of its services that result in changes to improve practice	How do we plan our work and then measure our performance to make improvements? How do we use quality management methods in our organisation?	☐ Policies, procedures and protocols that describe the processes and accountability for monitoring the organisation's quality management system ☐ Quality framework or plan ☐ Relevant documentation from committees and meetings that includes analyses of data on safety and quality of patient care and actions identified ☐ Audit of use of policies, procedures and protocols ☐ Reports, presentations and analysis of performance data ☐ Register of incident reports, adverse events and near misses ☐ Analysis of records of comments, complaints and incidents from patients, carers ☐ Analysis of patient experience surveys and organisational responses to issues identified ☐ Feedback to the workforce regarding safety and quality of patient care ☐ Individual healthcare identifier protocols used in electronic health records or electronic medical records ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and quality improvement systems

There are integrated systems of governance to actively manage patient safety and quality risks.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.6 Establishing an organisation-wide quality management system that monitors and reports on the safety and quality of patient care and informs changes in practice (continued)				
1.6.2 Actions are taken to maximise patient quality of care	**8.11** The MHS has a formal quality improvement program incorporating evaluation of its services that result in changes to improve practice	What action have we taken to ensure the highest quality of care for our patients?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to maximise quality of patient care ☐ Re-audit of identified deficiencies and areas requiring action ☐ Communication material developed for the workforce, patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Clinical practice

Care provided by the clinical workforce is guided by current best practice.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.7 Developing and/or applying clinical guidelines or pathways that are supported by the best available evidence				
1.7.1 Agreed and documented clinical guidelines and/or pathways are available to the clinical workforce	**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 **10.5.1** Treatment and support provided by the MHS reflect best available evidence and emphasise early intervention and positive outcomes for consumers and their carer(s)	Which clinical guidelines do we use, where do they come from and how do clinicians access them?	☐ Policies, procedures and protocols on access and use of clinical guidelines and pathways that reflect best practice and are appropriately referenced ☐ List of web addresses for the workforce to access electronic copies of clinical guidelines and pathways ☐ Observation of clinical guidelines and pathways available in clinical areas ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.7.2 The use of agreed clinical guidelines by the clinical workforce is monitored	**10.5.7** The MHS actively promotes adherence to evidence-based treatments through negotiation and the provision of understandable information to the consumer	How do we find out if clinicians are using the agreed clinical guidelines? How do clinicians communicate the information in guidelines to enable consumers to understand and make informed treatment choices?	☐ Observation of clinical guidelines and pathways available in clinical areas ☐ List of procedures with agreed clinical pathways available to the workforce ☐ Audit of adherence to available clinical guidelines and pathways via patient clinical record audit ☐ Audit of treatment plans indicating consumers are provided with information to make decisions based on best available evidence ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Clinical practice

Care provided by the clinical workforce is guided by current best practice.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.8 Adopting processes to support the early identification, early intervention and appropriate management of patients at increased risk of harm				
1.8.1 Mechanisms are in place to identify patients at increased risk of harm	**2.3** The MHS assesses and minimises the risk of deliberate self-harm and suicide within all MHS settings **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	How do we identify patients at an increased risk of harm? What mechanisms do we use to assess risk at known key points of risk?	☐ Policies, procedures and protocols available to guide workforce in identifying patients at increased risk of harm ☐ Organisational risk profile that details patient safety and quality risks and their potential impact ☐ Education resources and records of attendance at training by the workforce on the identification of at-risk patients ☐ Patient clinical records demonstrate that risk assessments are completed on admission, during an episode of care and at exit or transfer ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.8.2 Early action is taken to reduce the risks for at-risk patients	**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	What action have we taken to decrease the risk of harm to our vulnerable patients?	☐ Risk profile or management plan that includes an evaluation of risks and methods of eliminating or reducing identifiable risks ☐ Register of incident, adverse events and near misses that includes actions to address identified risks ☐ Risk management and action plans implemented for patients identified at increased risk of harm ☐ Treatment plans that indicate interventions offered in response to change in clinical need ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Clinical practice

Care provided by the clinical workforce is guided by current best practice.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.8 Adopting processes to support the early identification, early intervention and appropriate management of patients at increased risk of harm (continued)				
1.8.3 Systems exist to escalate the level of care when there is an unexpected deterioration in health status	**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 themself 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	How do we respond to a person whose health unexpectedly deteriorates? Do we have effective means in place for consumers and carers to escalate care?	☐ Policies, procedures and protocols regarding escalation of care ☐ Education resources and records of attendance at training by the workforce on escalating care when unexpected deterioration occurs ☐ Instructions on how to call for assistance are clearly displayed in areas where care is provided ☐ Audit of clinical records indicating escalation of care triggered in response to multiple triggers, included activation by consumers and/or carers ☐ Record of operational and mechanical call device testing ☐ Other _____ **Links with Item 9.1 regarding establishing recognition and response systems in the acute care setting**	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Clinical practice

Care provided by the clinical workforce is guided by current best practice.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.9 Using an integrated patient clinical record that identifies all aspects of the patient's care				
1.9.1 Accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point 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	How do we make patient clinical records available to clinicians when care is provided? How do we know our patient clinical records are comprehensive and accurate?	☐ Policies, procedures and protocols for ensuring patient clinical records are available at the point of care, including when a patient is transferred within or between organisations ☐ Policies, procedures and protocols for obtaining patient clinical records from storage and other areas of the organisation ☐ Audit of the accuracy, integration and currency of patient clinical records ☐ Audits of the availability of patient clinical records to the clinical workforce at the point of care ☐ Other _____ **Links with Action 1.19.1 regarding availability of patient clinical records at the point of care**	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.9.2 The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards	**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	How do we know our patient clinical records are meeting the key requirements of the Standards?	☐ Audit of patient clinical records that includes the requirements as stated in items and actions of the *NSQHS Standards* ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Performance and skills management

Managers and the clinical workforce have the right qualifications, skills and approach to provide safe, high quality health care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.10 Implementing a system that determines and regularly reviews the roles, responsibilities, accountabilities and scope of practice for the clinical workforce				
1.10.1 A system is in place to define and regularly review the scope of practice for the clinical workforce	No match to the *NSMHS*	How do we know we have the right people consistently doing the right job when providing clinical services?	☐ Policies, procedures and protocols regarding the scope of practice for clinicians ☐ Relevant documentation from committees and meetings that include information on the roles, responsibilities, accountabilities and scope of practice for the clinical workforce ☐ Audit of policies, procedures and protocols against scope of practice defined by credentialling bodies ☐ Audit of position descriptions, duty statements and employment contracts against the requirements and recommendations of clinical practice and professional guidelines ☐ Workforce performance appraisal and feedback records show a review of the scope of practice for clinical workforce ☐ Peer review reports ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.10.2 Mechanisms are in place to monitor that the clinical workforce are working within their agreed scope of practice	**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	How do we know that clinicians work within agreed boundaries when providing care to patients?	☐ Register of workforce qualifications and areas of credentialled practice ☐ Audit of compliance with policies, procedures and protocols ☐ Audit of clinical workforce who have a documented performance appraisal ☐ Audit of signatures and role designation in patient clinical records ☐ Observation of clinical practice ☐ Reports of key performance indicators for clinicians ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Performance and skills management

Managers and the clinical workforce have the right qualifications, skills and approach to provide safe, high quality health care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.10 Implementing a system that determines and regularly reviews the roles, responsibilities, accountabilities and scope of practice for the clinical workforce (continued)				
1.10.3 Organisational clinical service capability, planning, and scope of practice is directly linked to the clinical service roles of the organisation	**8.5** Identified resources are allocated to support the documented priorities of the MHS	How do we match: • what we can do; • what we plan to do; and • the agreed areas of clinical practice for the workforce with the services and care we provide?	☐ Strategic plan that outlines the organisation's overall objectives and services provided ☐ Register of workforce qualifications suitable for clinical service roles of the organisation ☐ Reports from clinical information systems ☐ Benchmarking reports ☐ Reports of inspections from regulators ☐ Evaluation of the organisation's clinical services targets ☐ Evaluation of the safety and quality of clinical services and programs ☐ Annual report that details the clinical service capability and clinical services provided ☐ Audit of Diagnostic Related Groups (DRGs) cared for by clinicians compared to their granted scope of clinical practice and the Clinical Services Capability Framework (CSCF) of the organisation ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Performance and skills management

Managers and the clinical workforce have the right qualifications, skills and approach to provide safe, high quality health care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.10 Implementing a system that determines and regularly reviews the roles, responsibilities, accountabilities and scope of practice for the clinical workforce (continued)				
1.10.4 The system for defining the scope of practice is used whenever a new clinical service, procedure or other technology is introduced	No match to the *NSMHS*	How do we assess the safety and impact on quality of care of a new clinical service, procedure or other technology before it is introduced?	☐ Policies, procedures, protocols and bylaws regarding scope of practice ☐ Planning documents to introduce new services (including workforce, equipment, procedures, scope of practice applications and approval for licensing) ☐ Defined competency standards for new services, procedures and technology ☐ Education resources and records of attendance at training by the workforce on new clinical services, procedures and technologies ☐ Communication to the workforce that defines the scope of practice for new clinical services, procedures or other technology ☐ Procedure manuals or guidelines for new services, procedures and technologies ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Performance and skills management

Managers and the clinical workforce have the right qualifications, skills and approach to provide safe, high quality health care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.10 Implementing a system that determines and regularly reviews the roles, responsibilities, accountabilities and scope of practice for the clinical workforce (continued)				
1.10.5 Supervision of the clinical workforce is provided whenever it is necessary for individuals to fulfil their designated role	**8.7** Staff are appropriately trained, developed and supported to safely perform the duties required of them	How do we supervise and support clinicians to practise within agreed professional and organisational boundaries when providing patient care? Is clinical supervision available to staff, either on an individual or group basis?	☐ Descriptions of roles and responsibilities for designated clinical leaders included in position descriptions, duty statements and employment contracts ☐ Register of workforce qualifications and areas of credentialled practice ☐ Documented review of qualifications and competencies for clinical workforce ☐ Individual performance reviews documented for all the clinical workforce ☐ Register of clinical supervision arrangements in place for clinicians ☐ Observation of clinical practice ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Performance and skills management

Managers and the clinical workforce have the right qualifications, skills and approach to provide safe, high quality health care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.11 Implementing a performance development system for the clinical workforce that supports performance improvement within their scope of practice				
1.11.1 A valid and reliable performance review process is in place for the clinical workforce	**8.7** Staff are appropriately trained, developed and supported to safely perform the duties required of them	How do we develop, support and manage the performance of each clinician?	☐ Policies, procedures and protocols on the performance review process for clinicians ☐ A documented performance development system that meets professional development guidelines and credentialling requirements ☐ Individual professional development plans and system-wide tracking of participation in reviews ☐ Audit of use of policies, procedures and protocols on the performance review process for clinical workforce ☐ Audit of clinical workforce with completed performance reviews ☐ Relevant documentation from committees and meetings regarding performance review and credentialling of clinicians ☐ Mentoring or peer review reports ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.11.2 The clinical workforce participates in regular performance reviews that support individual development and improvement	**8.7** Staff are appropriately trained, developed and supported to safely perform the duties required of them	What is our process for regularly reviewing the performance of each clinician?	☐ Individual performance reviews documented for the clinical workforce ☐ Workforce training and competency records consistent with organisational policies and credential requirements ☐ Workforce development plans that document training needs identified through individual performance reviews ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Performance and skills management

Managers and the clinical workforce have the right qualifications, skills and approach to provide safe, high quality health care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.12 Ensuring that systems are in place for ongoing safety and quality education and training				
1.12.1 The clinical and relevant non-clinical workforce have access to ongoing safety and quality education and training for identified professional and personal development	**8.7** Staff are appropriately trained, developed and supported to safely perform the duties required of them	What access does the workforce have to education and training in safe practice and good quality of care?	☐ Policies, procedures and protocols on training requirements for the organisation ☐ Education resources and records of attendance at training by the workforce on safety and quality ☐ Safety and quality resources and materials readily available to the workforce ☐ Communication to the workforce about education requirements ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.13 Seeking regular feedback from the workforce to assess their level of engagement with, and understanding of, the safety and quality system of the organisation				
1.13.1 Analyse feedback from the workforce on their understanding and use of safety and quality systems	No match to the *NSMHS*	How do we obtain feedback from the workforce on safety and quality matters to review their understanding and use of our processes?	☐ Records of workforce feedback regarding the use of safety and quality systems ☐ Analysis of workforce survey results regarding the use of safety and quality systems ☐ Relevant documentation from committees and meetings regarding feedback from the workforce on safety and quality systems ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Performance and skills management

Managers and the clinical workforce have the right qualifications, skills and approach to provide safe, high quality health care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.13 Seeking regular feedback from the workforce to assess their level of engagement with, and understanding of, the safety and quality system of the organisation (continued)				
1.13.2 Action is taken to increase workforce understanding and use of safety and quality systems	No match to the *NSMHS*	What action have we taken to increase the use and understanding of our safety and quality processes by the workforce?	☐ Relevant documentation from committees that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated for use of safety and quality systems ☐ Communication material developed for the workforce, patients and carers ☐ Succession plans for key safety and quality positions ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Incident and complaints management

Patient safety and quality incidents are recognised, reported and analysed, and this information is used to improve safety systems.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.14 Implementing an incident management and investigation system that includes reporting, investigating and analysing incidents, (including near misses), which all result in corrective actions				
1.14.1 Processes are in place to support the workforce recognition and reporting of incidents and near misses	**2.13** The MHS has a formal process for identification, mitigation, resolution (where possible) and review of any safety issues	How do we identify, record and respond to incidents and near misses?	☐ Policies, procedures and protocols for reporting, investigating and analysing incidents and near misses ☐ Risk assessment, incident and near miss reporting forms ☐ Register of incident reports, adverse events and near misses that includes actions to address identified risks ☐ Education resources and records of attendance at training by the workforce on recognising, reporting, investigating and analysing incidents, adverse events and near misses ☐ Documented support from the executive promoting incident reporting systems ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.14.2 Systems are in place to analyse and report on incidents	**2.13** The MHS has a formal process for identification, mitigation, resolution (where possible) and review of any safety issues	What is our process for reviewing information on incidents and near misses? How is the information from incidents and near misses used to improve patients care?	☐ A current register of incident reports, adverse events and near misses that includes actions to address identified risks ☐ Data that reports trends of incidents, adverse events and near misses are recorded such as in meeting minutes or annual reports ☐ Relevant documentation from committees and meetings that includes information from incident reports ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Incident and complaints management

Patient safety and quality incidents are recognised, reported and analysed, and this information is used to improve safety systems.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.14 Implementing an incident management and investigation system that includes reporting, investigating and analysing incidents, (including near misses), which all result in corrective actions (continued)				
1.14.3 Feedback on the analysis of reported incidents is provided to the workforce	**2.13** The MHS has a formal process for identification, mitigation, resolution (where possible) and review of any safety issues	How do we provide feedback on our incidents and near misses to the workforce?	☐ Incident reports are available to the workforce ☐ Relevant documentation from committees and meetings that contain an analysis of incidents and near misses are available to workforce ☐ Communication to the workforce on the analysis of incidents and trends in safety and quality ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.14.4 Action is taken to reduce risks to patients identified through the incident management system	**2.13** The MHS has a formal process for identification, mitigation, resolution (where possible) and review of any safety issues	What do we do to decrease the risk of an incident recurring?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to decrease the risk of incidents identified through the incident management system ☐ Communication material developed for workforce, patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.14.5 Incidents and analysis of incidents are reviewed at the highest level of governance in the organisation	**2.13** The MHS has a formal process for identification, mitigation, resolution (where possible) and review of any safety issues	What information is provided to the executive to review incidents and near misses?	☐ Relevant documentation from committees and meetings that detail strategies and actions to address risks ☐ Information on incidents presented to the executive and relevant committees ☐ Report of evidence-based interventions that have been initiated for identified risks ☐ Risk assessments and action plans ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Incident and complaints management

Patient safety and quality incidents are recognised, reported and analysed, and this information is used to improve safety systems.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.15 Implementing a complaints management system that includes partnership with patients and carers				
1.15.1 Processes are in place to support the workforce to recognise and report complaints	**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	How do we identify, report and deal with patient complaints?	☐ Policies, procedures and protocols that describe the processes for recording and managing patient and carers' complaints ☐ Comments and complaints forms are available for patients to complete ☐ Secure patient comments and complaints box in publicly accessible places ☐ Patient information that outlines the internal and external complaints mechanisms ☐ Education resources and records of attendance at training by the workforce on the complaints management system ☐ Relevant documentation from committees and meetings related to complaints management ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.15.2 Systems are in place to analyse and implement improvements in response to complaints	**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	What could we learn from complaints and patient feedback that will lead to better patient outcomes?	☐ A current complaints register which includes responses and actions to address identified issues ☐ Relevant documentation from committees and meetings related to complaints management ☐ Reports or briefings on analysis of complaints ☐ Quality improvement plan that includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Incident and complaints management

Patient safety and quality incidents are recognised, reported and analysed, and this information is used to improve safety systems.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.15 Implementing a complaints management system that includes partnership with patients and carers				(continued)
1.15.3 Feedback is provided to the workforce on the analysis of reported complaints	**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	How do we keep the workforce informed of trends or analysis of complaints and patient feedback?	☐ Relevant documentation from committees and meetings related to complaints management ☐ Reports or briefings on analysis of complaints ☐ Communication material developed for the workforce, patients and carers on complaints ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.15.4 Patient feedback and complaints are reviewed at the highest level of governance in the organisation	**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	What information is provided to the executive to review complaints and patient feedback?	☐ Relevant documentation from committees and meetings related to complaints management ☐ Data that reports trends in patient feedback and complaints ☐ Reports or briefings on analysis of complaints ☐ Risk management plan that includes strategies for managing complaints ☐ Evaluation reports note the effectiveness of responses and improvements in service delivery ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Incident and complaints management

Patient safety and quality incidents are recognised, reported and analysed, and this information is used to improve safety systems.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.16 Implementing an open disclosure process based on the national open disclosure standard				
1.16.1 An open disclosure program is in place and is consistent with the national open disclosure standard	**8.8** The MHS has a policy and process to support staff during and after critical incidents	How do our open disclosure processes align with the national open disclosure standard?	☐ Policies, procedures and protocols are consistent with the principles and processes outlined in the national open disclosure standard ☐ Reports on open disclosure are produced in the organisation ☐ Information and data on open disclosure presented to the executive and relevant committees ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.16.2 The clinical workforce are trained in open disclosure processes	**8.8** The MHS has a policy and process to support staff during and after critical incidents	How do we train relevant members of the workforce in our open disclosure processes? How do we support staff in implementing these processes?	☐ Education resources and records of attendance at training by the relevant workforce on the open disclosure processes ☐ Report on the evaluation of the open disclosure training program ☐ Evidence of debriefing meetings, where staff are supported in implementing open disclosure policies ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Patient rights and engagement

Patient rights are respected and their engagement in their care is supported.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.17 Implementing through organisational policies and practices a patient charter of rights that is consistent with the current national charter of healthcare rights				
1.17.1 The organisation has a charter of patient rights that is consistent with the current national charter of healthcare rights	**1.1** The MHS upholds the right of the consumer to be treated with respect and dignity at all times **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 **10.1.2** The MHS treats consumers and carers with respect and dignity	How do we align our approach to patient healthcare rights with the *Australian Charter of Healthcare Rights* and the *Mental Health Statement of Rights and Responsibilities*?	☐ Policies, procedures and protocols regarding the implementation and use of a charter of patients rights ☐ A charter of patient rights consistent with the *Australian Charter for Healthcare Rights* is available ☐ Copies of the *Mental Health Statement of Rights and Responsibilities* available ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.17.2 Information on patient rights is provided and explained to patients and carers	**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 **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	How do we provide and explain information to patients on their healthcare rights and responsibilities?	☐ A charter of patient rights and responsibilities displayed in areas accessible to the public ☐ Brochures, information sheets or other documents that explain the charter of rights and responsibilities are given to patients ☐ Charter of patient rights and responsibilities that is available in a range of languages and formats, consistent with the patient profile ☐ Admission checklist that includes provision and explanation of patient charter of rights and responsibilities ☐ Evidence that patients and carers understand their rights and responsibilities, for example via patient interview ☐ Evidence of use of interpreters and advocates to assist consumers in understanding their rights and responsibilities ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Patient rights and engagement

Patient rights are respected and their engagement in their care is supported.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.17 Implementing through organisational policies and practices a patient charter of rights that is consistent with the current national charter of healthcare rights (continued)				
1.17.3 Systems are in place to support patients who are at risk of not understanding their healthcare rights	**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	How do we identify and support people who may not understand their healthcare rights? Do we reassess consumers' readiness to engage in a discussion of their rights if this has been temporarily suspended?	☐ A register of interpreters and other advocacy and support services available to the workforce, patients and carers ☐ Interpreters are used for oral communication and sight communication for consent forms ☐ Observation that information about advocacy and support services is accessible to the workforce, patients and carers ☐ Patient clinical records reflect assessment of need and support provided ☐ Analysis of consumer feedback regarding healthcare rights ☐ Results of patient and carer experience surveys regarding healthcare rights ☐ Employment of consumer consultants ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Patient rights and engagement

Patient rights are respected and their engagement in their care is supported.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.18 Implementing processes to enable partnership with patients in decision about their care, including informed consent to treatment				
1.18.1 Patients and carers are partners in the planning for their treatment	**1.10** The MHS upholds the right of the consumer to be involved in all aspects of their treatment, care and recovery planning **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 **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 **10.4.3** The MHS, with the consumer's informed consent includes carers, other service providers and others nominated by the consumer in assessment **10.5.8** 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 **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	How do we involve patients and carers in decisions about their care and confirm their consent to treatment? How do we document the involvement of consumers and carers in their treatment planning?	☐ Patient clinical records include: – information provided to patients and carers about their proposed treatment – patient and carer involvement in pre-operative assessment – patient and carer involvement in discharge planning – case conference records with patients and carers – completed consent forms ☐ Analysis of consumer feedback regarding their participation in treatment planning ☐ Results of patient and carer experience surveys and actions taken to address issues identified regarding participation in making decisions about their care ☐ Patient information packages or resources about treatments ☐ Information for consumers and carers should be reviewed regularly and updated at least every 24 months, with links to current legislation and covenants ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Patient rights and engagement

Patient rights are respected and their engagement in their care is supported.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.18 Implementing processes to enable partnership with patients in decision about their care, including informed consent to treatment (continued)				
1.18.2 Mechanisms are in place to monitor and improve documentation of informed consent	**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	How do we know our patient and carer consent documentation and processes are applied correctly? How do we improve our patient and carer consent documentation and processes? In circumstances where consumers are subject to the provisions of mental health legislation, or have a legal guardian, are decision-making processes consistent with relevant legislation?	☐ Audit of patient clinical records and informed consent forms ☐ Translated patient and carer information resources ☐ Audit of patient clinical records documenting medico-legal processes ☐ Results of patient and carer experience surveys and actions taken to address issues identified regarding informed consent ☐ Feedback from patients and carers after treatment about the consent process ☐ Patient information packages or resources about treatments ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Patient rights and engagement

Patient rights are respected and their engagement in their care is supported.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.18 Implementing processes to enable partnership with patients in decision about their care, including informed consent to treatment				(continued)
1.18.3 Mechanisms are in place to align the information provided to patients with their capacity to understand	**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	How do we provide information about treatment options and risks to patients? How do we take into account a patient's ability to understand information?	☐ Policies, procedures and protocols on communicating and providing information to patients and carers ☐ Relevant documentation from committees and meetings that demonstrate consumer involvement in developing patient information resources ☐ A register of interpreter and other advocacy and support services available to the workforce, patients and carers ☐ Consumer feedback data analysed ☐ Translated patient information resources available (depending on the patient profile of the service) ☐ Patient information resources evaluated by consumers ☐ Other _____ **Links with Standard 2 and Items 3.19, 4.13, 4.15, 7.10, 8.9, 9.7 and 10.9 regarding provision of information to patients and carers**	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Patient rights and engagement

Patient rights are respected and their engagement in their care is supported.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.18 Implementing processes to enable partnership with patients in decision about their care, including informed consent to treatment (continued)				
1.18.4 Patients and carers are supported to document clear advance care directives and/or treatment-limiting orders	**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	How do we document the decisions of patients and carers about advance care directives and/or treatment limiting orders to ensure they are followed at the appropriate time? Do we support our consumers in developing recovery/relapse prevention plans? Do we deliver interventions consistent with these recovery/relapse prevention plans when consumers experience recurrence of symptoms?	☐ Policies, procedures and protocols on advanced care and end of life care that are consistent with jurisdictional guidelines and directives ☐ Patient clinical records that note information provided to patients on advanced care directives ☐ Audit of patient clinical records that contain advanced care directives or end of life plans ☐ Audit of patient clinical records containing recovery/relapse prevention plans ☐ Audit of patient clinical records documenting interventions aligned with these plans ☐ Patient information packages or resources about advanced care directives ☐ Other _____ **Links with Item 9.8 regarding ensuring information about advance care plans and treatment-limiting orders is in the patient clinical record**	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Patient rights and engagement

Patient rights are respected and their engagement in their care is supported.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.19 Implementing procedures that protect the confidentiality of patient clinical records without compromising appropriate clinical workforce access to patient clinical information				
1.19.1 Patient clinical records are available at the point of care	No match to the *NSMHS*	How do we ensure a patient's clinical record is available to the relevant clinician when care is being provided?	☐ Policies, procedures and protocols for ensuring patient clinical records are available at the point of care, including when a patient is transferred within the organisation and between organisations ☐ Policies, procedures and protocols for obtaining patient clinical records from storage ☐ Patient clinical records are available to clinicians at point of care ☐ Computer access to electronic records available to the clinical workforce in clinical areas including access for multidisciplinary team information such as pathology reports ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Patient rights and engagement

Patient rights are respected and their engagement in their care is supported.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.19 Implementing procedures that protect the confidentiality of patient clinical records without compromising appropriate clinical workforce access to patient clinical information (continued)				
1.19.2 Systems are in place to restrict inappropriate access to, and dissemination of, patient clinical information	**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	How do we protect the privacy and confidentiality of patient information from unauthorised access or distribution, and ensure it is in line with relevant legislation, guidelines and organisational policy?	☐ Policies, procedures and protocols on sharing patient information by telephone, electronically and other methods, are consistent with federal and state or territory privacy legislation and department and insurers' requirements ☐ Code of conduct that includes privacy and confidentiality of patient information ☐ Secure archival storage system ☐ Secure storage system in clinical areas ☐ Workforce confidentiality agreements ☐ Computers that are password protected ☐ Patient clinical records that include consent for transfer of information to other service providers or national health related registers ☐ Record of ethics approval for research activities ☐ Templates for the issuing of log-on and password details for electronic patient records systems ☐ Policies, procedures and protocols about the prohibition of sharing log-on and password details ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Patient rights and engagement

Patient rights are respected and their engagement in their care is supported.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
1.20 Implementing well designed, valid and reliable patient experience feedback mechanisms and using these to evaluate the health service performance				
1.20.1 Data collected from patient feedback systems are used to measure and improve health services in the organisation	**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	How do we obtain patient and carer feedback on the care and services we provide? How do we use patient and carer feedback to improve our performance in delivering care and services?	☐ Strategic, business and quality improvement plans describe how patient and carer feedback is used to evaluate the health service performance ☐ Data analysis and reports of consumer feedback ☐ Results of patient and carer experience surveys ☐ Register of patient comments and complaints ☐ Quality improvement plans that include actions to address issues identified ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Partnering with Consumers

Standard 2

Standard 2: Partnering with Consumers

Leaders of a health service organisation implement systems to support partnering with patients, carers and other consumers to improve the safety and quality of care. Patients, carers, consumers, clinicians and other members of the workforce use the systems for partnering with consumers.

The intention of this Standard is to:

Create a health service that is responsive to patient, carer and consumer input and needs.

Context:

This Standard provides the framework for active partnership with consumers by health service organisations. It is expected that this Standard will apply in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations*, in the implementation of all other Standards.

Criteria to achieve the Partnering with Consumers Standard:

- Consumer partnership in service planning
- Consumer partnership in designing care
- Consumer partnership in service measurement and evaluation

Consumer partnership in service planning

Governance structures are in place to form partnerships with consumers and/or carers.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
2.1 Establishing governance structures to facilitate partnership with consumers and/or carers				
2.1.1 Consumers and/or carers are involved in the governance of the health service organisation	**3.1** The MHS has processes to actively involve consumers and carers in planning, service delivery, evaluation and quality programs **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	How do we involve consumers and carers in our clinical and organisational governance processes?	☐ Policies, procedures and protocols related to engaging consumers and carers in the governance of the health service organisation ☐ Relevant documentation from committees and meetings that show consumer representation or consumer involvement in governance activities ☐ Documented mechanisms for engaging consumer representatives of the local community are included in policy documents, committee terms of reference and position descriptions (where relevant) ☐ A range of formal and informal mechanisms are available for the ongoing and short-term engagement of consumers ☐ Financial and physical resources are available to support consumer participation and input at the governance level ☐ Position descriptions for consumer and carer consultants ☐ Feedback from consumers and evaluation reports regarding the processes of engagement and support provided ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Consumer partnership in service planning

Governance structures are in place to form partnerships with consumers and/or carers.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
2.1 Establishing governance structures to facilitate partnership with consumers and/or carers				(continued)
2.1.2 Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people who do not usually provide feedback	**4.3** Planning and service implementation ensures differences and values of its community are recognised and incorporated as required **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	How do we ensure our consumer partners reflect the diversity of our patient population?	☐ Service profile or other document that shows the organisation's understanding of the background of consumers accessing the service ☐ Policies in place which describe how a diverse range of consumers and carers are involved in the governance of the organisation. ☐ The strategies used to engage with a diverse range of consumers are documented in policy and are linked to the governance framework of the organisation ☐ Feedback on governance issues is gained from diverse and hard-to-reach consumers, and documented ☐ Terms of reference describing the responsibilities of committees and boards for partnering with consumers from diverse backgrounds ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Consumer partnership in service planning

Governance structures are in place to form partnerships with consumers and/or carers.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
2.2 Implementing policies, procedures and/or protocols for partnering with patients, carers and consumers in: • **strategic and operational/services planning** • **decision-making about safety and quality initiatives** • **quality improvement activities**				
2.2.1 The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation	**3.1** The MHS has processes to actively involve consumers and carers in planning, service delivery, evaluation and quality programs **7.14** The MHS actively seeks participation of carers in the policy development, planning, delivery and evaluation of services to optimise outcomes for consumers **7.17** The MHS has documented policies and procedures for working with carers **10.1.8** The MHS demonstrates systems and processes for consumer and carer participation in the development, delivery and evaluation of the services	How are consumers and carers involved in strategic and/or operational planning?	☐ Policies or processes in place that articulate the role of consumers and carers in strategic, operational and service planning ☐ Committee terms of reference, membership, selection criteria, papers and minutes that demonstrate consumer engagement in strategic and operational planning ☐ Critical friends group established and meetings facilitated with clear objectives and consumer feedback recorded ☐ Planning day or forum with consumers and carers is held with agenda, attendees and feedback documented. Input is incorporated into strategic and operational planning process ☐ Consultation process held with consumers and feedback documented. Input is incorporated into strategic and operational planning ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
2.2.2 Consumers and/or carers are actively involved in decision-making about safety and quality	**3.1** The MHS has processes to actively involve consumers and carers in planning, service delivery, evaluation and quality programs	How do consumers and carers participate in decision-making for safety and quality?	☐ Policies or processes in place that describe the level of consumer engagement in safety and quality decision-making and quality improvement initiatives ☐ Committee terms of reference, membership, selection criteria, papers and minutes reflect the involvement of consumers and carers in decision-making about safety and quality ☐ Critical friends group established and meetings facilitated with clear objectives and consumer feedback recorded ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Consumer partnership in service planning

Governance structures are in place to form partnerships with consumers and/or carers.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
2.3 Facilitating access to relevant orientation and training for consumers and/or carers partnering with the organisation				
2.3.1 Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role	**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 **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 **3.6** Where the MHS employs consumers and carers, the MHS is responsible for ensuring mentoring and supervision is provided **7.15** The MHS provides ongoing training and support to carers who participate in representational and advocacy roles	What support do we give to consumers and carers who are involved with our health service? What ongoing training do we provide to maximise the contribution of consumers and carers?	☐ Policies or processes in place that describe the orientation and ongoing training provided to consumers and carers who are in partnerships with your organisation ☐ Training provided to staff of the MHS about working with consumers and carers in partnership ☐ Orientation and training is provided to consumers and carers partnering with your organisation and your organisation documents training attendance, training calendars and training materials ☐ Orientation and training is provided to consumers and carers partnering with the organisation via an external training provider. Your organisation documents training attendance, training calendars and training materials ☐ Consumer evaluation reports of orientation and training sessions ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Consumer partnership in service planning

Governance structures are in place to form partnerships with consumers and/or carers.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
2.4 Consulting consumers on patient information distributed by the organisation				
2.4.1 Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for distribution to patients)	**3.1** The MHS has processes to actively involve consumers and carers in planning, service delivery, evaluation and quality programs	How do we collect feedback from consumers and carers on the written material we give to patients?	☐ Policies or processes in place that describe how consumers are involved in providing feedback on patient information publications ☐ Reports describing patient, carer and consumer feedback sought, and where feedback has been utilised ☐ Examples that demonstrate consumers have been involved in the development of publications ☐ Evaluation of the organisation's existing patient information publications is undertaken, documented and appropriate revisions are made in response to consumer feedback ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
2.4.2 Action is taken to incorporate consumer and/or carers' feedback into publications prepared by the health service organisation for distribution to patients	No match to the *NSMHS*	What actions have we taken to include consumer and carer feedback in written materials we give to patients?	☐ Policies or processes in place that describe how feedback provided by consumers is linked to the development of patient information publications ☐ Committee terms of reference, membership, selection criteria, papers and minutes that describe discussions with consumers and carers and the use of their feedback on publications ☐ Action plan or other planning document for incorporating consumer input into patient information publications ☐ An evaluation is undertaken of externally sourced patient information publications prior to use by your organisation. The evaluation process is documented ☐ Records of publications which have changed in response to consumer and carer feedback ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Consumer partnership in designing care

Consumers and/or carers are supported by the health service organisation to actively participate in the improvement of the patient experience and patient health outcomes.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
2.5 Partnering with consumers and/or carers to design the way care is delivered to better meet patient needs and preferences				
2.5.1 Consumers and/or carers participate in the design and redesign of health services	**3.1** The MHS has processes to actively involve consumers and carers in planning, service delivery, evaluation and quality programs **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	How do consumers and carers participate in design and redesign projects?	☐ Membership of groups tasked with steering design and redesign projects include consumers and carers ☐ Agenda items, minutes and other meeting records which describe discussions and consumer involvement in the planning of the design or redesign of the health service ☐ Project plans which include information on how consumers and carers have been involved in the development of the design or redesign projects ☐ Reports from designers and architects outlining how they have responded to consumer suggestions for improvements ☐ Records of focus groups, proposals sent to consumers and carers for comment and other activities focusing on eliciting consumer perspectives ☐ Programs incorporating or modified following consumer feedback ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Consumer partnership in designing care

Consumers and/or carers are supported by the health service organisation to actively participate in the improvement of the patient experience and patient health outcomes.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
2.6 Implementing training for clinical leaders, senior management and the workforce on the value of and ways to facilitate consumer engagement and how to create and sustain partnerships				
2.6.1 Clinical leaders, senior managers and the workforce access training on patient-centred care and the engagement of individuals in their care	**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 **7.16** The MHS provides training to staff to develop skills and competencies for working with carers	How do we provide the executive and senior clinicians with training on patient-centred care?	☐ Training curricula, resources or materials that include sections on consumer-centred care, implementation of a personally controlled electronic health record, partnerships and consumer perspectives are utilised for orientation and ongoing training ☐ Scheduled training dates include sections on consumer-centred care, partnerships and consumer perspectives ☐ Resources on consumer-centred care, partnerships and consumer perspectives are developed and disseminated ☐ Evaluation and feedback from participants on training that includes sections on consumer-centred care, partnerships and consumer perspectives is analysed and used to refine training ☐ Feedback from consumers and carers involved in developing training and resources is analysed and used to refine training ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
2.6.2 Consumers and/or carers are involved in training the clinical workforce	No match to the *NSMHS*	How do we involve consumers and carers in training the clinical workforce?	☐ Agenda items, minutes or other records of meetings involving consumers indicating that training curricula were discussed and feedback provided by consumers ☐ Records of focus groups, community meetings or discussions involving consumers and carers where feedback on training curricula and materials has been sought ☐ Project plans, communication strategies or consultation plans detailing involvement of consumers in the development of training curricula and materials ☐ Feedback from consumers and carers involved in developing training and resources ☐ Records of training provided by consumers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Consumer partnership in service measurement and evaluation

Consumers and/or carers receive information on the health service organisation's performance and contribute to the ongoing monitoring, measurement and evaluation of performance for continuous quality improvement.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
2.7 Informing consumers and/or carers about the organisation's safety and quality performance in a format that can be understood and interpreted independently				
2.7.1 The community and consumers are provided with information that is meaningful and relevant on the organisation's safety and quality performance	No match to the *NSMHS*	How do we inform consumers and our community about our safety and quality performance?	☐ Communication and consultation strategy that describes processes for disseminating information on safety and quality performance to community ☐ Records of safety and quality performance information published in annual reports, newsletters, newspaper articles, radio items, website or other local media ☐ Records of focus groups, meetings with consumers, committee meetings which have discussed appropriateness and accessibility of safety and quality performance information ☐ Records of improvements made to information presentation and dissemination based on feedback from consumers, carers and community groups ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Consumer partnership in service measurement and evaluation

Consumers and/or carers receive information on the health service organisation's performance and contribute to the ongoing monitoring, measurement and evaluation of performance for continuous quality improvement.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
2.8 Consumers and/or carers participating in the analysis of safety and quality performance information and data, and the development and implementation of action plans				
2.8.1 Consumers and/or carers participate in the analysis of organisational safety and quality performance	No match to the *NSMHS*	How do consumers and carers participate in the analysis and review of our safety and quality performance?	☐ Record of review of processes and structures for review of organisational safety and quality performance to identify level of consumer and carer involvement ☐ Project plans, consultation plans, communication plans or reports on the process for review of organisational safety and quality performance ☐ Membership of groups tasked with reviewing organisational safety and quality performance include consumers and carers ☐ Agenda items, minutes and other records of meetings demonstrate involvement of consumers in the analysis of organisational safety and quality performance data ☐ Consumer and carer feedback on their involvement in the review and analysis of organisational safety and quality performance data ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Consumer partnership in service measurement and evaluation

Consumers and/or carers receive information on the health service organisation's performance and contribute to the ongoing monitoring, measurement and evaluation of performance for continuous quality improvement.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
2.8 Consumers and/or carers participating in the analysis of safety and quality performance information and data, and the development and implementation of action plans (continued)				
2.8.2 Consumers and/or carers participate in the planning and implementation of quality improvements	No match to the *NSMHS*	How do consumers and consumers participate in planning and implementing our quality improvement activities?	☐ Record of review of processes and structures identify level of consumer and carer involvement in quality improvement activities ☐ Project plans, consultation plans, communication plans or reports on quality improvement activities which detail consumer and carer involvement ☐ Membership of groups tasked with steering and advising on quality improvement activities include consumers and carers ☐ Agenda items, minutes and other records of meetings demonstrate involvement of consumers and carers in quality improvement activities ☐ Consumer and carer feedback on their involvement in quality activities ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Consumer partnership in service measurement and evaluation

Consumers and/or carers receive information on the health service organisation's performance and contribute to the ongoing monitoring, measurement and evaluation of performance for continuous quality improvement.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
2.9 Consumers and/or carers participating in the evaluation of patient feedback data and development of action plans				
2.9.1 Consumers and/or carers participate in the evaluation of patient feedback data	**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	How do consumers and carers participate in the evaluation of our patient feedback?	☐ Membership of groups tasked with evaluating patient feedback include consumers and carers ☐ Agenda items, minutes and other meeting records describe discussion of patient feedback involving consumers and carers ☐ Reports describing patient feedback describe the level of consumer and carer involvement in the review and analysis of the feedback data ☐ Reports or statements from consumers and carers describing their involvement in the evaluation of patient feedback ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
2.9.2 Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data	No match to the *NSMHS*	How do consumers and carers participate in improvement activities based on feedback from our patients?	☐ Membership of groups tasked with implementation of quality activities identified through patient feedback include consumers and carers ☐ Agenda papers, meeting minutes or reports of relevant committees that document involvement of consumers and carers in discussions about implementation of quality activities based on patient feedback ☐ Documentation detailing processes for involving consumers and carers in implementation of quality activities developed in response to patient feedback ☐ Action plan identifying future quality activities in response to patient feedback including detail of processes for involving consumers and carers ☐ Reports of statements from consumers and carers describing their involvement in implementation of quality activities designed to respond to patient feedback ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Preventing and Controlling Healthcare Associated Infections

Standard 3

Standard 3: Preventing and Controlling Healthcare Associated Infections

Clinical leaders and senior managers of a health service organisation implement systems to prevent and manage healthcare associated infections and communicate these to the workforce to achieve appropriate outcomes. Clinicians and other members of the workforce use the healthcare associated infection prevention and control systems.

The intention of this Standard is to:

Prevent patients from acquiring preventable healthcare associated infections and effectively manage infections when they occur by using evidence-based strategies.

Context:

It is expected that this Standard will be applied in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations* and *Standard 2: Partnering with Consumers*.

Criteria to achieve the Preventing and Controlling Healthcare Associated Infections Standard:

- Governance and systems for infection prevention, control and surveillance
- Infection prevention and control strategies
- Managing patients with infections or colonisations
- Antimicrobial stewardship
- Cleaning, disinfection and sterilisation
- Communicating with patients and carers

Governance and systems for infection prevention, control and surveillance

Effective governance and management systems for healthcare associated infections are implemented and maintained.

This criterion and each of the actions should be considered in relation to the criterion and actions detailed in *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.1 Developing and implementing governance systems for effective infection prevention and control, to minimise the risk to patients of healthcare associated infections				
3.1.1 A risk management approach is taken when implementing policies, procedures and/or protocols for: • standard infection control precautions • transmission-based precautions • aseptic technique • safe handling and disposal of sharps • prevention and management of occupational exposure to blood and body substances • environmental cleaning and disinfection • antimicrobial prescribing • outbreaks or unusual clusters of communicable infection • processing of reusable medical devices • single-use devices • surveillance and reporting of data where relevant • reporting of communicable and notifiable diseases • provision of risk assessment guidelines to workforce • exposure-prone procedures	**2.7** The MHS complies with infection control requirements	Are our infection prevention and control policies, procedures and protocols consistent with *Australian Guidelines for the Prevention and Control of Infections in Health Care*? How do our policies, procedures and protocols for infection prevention and control ensure risks are identified and managed?	☐ Policies, procedures and protocols for items listed in 3.1.1: – are referenced to *Australian Guidelines for the Prevention and Control of Infections in Health Care*, best practice, regulatory and legislative requirements and additional jurisdictional protocols – use nationally agreed definitions for healthcare associated infection – provide links to relevant resource materials – include a date of effect and revision date ☐ Relevant documentation from committees and meetings related to infection control or clinical risk ☐ A risk assessment tool that is in use throughout the organisation ☐ Organisational risk management plan that describes the mechanisms for identifying, escalating and reviewing healthcare associated infection risks and mechanisms for organisation consultation	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and systems for infection prevention, control and surveillance

Effective governance and management systems for healthcare associated infections are implemented and maintained.

This criterion and each of the actions should be considered in relation to the criterion and actions detailed in *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.1 Developing and implementing governance systems for effective infection prevention and control, to minimise the risk to patients of healthcare associated infections (continued)				
3.1.2 The use of policies, procedures and/or protocols is regularly monitored	**2.7** The MHS complies with infection control requirements	How do we find out if our infection prevention and control measures are used by our workforce?	☐ Audit of use of infection control policies ☐ Reports on the review of infection risks or data for interventions to manage healthcare associated infection risks ☐ Relevant documentation from committees and meetings related to infection control or clinical risk ☐ Education resources and records of attendance at training by the workforce on infection prevention and control ☐ Appraisal process that includes review, utilisation of policies, protocols and procedures with a follow-up process (if required) ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
3.1.3 The effectiveness of the infection prevention and control systems is regularly reviewed at the highest level of governance in the organisation	**2.7** The MHS complies with infection control requirements	What information do we provide to the executive on our infection prevention and control performance?	☐ Relevant documentation from committees and meetings that detail strategies and actions to address risks ☐ Information on infection prevention and control presented to the executive and relevant committees ☐ Risk assessments and action plans ☐ Reports of evidence-based interventions that have been initiated for identified risks ☐ A business plan that demonstrates review of health service performance against key performance indicators (KPIs) established by external bodies or internal systems ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Governance and systems for infection prevention, control and surveillance

Effective governance and management systems for healthcare associated infections are implemented and maintained.

This criterion and each of the actions should be considered in relation to the criterion and actions detailed in *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.1 Developing and implementing governance systems for effective infection prevention and control, to minimise the risk to patients of healthcare associated infections (continued)				
3.1.4 Action is taken to improve the effectiveness of infection prevention and control policies, procedures and/or protocols	**2.7** The MHS complies with infection control requirements	What action have we taken to improve the outcomes of our infection prevention and control performance?	☐ Relevant documentation from committees that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to improve the effectiveness of infection prevention and control ☐ Competency assessments undertaken align with policies, protocols and procedures. ☐ Communication material developed for workforce, patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and systems for infection prevention, control and surveillance

Effective governance and management systems for healthcare associated infections are implemented and maintained.

This criterion and each of the actions should be considered in relation to the criterion and actions detailed in *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.2 Undertaking surveillance of healthcare associated infections				
3.2.1 Surveillance systems for healthcare associated infections are in place	No match to the *NSMHS*	How do we identify our healthcare associated infections?	☐ Surveillance data on healthcare associated infections appropriate to the organisation is collected and reviewed. Consider: *Staphylococcus aureus* bacteraemia, central line associated blood stream infections, multi-resistant organisms, catheter-associated urinary tract infection, artificial ventilation associated infections, or other causes of infection. ☐ Risk management plan ☐ Surveillance systems for infections on discharge for specified organisational surgical procedures (if appropriate) ☐ Analysis of data from microbiology laboratories that is used to identify multi-resistant organisms and the actions taken to prevent transmission ☐ Data collection forms and tools ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
3.2.2 Healthcare associated infection surveillance data are regularly monitored by the delegated workforce and/or committees	No match to the *NSMHS*	How is healthcare associated infection surveillance data reported to the health service organisation?	☐ Relevant documentation from committees or meetings with delegated responsibilities for healthcare associated infection surveillance, including infection control and risk management ☐ Regular reports to executive, owners, regulators, insurers or departments ☐ Annual reports on healthcare associated infections ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Governance and systems for infection prevention, control and surveillance

Effective governance and management systems for healthcare associated infections are implemented and maintained.

This criterion and each of the actions should be considered in relation to the criterion and actions detailed in *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.3 Developing and implementing systems and processes for reporting, investigating and analysing healthcare associated infections, and aligning these systems to the organisation's risk management strategy				
3.3.1 Mechanisms to regularly assess the healthcare associated infection risks are in place	**2.13** The MHS has a formal process for identification, mitigation, resolution (where possible) and review of any safety issues	How do we identify, report and manage healthcare associated infection risks?	☐ Relevant documentation from committees or meetings that include information on healthcare associated infection risks ☐ Records of healthcare associated infection incidents collected and analysed ☐ Completed risk assessment documents ☐ Current risk management plan and register ☐ The *Australian Guidelines for the Prevention and Control of Infections in Health Care* is accessible to staff responsible for assessing healthcare associated infection risks ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
3.3.2 Action is taken to reduce the risks of healthcare associated infection	**2.13** The MHS has a formal process for identification, mitigation, resolution (where possible) and review of any safety issues	How do we use this information to decrease the risks of healthcare related infections?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to reduce the risks of healthcare associated infection ☐ Communication material developed for executive, workforce, patients and carers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Governance and systems for infection prevention, control and surveillance

Effective governance and management systems for healthcare associated infections are implemented and maintained.

This criterion and each of the actions should be considered in relation to the criterion and actions detailed in *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.4 Undertaking quality improvement activities to reduce healthcare associated infections through changes to practice				
3.4.1 Quality improvement activities are implemented to reduce and prevent healthcare associated infections	No match to the *NSMHS*	What action have we taken to reduce or prevent healthcare associated infections?	☐ Risk register that includes actions to address identified risks ☐ A quality improvement plan that shows implementation, regular review, revision and evaluation of outcomes ☐ Examples of improvement activities that have had uptake or been approved across the organisation ☐ Relevant documentation from committees or meetings that include quality activities undertaken ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
3.4.2 Compliance with changes in practice is monitored	No match to the *NSMHS*	How do we find out if the workforce has changed their work practices?	☐ Reports from data systems or audits, for example hand hygiene compliance audits or reports on completion of online hand hygiene education ☐ Data reports collected and monitored from pre- and post-change implementation ☐ Education resources and records of attendance at training by the workforce on practice changes ☐ Usage rates of specified products and equipment ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
3.4.3 The effectiveness of changes to practice are evaluated	No match to the *NSMHS*	How do we know if changes to our policies, procedures or protocols have improved patient outcomes?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Evaluation reports and results of follow-up audits ☐ Reports or analysis of reviews of patient infection outcomes ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Infection prevention and control strategies

Strategies for the prevention and control of healthcare associated infections are developed and implemented.

Actions under this criterion should be considered in relation to the criterion and actions detailed in *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.5 Developing, implementing and auditing a hand hygiene program consistent with the current national hand hygiene initiative				
3.5.1 Workforce compliance with current national hand hygiene guidelines is regularly audited	**2.7** The MHS complies with infection control requirements	How do we measure hand hygiene compliance with the national hand hygiene guidelines?	☐ Policies, procedures and protocols for hand hygiene activities (consistent with the National Hand Hygiene Initiative) are available to the workforce ☐ Gap analysis and action plan to support sustaining the scope of the program required for your organisation in line with the National Hand Hygiene Initiative ☐ Results of audited clinical environments against the National Hand Hygiene Initiative audit tool ☐ Analysis of trends in healthcare associated infection rates in the organisation ☐ Education resources and records of attendance at training by the workforce on hand hygiene ☐ Audit of the amounts of hand hygiene products used ☐ Audit of the types of products available for hand hygiene ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Infection prevention and control strategies

Strategies for the prevention and control of healthcare associated infections are developed and implemented.

Actions under this criterion should be considered in relation to the criterion and actions detailed in *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.5 Developing, implementing and auditing a hand hygiene program consistent with the current national hand hygiene initiative (continued)				
3.5.2 Compliance rates from hand hygiene audits are regularly reported to the highest level of governance in the organisation	**2.7** The MHS complies with infection control requirements	What information do we provide to the executive on our hand hygiene performance?	☐ Relevant documentation from committees and meetings that include information from hand hygiene audits ☐ Audit of compliance using the National Hand Hygiene Initiative audit tool ☐ Alternative measures for evaluating hand hygiene compliance if no audit is conducted using the National Hand Hygiene Initiative tool. Consider: amounts of hand hygiene products used or completion of hand hygiene education. ☐ Review of equipment, supplies and products required to comply with hand hygiene requirements ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Infection prevention and control strategies

Strategies for the prevention and control of healthcare associated infections are developed and implemented.

Actions under this criterion should be considered in relation to the criterion and actions detailed in *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.5 Developing, implementing and auditing a hand hygiene program consistent with the current national hand hygiene initiative (continued)				
3.5.3 Action is taken to address non-compliance, or the inability to comply, with the requirements of the current national hand hygiene guidelines	**2.7** The MHS complies with infection control requirements	What have we done to improve compliance with hand hygiene guidelines?	☐ Amended procedures, protocols or work practices that address identified issues ☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Results of targeted auditing on specific procedures as an indicator for compliance ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to address non-compliance with current *National Hand Hygiene Guidelines* ☐ Communication material developed for workforce, patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Infection prevention and control strategies

Strategies for the prevention and control of healthcare associated infections are developed and implemented.

Actions under this criterion should be considered in relation to the criterion and actions detailed in *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.6 Developing, implementing and monitoring a risk-based workforce immunisation program in accordance with the current National Health and Medical Research Council Australian immunisation guidelines				
3.6.1 A workforce immunisation program that complies with current national guidelines is in use	No match to the *NSMHS*	Is our immunisation program consistent with the national immunisation guidelines?	☐ Policies, procedures and protocols consistent with national guidelines, relevant legislation and jurisdictional requirements ☐ Relevant documentation from committees and meetings related to the systems and processes used by the health service organisation to comply with workforce immunisation, recommendations, actions and feedback ☐ Register, report or review of vaccination to demonstrate workforce compliance rates ☐ Documents accessible to authorised personnel that: – identify the requirements for vaccination as part of recruitment of workforce – demonstrate maintenance of vaccination status of existing workforce employees – identify subsequent additional vaccination requirements for relevant members of the workforce – record immunisation refusals and organisational risk management response to refusals ☐ Availability of information relating to prevention strategies and risks associated with vaccine preventable diseases for the workforce, and patients and carers ☐ If relevant – agreements with external providers or other organisations for the provision of vaccination services ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Infection prevention and control strategies

Strategies for the prevention and control of healthcare associated infections are developed and implemented.

Actions under this criterion should be considered in relation to the criterion and actions detailed in *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.7 Promoting collaboration with occupational health and safety programs to decrease the risk of infection or injury to healthcare workers				
3.7.1 Infection prevention and control consultation related to occupational health and safety policies, procedures and/or protocols are being implemented to address: • communicable disease status • occupational management and prophylaxis • work restrictions • personal protective equipment • assessment of risk to healthcare workers for occupational allergy • evaluation of new products and procedures	**2.6** The MHS meets their legal occupational health and safety obligations to provide a safe workplace and environment **2.9** The MHS conducts a risk assessment of staff working conditions and has documented procedures to manage and mitigate identified risks	Do our infection prevention and control activities include measures to reduce our occupational health and safety risks?	☐ Policies, procedures and protocols for the management of occupational exposures ☐ Policies, procedures and protocols that address vaccination refusal ☐ Completed risk assessments for members of the workforce undertaking exposure-prone procedures ☐ Management plan or protocol for identified occupational allergies. These could include: skin conditions related to dermatitis, allergy to personal protective equipment (e.g. latex gloves), skin antiseptics, hand hygiene products ☐ Occupational exposure data assessed prior to the introduction of safety devices and equipment that minimises the risks to workforce and patients ☐ Information from monitoring members of the workforce infected or colonised with an infectious agent ☐ Competency assessments of workforce on use of personal protective equipment ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Infection prevention and control strategies

Strategies for the prevention and control of healthcare associated infections are developed and implemented.

Actions under this criterion should be considered in relation to the criterion and actions detailed in *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.8 Developing and implementing a system for use and management of invasive devices based on the current national guidelines for preventing and controlling infections in health care				
3.8.1 Compliance with the system for the use and management of invasive devices is monitored	No match to the *NSMHS*	How do we know healthcare workers are safely using and maintaining invasive devices to reduce the infection risk to patients?	☐ Policies, procedures and protocols relating to the supply, procurement, introduction, storage, use, reuse and management of invasive devices, based on regulations and evidence-based guidelines ☐ Organisational strategic plan that incorporates invasive device risks for the health service organisation ☐ Relevant documentation from committees and meetings related to infection control and risk management ☐ Register or reports on invasive device risks or faults and interventions to manage these risks ☐ Audits and reports from data systems ☐ Audit report on the integrity of critical devices including storage and packaging ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Infection prevention and control strategies

Strategies for the prevention and control of healthcare associated infections are developed and implemented.

Actions under this criterion should be considered in relation to the criterion and actions detailed in *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.9 Implementing protocols for invasive device procedures regularly performed within the organisation				
3.9.1 Education and competency-based training in invasive devices protocols and use is provided for the workforce who perform procedures with invasive devices	No match to the *NSMHS*	How do we train relevant members of our workforce to use and reduce the risk of harm from invasive devices?	☐ Education resources and records of attendance at training by the workforce on the use of invasive devices ☐ Training schedule for ongoing education and training of members of the workforce who perform procedures with invasive devices ☐ Evaluations of education and competency-based training needs ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
3.10 Developing and implementing protocols for aseptic technique				
3.10.1 The clinical workforce is trained in aseptic technique	No match to the *NSMHS*	How do we know the clinical workforce is trained in aseptic technique?	☐ Policies, procedures and protocols on aseptic techniques that are consistent with relevant best practice and guidelines ☐ Education resources and records of attendance at training by the workforce on aseptic technique ☐ Training schedule for ongoing education and training of members of the workforce who perform procedures requiring aseptic technique ☐ Evaluations of education and competency-based training needs ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Infection prevention and control strategies

Strategies for the prevention and control of healthcare associated infections are developed and implemented.

Actions under this criterion should be considered in relation to the criterion and actions detailed in *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.10 Developing and implementing protocols for aseptic technique				(continued)
3.10.2 Compliance with aseptic technique is regularly audited	No match to the *NSMHS*	How do we find out if our clinicians routinely follow aseptic technique when required?	☐ Risk assessment to identify priority areas for highest risk and highest use of aseptic technique ☐ Use of existing validated audit tools to assess compliance, for example Central Line Associated Blood Stream Infections audit tool for assessing insertion and maintenance of central venous access devices and the Australian Council for Operating Room Nurses Standards in the operating theatre ☐ Audit results for compliance with aseptic technique ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
3.10.3 Action is taken to increase compliance with aseptic technique protocols	No match to the *NSMHS*	What action have we taken to improve workforce compliance with aseptic technique?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to increase compliance with aseptic technique protocols ☐ Communication material developed for the workforce, patients and carers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Managing patients with infections or colonisations

Patients presenting with, or acquiring an infection or colonisation during their care are identified promptly and receive the necessary management and treatment.

This criterion should be read and considered in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations* and *Standard 6: Clinical Handover*. Strategies for monitoring compliance and use of policies are also considered in the criterion of Standard 3.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.11 Implementing systems for using standard precautions and transmission-based precautions				
3.11.1 Standard precautions and transmission-based precautions	No match to the *NSMHS*	Are our standard precautions and transmission-based precautions consistent with national guidelines?	☐ Policies, procedures and protocols that are based on the *Australian Guidelines for the Prevention and Control of Infections in Health Care* ☐ Relevant documentation from committees and meetings that demonstrate an analysis of policy documents to determine areas for review or action to achieve consistency with the national guidelines ☐ Standardised signage and other information resources consistent with current national guidelines for standard and transmission-based precautions ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
3.11.2 Compliance with standard precautions is monitored	No match to the *NSMHS*	How do we know it our workforce consistently follow standard precautions?	☐ Audits of workplace practices, for example, environmental cleaning, hand hygiene practices, and use of personal protective equipment ☐ Reports on review of compliance with standard precautions ☐ Reports from data systems and surveillance programs ☐ Relevant documentation from committees and meetings on monitoring compliance with standard precautions ☐ Education resources and records of attendance at training by the workforce on standard precautions ☐ Organisational strategic plans that review compliance and have included consultation across the organisation ☐ Standard and transmission-based precaution signage available and accessible to the health workforce ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Managing patients with infections or colonisations

Patients presenting with, or acquiring an infection or colonisation during their care are identified promptly and receive the necessary management and treatment.

This criterion should be read and considered in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations* and *Standard 6: Clinical Handover*. Strategies for monitoring compliance and use of policies are also considered in the criterion of Standard 3.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.11 Implementing systems for using standard precautions and transmission-based precautions				(continued)
3.11.3 Action is taken to improve compliance with standard precautions	No match to the *NSMHS*	What action have we taken to improve the use of standard precautions by our workforce?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to improve compliance with standard precautions ☐ Communication material developed for the workforce, patients and carers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
3.11.4 Compliance with transmission-based precautions is monitored	No match to the *NSMHS*	How do we find out if our workforce correctly follows transmission-based precautions?	☐ Audits of workplace practices, for example, environmental cleaning, hand hygiene practices, and use of personal protective equipment ☐ Reports on review of compliance with transmission-based precautions ☐ Reports from data systems and surveillance programs ☐ Relevant documentation from committees and meetings on monitoring compliance with transmission-based precautions ☐ Education resources and records of attendance at training by the workforce on transmission-based precautions ☐ Standard and transmission-based precaution signage available and accessible to the health workforce ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Managing patients with infections or colonisations

Patients presenting with, or acquiring an infection or colonisation during their care are identified promptly and receive the necessary management and treatment.

This criterion should be read and considered in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations* and *Standard 6: Clinical Handover*. Strategies for monitoring compliance and use of policies are also considered in the criterion of Standard 3.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.11 Implementing systems for using standard precautions and transmission-based precautions				(continued)
3.11.5 Action is taken to improve compliance with transmission-based precautions	No match to the *NSMHS*	What action have we taken to improve the use of transmission-based precautions by our workforce?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to improve compliance with transmission-based precautions ☐ Communication material developed for the workforce, patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Managing patients with infections or colonisations

Patients presenting with, or acquiring an infection or colonisation during their care are identified promptly and receive the necessary management and treatment.

This criterion should be read and considered in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations* and *Standard 6: Clinical Handover*. Strategies for monitoring compliance and use of policies are also considered in the criterion of Standard 3.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.12 Assessing the need for patient placement based on the risk of infection transmission				
3.12.1 A risk analysis is undertaken to consider the need for transmission-based precautions including: • accommodation based on the mode of transmission • environmental controls through air flow • transportation within and outside the facility • cleaning procedures • equipment requirements	No match to the *NSMHS*	How do we determine when we need to apply transmission-based precautions?	☐ Policies, procedures and protocols based on risk assessment, analysis and risk management processes addressing the priority areas in 3.12.1 ☐ Relevant documentation from committees and meetings regarding the systems and processes to address risks related to patient placement ☐ Risk register that includes actions to address issues identified ☐ Audit of risk assessment practices against guidelines and policies ☐ Surveillance data and reports ☐ Audit data on use of risk alerts ☐ Review of maintenance and air handling system requirements ☐ Relevant documentation from committees and meetings that include reports of infection control and clinical review outcomes and improvement actions ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Managing patients with infections or colonisations

Patients presenting with, or acquiring an infection or colonisation during their care are identified promptly and receive the necessary management and treatment.

This criterion should be read and considered in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations* and *Standard 6: Clinical Handover*. Strategies for monitoring compliance and use of policies are also considered in the criterion of Standard 3.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.13 Developing and implementing protocols relating to the admission, receipt and transfer of patients with an infection				
3.13.1 Mechanisms are in use to check for pre-existing healthcare associated infection or communicable disease on presentation for care	No match to the *NSMHS*	How do we check the infectious status of a patient when they present for care?	☐ Policies, procedures and protocols that address the identification of pre-existing healthcare associated infection or communicable disease ☐ Policies, procedures and protocols addressing clinical handover of risk, receipt and transfer of patients with infections ☐ Relevant documentation from committees and meetings related to healthcare associated infection screening ☐ Systems that indicate the patient's infectious risk is checked on presentation ☐ Audit of screening for healthcare associated infections or communicable diseases in accordance with local or jurisdictional screening policies ☐ Risk management plan that outlines the risks identified and addresses actions to be undertaken to minimise or eliminate the risks ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
3.13.2 A process for communicating a patient's infectious status is in place whenever responsibility for care is transferred between service providers or facilities	No match to the *NSMHS*	How do we alert health service organisations and carers of the infectious status of a patient when care is transferred?	☐ Policies, procedures and protocols related to transfer of care between service providers ☐ Handover sheets, discharge forms or similar documents stating infectious status ☐ Electronic or documented flagging of patient clinical records and discharge summaries ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Antimicrobial stewardship

Safe and appropriate antimicrobial prescribing is a strategic goal of the clinical governance system.

The actions in this criterion should be considered in relation to *Standard 4: Medication Safety* and *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.14 Developing, implementing and regularly reviewing the effectiveness of the antimicrobial stewardship system				
3.14.1 An antimicrobial stewardship program is in place	No match to the *NSMHS*	What systems, processes and structures do we have in place to support appropriate prescribing and use of antimicrobials?	☐ A documented structure/organisational chart that includes an antimicrobial stewardship (AMS) program. ☐ Results of risk assessments to identify areas of priority ☐ Documented AMS program action plan ☐ An AMS Policy (at facility or network level) incorporating: – governance/reporting processes – prescribing process in accordance with therapeutic guidelines – list of restricted antimicrobials and approval processes – specialist/senior clinical review and referral process – education process – policy review process ☐ Observation that guides such as the *Therapeutic Guidelines: Antibiotic* are available to the prescribers and workforce ☐ Relevant documentation from committees and meetings related to antimicrobial stewardship ☐ Education resources and records of attendance at training by prescribers and the clinical workforce administering antimicrobials on antimicrobial usage, development of resistance, and judicious prescribing ☐ Audit of antimicrobial usage, particularly of high-risk antimicrobials or high-risk clinical areas ☐ Reports and recommendations from team or committee overseeing antimicrobial stewardship ☐ Restriction, approval or review systems to guide the use of broad spectrum antimicrobials, where relevant ☐ Referral process to infectious disease physician or clinical microbiologist ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Antimicrobial stewardship

Safe and appropriate antimicrobial prescribing is a strategic goal of the clinical governance system.

The actions in this criterion should be considered in relation to *Standard 4: Medication Safety* and *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.14 Developing, implementing and regularly reviewing the effectiveness of the antimicrobial stewardship system				(continued)
3.14.2 The clinical workforce prescribing antimicrobials have access to current, endorsed therapeutic guidelines on antibiotic usage	No match to the *NSMHS*	In what ways is access to current, endorsed therapeutic guidelines for clinicians who prescribe antibiotics provided?	☐ Access to the therapeutic guidelines on antibiotic usage either as printed or electronic resources is provided for all clinicians authorised to prescribe ☐ Locally adapted guidelines used are consistent with *Therapeutic Guidelines: Antibiotic* ☐ Observation of the clinical workforce who prescribe antimicrobials accessing endorsed therapeutic guidelines on antibiotic usage ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
3.14.3 Monitoring of antimicrobial usage and resistance is undertaken	No match to the *NSMHS*	In what ways do we monitor antimicrobial usage and resistance? What systems and processes are in place to facilitate this?	☐ Policies, procedures, protocols and guidelines on prescribing antimicrobials ☐ Relevant documentation from committees and meetings that include information on monitoring outcomes ☐ Records of antimicrobial consumption ☐ Reviews of antimicrobial usage and feedback to prescribers ☐ Laboratory-based data including analysis of antimicrobial resistance ☐ Audit of prescribing practices ☐ Documented surveillance program ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Antimicrobial stewardship

Safe and appropriate antimicrobial prescribing is a strategic goal of the clinical governance system.

The actions in this criterion should be considered in relation to *Standard 4: Medication Safety* and *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.14 Developing, implementing and regularly reviewing the effectiveness of the antimicrobial stewardship system (continued)				
3.14.4 Action is taken to improve the effectiveness of antimicrobial stewardship	No match to the *NSMHS*	What actions have we taken to improve the effectiveness of our antimicrobial stewardship processes?	☐ Orientation and education program attendance records demonstrate prescribers and clinical staff are informed and educated about antimicrobial resistance, local stewardship activities and their roles and responsibilities ☐ Records of attendance of pharmacists and clinicians at relevant conferences or seminars specific to AMS supported by the health service organisation ☐ Record of prescribers completing ACSQHC/NPS antibiotic prescribing modules ☐ Patient education materials relevant to antimicrobial resistance and use ☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to improve the effectiveness of antimicrobial stewardship ☐ Communication material developed for the workforce, patients and carers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Cleaning, disinfection and sterilisation

Healthcare facilities and the associated environment are clean and hygienic. Reprocessing of equipment and instrumentation meets current best practice guidelines.

This criterion should be read and considered in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.15 Using risk management principles to implement systems that maintain a clean and hygienic environment for patients and healthcare workers				
3.15.1 Policies, procedures and/or protocols for environmental cleaning that address the principles of infection prevention and control are implemented, including: • maintenance of building facilities • cleaning resources and services • risk assessment for cleaning and disinfection based on transmission-based precautions and the infectious agent involved • waste management within the clinical environment • laundry and linen transportation, cleaning and storage • appropriate use of personal protective equipment	**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	How do we maintain a clean and hygienic environment for patients?	☐ Policies, procedures and protocols on environmental cleaning that are consistent with current guidelines such as the *Australian Guidelines for the Prevention and Control of Infections in Health Care* ☐ Maintenance schedules for infrastructure ☐ Material safety data sheets or chemical register of cleaning resources utilised ☐ Audit of the collection, transport and storage of linen ☐ Audit of the use of personal protective equipment ☐ Cleaning schedules ☐ Service schedules for infection prevention and control equipment ☐ Waste management plan that includes actions to address identified risks ☐ Environmental risk assessment that includes action to address identified risks ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Cleaning, disinfection and sterilisation

Healthcare facilities and the associated environment are clean and hygienic. Reprocessing of equipment and instrumentation meets current best practice guidelines.

This criterion should be read and considered in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.15 Using risk management principles to implement systems that maintain a clean and hygienic environment for patients and healthcare workers (continued)				
3.15.2 Policies, procedures and/or protocols for environmental cleaning are regularly reviewed	**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	How do we ensure our cleaning policies, procedures and protocols are effective?	☐ Policies, procedures and protocols that are consistent with relevant jurisdictional cleaning standards ☐ Schedule of review of cleaning policies, procedures and protocols ☐ Work instructions, duty lists and job descriptions ☐ Cleaning contracts that are consistent with policy documents ☐ Relevant documentation from committees and meetings related to reviews of policies for environmental cleaning ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
3.15.3 An established environmental cleaning schedule is in place and environmental cleaning audits are undertaken regularly	**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	What action have we taken to maintain cleaning standards and services?	☐ Cleaning schedules that are consistent with current guidelines such as the *Australian Guidelines for the Prevention and Control of Infections in Health Care* ☐ Audit of compliance with cleaning schedule ☐ Work instructions, duty lists and job descriptions ☐ Relevant documentation from committees and meetings related to the maintenance of cleaning standards and services ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Cleaning, disinfection and sterilisation

Healthcare facilities and the associated environment are clean and hygienic. Reprocessing of equipment and instrumentation meets current best practice guidelines.

This criterion should be read and considered in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.16 Reprocessing reusable medical equipment, instruments and devices in accordance with relevant national or international standards and manufacturers' instructions				
3.16.1 Compliance with relevant national or international standards and manufacturer's instructions for cleaning, disinfection and sterilisation of reusable instruments and devices is regularly monitored	No match to the *NSMHS*	How do we know if the reprocessing of reusable medical devices happens in accordance with national standards and manufacturer's instructions?	☐ Policies, procedures and protocols for processing reusable medical equipment, instruments and devices that are consistent with relevant national or international standards and manufacturer's instructions ☐ Records of sterilisation verifying reprocessing that is consistent with legislation ☐ Maintenance schedules for equipment used in the reprocessing process are monitored and reviewed ☐ Audit of validation and compliance monitoring systems for sterilisers ☐ Audits of sterile stock integrity and supply ☐ Relevant documentation from committees and meetings that address cleaning, disinfection and sterilisation of reusable instruments ☐ Risk assessments where there are deviations in the requirements of relevant standards and the manufacturer's instructions ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Cleaning, disinfection and sterilisation

Healthcare facilities and the associated environment are clean and hygienic. Reprocessing of equipment and instrumentation meets current best practice guidelines.

This criterion should be read and considered in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.17 Implementing systems to enable the identification of patients on whom the reusable medical devices have been used				
3.17.1 A traceability system that identifies patients who have a procedure using sterile reusable medical instruments and devices is in place	No match to the *NSMHS*	How do we identify patients and procedures where sterile reusable instruments and devices have been used?	☐ Policies, procedures and protocols that reflect the risk and scope of the requirements for the health service ☐ Register or record of patients who have procedures using reusable instruments and devices ☐ Traceability systems used during the reprocessing of reusable items ☐ Audit of medical records (patient clinical records or records regarding the use of reusable medical instruments and devices) ☐ Relevant documentation from committees and meetings regarding the use of reusable medical devices ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Cleaning, disinfection and sterilisation

Healthcare facilities and the associated environment are clean and hygienic. Reprocessing of equipment and instrumentation meets current best practice guidelines.

This criterion should be read and considered in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations*.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.18 Ensuring workforce who decontaminate reusable medical devices undertake competency-based training in these practices				
3.18.1 Action is taken to maximise coverage of the relevant workforce trained in a competency-based program to decontaminate reusable medical devices	No match to the *NSMHS*	What training have we provided to relevant members of the workforce to decontaminate reusable instruments and devices?	☐ Policies, procedures and protocols to decontaminate reusable medical instruments that are consistent with best practice and guidelines, such as the *Australian Guidelines for the Prevention and Control of Infections in Health Care* ☐ Evaluations of education and competency-based training needs ☐ Education resources and records of attendance at training by the workforce on decontamination of reusable instruments and devices ☐ Training schedule for ongoing education and training of members of the workforce on decontamination of reusable instruments and devices ☐ Relevant documentation from committees and meetings related to workforce training on decontamination of reusable instruments and devices ☐ Observation that relevant current standards and guidelines are accessible to relevant workforce ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Communicating with patients and carers

Information on healthcare associated infection is provided to patients, carers, consumers and service providers.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.19 Ensuring access to consumer-specific information on the management and reduction of healthcare associated infections is available at the point of care				
3.19.1 Information on the organisation's corporate and clinical infection risks and initiatives implemented to minimise patient infection risks is provided to patients and/or carers	No match to the *NSMHS*	How do we tell patients and carers about our work to decrease infection risks to patients?	☐ Materials used for patient and carer education ☐ Risk alert information and materials provided to patients and their carers, for example respiratory precautions ☐ Risk alert information and materials placed on public display in areas such as reception and waiting areas ☐ Publication of information on infection rates and risks that are accessible to the public ☐ Web site information available to the public ☐ Information included in pre-admission information dedicated to infection control practices ☐ Information provided to visiting medical specialists for distribution to patients and carers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
3.19.2 Patient infection prevention and control information is evaluated to determine if it meets the needs of the target audience	No match to the *NSMHS*	How do we collect feedback from patients and carers on our infection prevention and control information?	☐ Results of patient experience survey on patient infection prevention and control information ☐ Reports on the evaluation of patient information ☐ Documented feedback received from patients and carers ☐ Consumer representation on relevant focus groups, committees or working parties ☐ Relevant documentation from committees regarding the evaluation of patient information on infection prevention and control ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Medication Safety

Standard 4

Standard 4: Medication Safety

Clinical leaders and senior managers of a health service organisation implement systems to reduce the occurrence of medication incidents, and improve the safety and quality of medicine use. Clinicians and other members of the workforce use the systems to safely manage medicines.

The intention of this Standard is to:

Ensure competent clinicians safely prescribe, dispense and administer appropriate medicines to informed patients and carers.

Context:

It is expected that this Standard will be applied in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations* and *Standard 2: Partnering with Consumers*.

Criteria to achieve the Medication Safety Standard:

- Governance and systems for medication safety
- Documentation of patient information
- Medication management processes
- Continuity of medication management
- Communication with patients and carers

Governance and systems for medication safety

Health service organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing, manufacturing, compounding and monitoring of the effects of medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.1 Developing and implementing governance arrangements and organisational policies, procedures and/or protocols for medication safety, which are consistent with national and jurisdictional legislative requirements, policies and guidelines				
4.1.1 Governance arrangements are in place to support the development, implementation and maintenance of organisation- wide medication safety systems	**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	How do we describe our decision-making and management of our medication safety? What documents do we use to check we meet regulatory and professional requirements?	☐ Governance framework for medication safety with reporting lines, roles and responsibilities, and indicators for measuring and monitoring improvements in the medication management process ☐ Relevant documentation from committees and meetings, such as drug and therapeutics committees, medication safety committee related to the medication safety systems ☐ Terms of reference of the medication safety governance group that include functions specific to safe management of medicines within the organisation including (but not limited to): – monitoring the safety and quality of medicines use – implementing interventions to improve safety and quality of medicines use – managing adverse drug reactions and medication incidents – informing the workforce about medication safety issues, policies, decisions – use of the Individual Healthcare Identifier ☐ Strategic and operational plans detailing the development, implementation and maintenance of organisation-wide medication safety systems ☐ Documents that detail responsibilities for organisation-wide medication safety systems at all levels of the organisation including board members or owners, senior executive or senior managers, unit or facility managers and clinicians ☐ Position descriptions, duty statements and employment contracts that outline roles, responsibilities and accountabilities for clinical and organisational medication management activities ☐ Information identifying patient safety and quality risks in medication management systems, for example a medication safety risk register ☐ Quality improvement plans that outline designated responsibilities and timeframes for completion of improvement actions	☐ No → further action is required ☐ Yes → list source of evidence

Governance and systems for medication safety

Health service organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing, manufacturing, compounding and monitoring of the effects of medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.1 Developing and implementing governance arrangements and organisational policies, procedures and/or protocols for medication safety, which are consistent with national and jurisdictional legislative requirements, policies and guidelines (continued)				
4.1.1 Governance arrangements are in place to support the development, implementation and maintenance of organisation- wide medication safety systems *(continued)*			☐ A mechanism for dissemination of medication safety alerts ☐ Education resources and records of attendance at training of the workforce on the medication management system and medication safety ☐ Orientation and ongoing education on medication safety and risk awareness for the workforce who prescribe, dispense and administer medications ☐ Records of workforce completing National Inpatient Medication Chart on-line training course ☐ Records of workforce completing medication safety on-line training modules (available from NPS MedicineWise) ☐ Records of workforce completing antimicrobial prescribing on-line training modules (available from NPS MedicineWise) ☐ Audits of indicators (for example *Indicators 1.4, 2.2 and 6.4 – Indicators for Quality Use of Medicines in Australian Hospitals*) ☐ Other _____ **Links with Item 1.1 regarding governance systems that set out policies, procedures and protocols**	

Governance and systems for medication safety

Health service organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing, manufacturing, compounding and monitoring of the effects of medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.1 Developing and implementing governance arrangements and organisational policies, procedures and/or protocols for medication safety, which are consistent with national and jurisdictional legislative requirements, policies and guidelines (continued)				
4.1.2 Policies, procedures and/or protocols are in place that are consistent with legislative requirements, national, jurisdictional and professional guidelines	**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	Are our policies, procedures and protocols for: • ordering • storing • prescribing • administering • supplying, and • disposing of medicines consistent with regulations and national guidelines? How do we ensure these documents are updated and available for use by our workforce?	☐ Policies, procedures, protocols and guidelines related to safe management and quality use of medicines that are consistent with best practice, national guidelines, legislative requirements and jurisdictional directives ☐ Policies, procedures, protocols and guidelines accessible to the workforce that include (but are not limited to): – prescribing policies and guidelines – policies, procedures, protocols or guidelines for administering medicines, including specific procedures and guidelines for areas of high risk such as oncology and anaesthesia – use of National Inpatient Medication Chart and ancillary charts – procedures for checking patient identification in all patient associated tasks in the medication management pathway (see Standard 5) – procedures for managing high-risk medicines, including a list of high-risk medicines relevant to the organisation – procedures for labelling injectable medicines, fluids and lines – use of approved abbreviations for use in prescribing and administering of medicines – use of oral dispensers for administering liquid oral medicines – purchasing of new medicines, including a risk assessment of the labelling and packaging of the medicine ☐ Polices, procedures, protocols and guidelines have a review date and are subject to version control. ☐ Other _____ **Links with Item 1.1 regarding governance systems that set out policies, procedures and protocols**	☐ No → further action is required ☐ Yes → list source of evidence

Governance and systems for medication safety

Health service organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing, manufacturing, compounding and monitoring of the effects of medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.2 Undertaking a regular, comprehensive assessment of medication use systems to identify risks to patient safety and implementing system changes to address the identified risks				
4.2.1 The medication management system is regularly assessed	**2.4** The MHS minimises the occurrence of adverse medication events within all MHS settings	How do we know the medication management system is regularly assessed? How do we identify the risks associated with our medication management system?	☐ Audit of use of policies on medication management systems ☐ Completed risk assessments of: – systems for managing medicines in the organisation, for example completed *Medication Safety Self Assessment® for Australian Hospitals* – processes for handling high-risk medicines, for example completed *International Medication Safety Self Assessment® for Oncology, Self Assessment® for Antithrombotic Therapy in Australian Hospitals* ☐ Separate risk assessments, registers and action plans completed for units or service areas ☐ Information on the results of the assessment of the medication management system presented to the senior executive and relevant committees ☐ Results of National Inpatient Medication Chart audit ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and systems for medication safety

Health service organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing, manufacturing, compounding and monitoring of the effects of medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.2 Undertaking a regular, comprehensive assessment of medication use systems to identify risks to patient safety and implementing system changes to address the identified risks (continued)				
4.2.2 Action is taken to reduce the risks identified in the medication management system	**2.4** The MHS minimises the occurrence of adverse medication events within all MHS settings	What action have we taken to reduce the risks associated with our medication management system?	☐ Report of actions to address issues identified in the assessment of the safety of the medication management system ☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities to reduce the risks identified in the medication management system that have been implemented and evaluated ☐ Results of audits, indicator data, state/territory performance measures used to monitor effect of implemented actions ☐ Communication material developed for workforce and patients and carers ☐ Other _____ **Links with Action 4.4.2 regarding actions taken to reduce the risk of adverse medication incidents** **Links with Action 4.5.2 regarding quality improvement activities to reduce the risk of patient harm and increase the quality and effectiveness of medicines use**	☐ No → further action is required ☐ Yes → list source of evidence

Governance and systems for medication safety

Health service organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing, manufacturing, compounding and monitoring of the effects of medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.3 Authorising the relevant clinical workforce to prescribe, dispense and administer medications				
4.3.1 A system is in place to verify that the clinical workforce have medication authorities appropriate to their scope of practice	No match to the *NSMHS*	How does our organisation ensure only the workforce with the relevant authority prescribes, administers or supplies medicines?	☐ Policies, procedures and protocols detailing roles, responsibilities and accountabilities of clinicians for medication management processes ☐ Delegations detailing clinical positions that have the authority to prescribe, dispense, compound, manufacture or administer medicines ☐ A list or register that specifies individual workforce members with authority to prescribe, dispense or administer medicines ☐ Position descriptions, duty statements and employment contracts detailing responsibilities, accountabilities and scope of practice of the workforce in medication management ☐ Records of competency assessments of workforce where medication authority requires demonstration of competency ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
4.3.2 The use of the medication authorisation system is regularly monitored	No match to the *NSMHS*	How do we know if our medication authorisation system is functioning?	☐ Relevant documentation from committees and meetings that include an analysis of medication incidents where the authorisation system has been breached ☐ Audits of registers or logs documenting verification of the authorisation of practitioners prescribing, supplying and administering medicines ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
4.3.3 Action is taken to increase the effectiveness of the medication authority system	No match to the *NSMHS*	What action have we taken to improve the usefulness and reliability of our medication authorisation system?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities to increase the effectiveness of the medication authority system that have been implemented and evaluated ☐ Communication material developed for workforce ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Governance and systems for medication safety

Health service organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing, manufacturing, compounding and monitoring of the effects of medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.4 Using a robust organisation-wide system of reporting, investigating and managing change to respond to medication incidents				
4.4.1 Medication incidents are regularly monitored, reported and investigated	No match to the *NSMHS*	How do we identify and respond to medication incidents?	☐ Policies, procedures and protocols for reporting, investigating and managing medication incidents and adverse drug reactions ☐ Relevant documentation from committees and meetings that demonstrate medication incidents are routinely reviewed ☐ Incident reporting management system, where medication incidents are reviewed, analysed and documented ☐ Documented investigations of medication incidents ☐ Data analyses from adverse drug reactions and the medication incident reporting system ☐ Root cause analysis of sentinel events involving medicines ☐ Investigation of serious breaches of policies, procedures and protocols involving medicines ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Governance and systems for medication safety

Health service organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing, manufacturing, compounding and monitoring of the effects of medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.4 Using a robust organisation-wide system of reporting, investigating and managing change to respond to medication incidents (continued)				
4.4.2 Action is taken to reduce the risk of adverse medication incidents	No match to the *NSMHS*	What action have we taken to decrease the risk of medication incidents?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to reduce the risk of adverse medication incidents, for example: – implementation of specific medication forms, where appropriate – development of guides for safe use of medicines – implementation of recommendations for safe medication practices – inclusion of alerts and decision support tools in electronic medication management systems (where used to prescribe, dispense and record administration of medicines) ☐ Communication material developed for workforce, patients and carers ☐ Other _____ **Links with Action 4.4.2 regarding actions taken to reduce the risk of adverse medication incidents** **Links with Action 4.5.2 regarding quality improvement activities to reduce the risk of patient harm and increase the quality and effectiveness of medicines use**	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and systems for medication safety

Health service organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing, manufacturing, compounding and monitoring of the effects of medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.5 Undertaking quality improvement activities to enhance the safety of medicines use				
4.5.1 The performance of the medication management system is regularly assessed	No match to the *NSMHS*	How do we identify, record and implement changes to make our medication practices safer?	☐ Results of activities such as monitoring quality use of medicines indicators and other performance measures of medication safety ☐ Results of audits of national recommendations and medication safety alerts. For example: – *National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines* – percentage of medication areas (outside pharmacy) where potassium ampoules are available (*Indicator 6.1 – Indicators for Quality Use of Medicines in Australian Hospitals*) – use of safety controls on storage of potassium ampoules – number of vincristine doses prepared in syringes, mini-bags – percentage of medication orders that include error prone abbreviations (for example, *Indicator 3.3 – Indicators for Quality Use of Medicines in Australian Hospitals*) ☐ Regular (annual) auditing of the National Inpatient Medication Chart to monitor safety and clarity of prescribing and documentation of administration of medicines ☐ Relevant documentation from committees of committees or meetings that detail audit reports or results ☐ Published work on quality improvement activities ☐ Audits of patient clinical records using Institute for Healthcare Improvement trigger tools to identify adverse medicines events ☐ Results of audits of usage, for example drug use evaluation studies ☐ Review of clinical pharmacy reports/interventions that identify medication-related risks ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Governance and systems for medication safety

Health service organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing, manufacturing, compounding and monitoring of the effects of medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.5 Undertaking quality improvement activities to enhance the safety of medicines use				(continued)
4.5.2 Quality improvement activities are undertaken to reduce the risk of patient harm and increase the quality and effectiveness of medicines use	No match to the *NSMHS*	What action have we taken to improve our medication management processes?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks and documentation of completed actions ☐ Quality improvement plan that includes actions to address issues identified and evaluation of outcomes ☐ Examples of improvement activities that have been implemented across the organisation and evaluated ☐ Reports on the implementation of national recommendations and safety alerts: – *National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines* – national medication safety alerts for: intravenous potassium chloride, vincristine – *Recommendations for Terminology, Abbreviations and Symbols used in Prescribing and Administering of Medicines* – patient identification processes consistent with Standard 5 throughout the medication management cycle ☐ Examples of improvement activities to reduce gaps in practice that have been implemented and evaluated. For example: – actions to improve venous thromboembolism (VTE) risk assessment and appropriate VTE prophylaxis prescribing – implementation of an antibiotic stewardship program – safe management of high-risk medicines, for example anticoagulants, insulin ☐ Reports on use of indicators to monitor appropriateness of interventions, for example *Indicators for Quality Use of Medicines in Australian Hospitals* ☐ Examples of standardised work practices and products. For example: – premixed solutions or preloaded syringes for injectable high-risk medicines – standardised single concentrations of infusions of high-risk medicines – standardised dosing protocols	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and systems for medication safety

Health service organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing, manufacturing, compounding and monitoring of the effects of medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.5 Undertaking quality improvement activities to enhance the safety of medicines use				(continued)
4.5.2 Quality improvement activities are undertaken to reduce the risk of patient harm and increase the quality and effectiveness of medicines use *(continued)*			☐ Implementation of infusion pumps with safety software ('smart pumps') ☐ Implementation of oral dispensers for oral liquid medicines ☐ Communication material developed for the workforce, patients and consumers ☐ Other _____ **Links with Action 4.2.2 regarding actions taken to reduce the risks identified in the medication management system** **Links with Action 4.4.2 regarding actions taken to reduce the risks of adverse medication events**	

Documentation of patient information

The clinical workforce accurately records a patient's medication history and this history is available throughout the episode of care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.6 The clinical workforce taking an accurate medication history when a patient presents to a health service organisation, or as early as possible in the episode of care, which is then available at the point of care				
4.6.1 A best possible medication history is documented for each patient	**10.5.8** The views of the consumer and their carer(s), and the history of previous treatment are considered and documented prior to administration of new medication and/or other technologies	How do we record a medication history in the patient's clinical record?	☐ Policies, procedures and protocols for obtaining and documenting a best possible medication history ☐ Patient clinical records, either hard copy or electronic document best possible medication history listing current medicines (including prescription, over the counter and complementary medicines), medicines recently ceased or changed, and verification of history with one or more sources ☐ Best possible medication history documented on National Inpatient Medication Chart or a standard form (hard copy or electronic) such as the National Medication Management Plan ☐ Audit of admitted patients with a best possible medication history ☐ Audit of *Indicator 6.2 – Indicators for Quality Use of Medicines in Australian Hospitals* ☐ Educational resources and records of attendance at training of workforce in obtaining and documenting a best possible medication history ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
4.6.2 The medication history and current clinical information are available at the point of care	No match to the *NSMHS*	How do we ensure a patient's medication history and clinical information are available to the relevant clinician when care is provided?	☐ Policies, procedures and protocols for accessing clinical information at the point of care ☐ Observation of patient clinical records accessible at point of patient care ☐ National Medication Management Plan or equivalent, including electronic versions is available with the patient clinical record at the point of care ☐ Medication management plan or equivalent kept with current National Inpatient Medication Chart ☐ Other _____ **Links with Action 1.19.1 regarding availability of patient clinical records at the point of care**	☐ No → further action is required ☐ Yes → list source of evidence

Documentation of patient information

The clinical workforce accurately records a patient's medication history and this history is available throughout the episode of care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.7 The clinical workforce documenting the patient's previously known adverse drug reactions on initial presentation and updating this if an adverse reaction to a medicine occurs during the episode of care				
4.7.1 Known medication allergies and adverse drug reactions are documented in the patient clinical record	No match to the *NSMHS*	How do we know if our clinicians ask about allergy and adverse drug reactions and record the results?	☐ Policies, procedures and protocols for documenting, managing and reporting adverse drug reactions ☐ Policies, procedures and protocols for checking adverse drug reaction history prior to prescribing, dispensing or administering medicines ☐ Audit of patient clinical records where known adverse drug reactions are documented on the current medication chart or entered into the patient's electronic record ☐ Audit of patient clinical records shows information on new adverse drug reactions and allergies is documented ☐ Audit of use of adverse drug reaction alert systems in electronic medicines management systems used for prescribing, dispensing and administering medicines ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
4.7.2 Action is taken to reduce the risk of adverse reactions	No match to the *NSMHS*	What actions have we taken to decrease the risk to patients of adverse drug reactions?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Register of adverse drug reactions that includes actions to address identified risks and documentation of completed actions ☐ Quality improvement plan includes actions to address issues identified and evaluation of outcomes ☐ Examples of improvement activities that have been implemented to reduce the risk of adverse reactions. For example: – changes to policy and procedures – publication of actions in medication safety or quality use of medicines bulletins ☐ Education resources and records of attendance at training of workforce on obtaining and documenting an allergy and adverse drug reaction history and documenting and reporting adverse drug reactions occurring during the episode of care ☐ Communication material developed for workforce, patients and carers	☐ No → further action is required ☐ Yes → list source of evidence

Documentation of patient information

The clinical workforce accurately records a patient's medication history and this history is available throughout the episode of care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.7 The clinical workforce documenting the patient's previously known adverse drug reactions on initial presentation and updating this if an adverse reaction to a medicine occurs during the episode of care (continued)				
4.7.2 Action is taken to reduce the risk of adverse reactions *(continued)*			☐ Audit of patient clinical records for patients administered a medicine to which they have had an allergy or previous adverse drug reaction ☐ Audit of patient clinical records that confirms any new adverse drug reactions has been communicated to the patient and carer and the primary care clinician ☐ Other _____	
4.7.3 Adverse drug reactions are reported within the organisation and to the Therapeutic Goods Administration	No match to the *NSMHS*	How do we report adverse drug reactions within our drug organisation? How do we know we report adverse drug reaction to the Therapeutic Goods Administration (TGA)?	☐ Policies, procedures and protocols for documenting, managing and reporting adverse drug reactions within the organisation and to the Therapeutic Goods Administration ☐ Record of adverse drug reactions reports submitted to the Therapeutic Goods Administration ☐ Register of adverse drug reactions that includes actions to address the identified risks ☐ Relevant documentation from committees and meetings that include information about adverse drug reactions reported ☐ Access to tools for reporting adverse drug reactions, for example online reporting and Therapeutic Goods Administration's Blue reporting cards ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Documentation of patient information

The clinical workforce accurately records a patient's medication history and this history is available throughout the episode of care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.8 The clinical workforce reviewing the patient's current medication orders against their medication history and prescriber's plan, and reconciling any discrepancies				
4.8.1 Current medicines are documented and reconciled at admission and transfer of care between healthcare settings	No match to the *NSMHS*	How do we know if our clinicians review their patient's current medication orders against the medication history? How are medication discrepancies documented and reconciled?	☐ Policies, procedures and protocols on reconciling medicines on admission, transfer within the organisation and discharge to another healthcare setting ☐ Audit of patient clinical records in relation to rate of medication reconciliation on admission ☐ Audit of patient clinical records in relation to rate of medication reconciliation on discharge ☐ Audit of patient clinical records note review of discharge prescriptions ☐ Audit of patient clinical records with a completed medication management plan or equivalent (manual or electronic) ☐ Education resources developed and records of attendance at training provided for workforce assigned responsibility for reconciling medicines ☐ Audit of indicators, for example *Indicators 3.1 and 5.3 – Indicators for Quality Use of Medicines in Australian Hospitals* ☐ Other _____ **Links with Item 4.12 regarding availability of a current comprehensive list of medicines at clinical handover**	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Medication management processes

The clinical workforce is supported for the prescribing, dispensing, administering, storing, manufacturing, compounding and monitoring of medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.9 Ensuring that current and accurate medicines information and decision support tools are readily available to the clinical workforce when making clinical decisions related to medicines use				
4.9.1 Information and decision support tools for medicines are available to the clinical workforce at the point of care	No match to the *NSMHS*	What medicines information and decision support tools do we provide to our clinicians?	☐ Current medicines reference texts (electronic or hard copy) available in patient care areas ☐ Clinical decision support tools such as protocols, guidelines, medicines information resources are accessible in clinical areas (electronic or hard copy) ☐ Access to current resources (online or hard copy) in clinical areas including: MIMS (or equivalent); therapeutic guidelines; *Australian Medicines Handbook*; pharmacy manual; injectable medicines guidelines; guidelines on medicines that can be crushed ☐ Availability of electronic decision support tools (for example, medication dosing calculators, antibiotic approval systems) ☐ Decision support tools (passive and active) available in electronic medicines management systems ☐ Other_____	☐ No → further action is required ☐ Yes → list source of evidence
4.9.2 The use of the information and decision support tools is regularly reviewed	No match to the *NSMHS*	How do we know that our decision support tools are current and of use to our clinicians?	☐ Relevant documentation from committees and meetings regarding the development and maintenance of information resources and decision support tools ☐ Risk assessment of medicines information system. For example, using the drug information domain in *Medication Safety Self Assessment® in Australian Hospitals* ☐ Observation of clinical practice regarding the use of decision support tools ☐ Records of clinical workforce accessing the organisation's medicines information service (if available) ☐ Records of pharmacy and clinical workforce access to electronic medicines information systems (where available) ☐ Record of workforce feedback and suggestions on decision support tools ☐ Observational audit or survey on use and currency of decision support tools ☐ Other_____	☐ No → further action is required ☐ Yes → list source of evidence

Medication management processes

The clinical workforce is supported for the prescribing, dispensing, administering, storing, manufacturing, compounding and monitoring of medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.9 Ensuring that current and accurate medicines information and decision support tools are readily available to the clinical workforce when making clinical decisions related to medicines use (continued)				
4.9.3 Action is taken to improve the availability and effectiveness of information and decision support tools	No match to the *NSMHS*	What action have we taken to improve access to, and use of, medicines information resources and decision support tools?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to improve the availability and effectiveness of information and decision support tools ☐ Communication material developed for workforce and patients and carers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
4.10 Ensuring that medicines are distributed and stored securely, safely and in accordance with the manufacturer's directions, legislation, jurisdictional orders and operational directives				
4.10.1 Risks associated with secure storage and safe distribution of medicines are regularly reviewed	**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	How do we identify, report and manage risks associated with the storage of medicines in our organisation?	☐ Completed risk assessment of system for distributing and storing medicines. For example, using drug standardisation, storage and distribution domain in *Medication Safety Self Assessment® in Australian Hospitals* ☐ Audit of compliance with policies, procedures and protocols ☐ Review of reports of incidents associated with distribution and storage of medicines ☐ Risk register that includes actions to address identified risks ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Medication management processes

The clinical workforce is supported for the prescribing, dispensing, administering, storing, manufacturing, compounding and monitoring of medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.10 Ensuring that medicines are distributed and stored securely, safely and in accordance with the manufacturer's directions, legislation, jurisdictional orders and operational directives (continued)				
4.10.2 Action is taken to reduce the risks associated with storage and distribution of 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	What action have we taken to decrease risks of errors storage and distribution?	☐ Policies, procedures and protocols for safe distribution and storage of medicines ☐ Policies and procedures for management of patients own medicines brought into hospital ☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Report of actions to address issues identified in the risk assessment of the storage and distribution systems undertaken in 4.10.1 ☐ Risk registers that demonstrate action taken to reduce risk ☐ Quality improvement plan includes actions to address issues identified ☐ Observation that barcode scanners are used when medicines are dispensed ☐ Examples of improvement activities that have been implemented and evaluated to reduce the risks associated with storage and distribution of medicines. For example: – use of 'Tall Man Lettering' system to reduce errors from 'look alike' and 'sound alike' medicines in shelving in pharmacies and ward medicines storage areas – products with similar packaging are separated in medicines storage areas ☐ Communication material developed for workforce, patients and carers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Medication management processes

The clinical workforce is supported for the prescribing, dispensing, administering, storing, manufacturing, compounding and monitoring of medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.10 Ensuring that medicines are distributed and stored securely, safely and in accordance with the manufacturer's directions, legislation, jurisdictional orders and operational directives (continued)				
4.10.3 The storage of temperature-sensitive medicines is monitored	**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	How do we monitor the storage of temperature-sensitive medicines?	☐ Policies, procedures and protocols on monitoring of temperature in refrigerators and freezers used to store medicines and vaccines throughout the facility ☐ Record of daily checks and scheduled maintenance of the medicines and vaccines refrigerators ☐ Audit of compliance with processes for daily checks of medicines and vaccine refrigerators ☐ Record of temperature reading devices in fridges ☐ Record of review of alarm settings and associated response processes to activated alarms ☐ Risk register that includes actions to address identified risks ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
4.10.4 A system that is consistent with legislative and jurisdictional requirements for the disposal of unused, unwanted or expired medications is in place	**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	Are our medicines disposal processes consistent with jurisdictional requirements and the manufacturer's instructions?	☐ Policies, procedures and protocols on the disposal of unused, unwanted or expired medicines that align with legislative and jurisdictional requirements including S8 medicines, chemotherapy and hazardous substances ☐ Education resources and records of attendance at training by the workforce on the disposal of unused, unwanted or expired medicines ☐ Observation of workforce access to infrastructure and equipment necessary to comply with policy, procedures and protocols ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Medication management processes

The clinical workforce is supported for the prescribing, dispensing, administering, storing, manufacturing, compounding and monitoring of medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.10 Ensuring that medicines are distributed and stored securely, safely and in accordance with the manufacturer's directions, legislation, jurisdictional orders and operational directives (continued)				
4.10.5 The system for disposal of unused, unwanted or expired medications is routinely monitored	**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	How do we know if our processes for the disposal of medicines are being used by our workforce?	☐ Completed risk assessment of system for disposing of medicines in the organisation ☐ Risk register that includes actions to address identified risks ☐ Audit of compliance with policies, procedures and protocols ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
4.10.6 Action is taken to increase compliance with the system for storage, distribution and disposal of medications	**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	What action have we taken to improve our systems for storing, distributing and disposing of medicines?	☐ Policies and procedures for safe handling and disposal of S8 medicines, cytotoxic products and hazardous substances that align with legislative and jurisdictional requirements ☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to reduce the risks associated with storage and distribution of medicines ☐ Communication material developed for workforce, patients and carers ☐ Education resources and records of attendance of workforce at training on safe storage and disposal of medicines ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Medication management processes

The clinical workforce is supported for the prescribing, dispensing, administering, storing, manufacturing, compounding and monitoring of medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.11 Identifying high-risk medicines in the organisation and ensuring they are stored, prescribed, dispensed and administered safely				
4.11.1 The risks for storing, prescribing, dispensing and administration of high-risk medicines are regularly reviewed	No match to the *NSMHS*	How do we determine which medicines are high-risk and how should they be stored, prescribed, administered and supplied? How do we identify, report and manage the risks associated with high-risk medicines?	☐ Policies, procedures, and protocols for storing, prescribing, dispensing, administering and monitoring high-risk medicines ☐ Completed risk assessment of management of high-risk medicines ☐ Risk register that includes actions to address identified risks ☐ Review of reports of incidents associated with high-risk medicines ☐ Audit of compliance with policy, procedures, protocols and guidelines for prescribing, dispensing, administering and monitoring specific high-risk medicines such as anticoagulants, chemotherapy, opioids and insulin ☐ Audit of compliance with specific storage requirements for high-risk medicines such as concentrated injectables (potassium, electrolytes) and opioids ☐ Audit of compliance with recommendations from national alerts on high-risk medicines. For example: – percentage of medication areas (outside pharmacy) where potassium ampoules are available (*Indicator 6.1 – Indicators for Quality Use of Medicines in Australian Hospitals*) – use of safety controls on storage of potassium ampoules – number of vincristine doses prepared in syringes, mini-bags ☐ Physical security that restricts access to high-risk medicines ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Medication management processes

The clinical workforce is supported for the prescribing, dispensing, administering, storing, manufacturing, compounding and monitoring of medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.11 Identifying high-risk medicines in the organisation and ensuring they are stored, prescribed, dispensed and administered safely (continued)				
4.11.2 Action is taken to reduce the risks of storing, prescribing, dispensing and administering high-risk medicines	No match to the *NSMHS*	What action have we taken to decrease the risks associated with high-risk medicines?	☐ Policies, procedures, protocols and guidelines for prescribing, dispensing, administering and monitoring specific high-risk medicines such as anticoagulants, chemotherapy, concentrated electrolytes (potassium), opioids and insulin that are available to the clinical workforce ☐ A list of high-risk medicines used in the facility and available to workforce ☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to reduce the risks of storing, prescribing, dispensing and administering high-risk medicines ☐ Examples of standardisation of high-risk medicines – premixed solutions or preloaded syringes for injectable high-risk medicines – standardised single concentrations of infusions of high-risk medicines ☐ Use of infusion pumps with safety software (smart pump technology) to infuse high-risk medicines ☐ Communication material developed for workforce and patients and carers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Continuity of medication management

The clinician provides a complete list of a patient's medicines to the receiving clinician and patient when handing over care or changing medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.12 Ensuring a current comprehensive list of medicines, and the reason(s) for any change, is provided to the receiving clinician and the patient during clinical handovers				
4.12.1 A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in medicines	**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	How do we generate a current and comprehensive list of medicines, including any changes, for use at clinical handover?	☐ Policies, procedures and protocols on patient's medicines information to be provided on transfer and discharge ☐ Patient clinical records that contain a medicines list and explanation of changes used at handover of care such as transfer or discharge ☐ Audit of discharge summaries that include medication therapy changes and reasons for any changes ☐ Audit of compliance with policies, procedures and protocols on patient's medicines information to be provided on transfer and discharge ☐ Education resources and records of attendance at training of workforce on use of system to generate medicines list ☐ Other_____ **Links with Action 6.2.1 regarding structured and documented processes for clinical handover**	☐ No → further action is required ☐ Yes → list source of evidence
4.12.2 A current and comprehensive list of medicines is provided to the patient and/or carer when concluding an episode 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	Do we provide a current list of medicines to patients or carers at the end of an episode care?	☐ Policy, procedures or guidelines on provision of medicines list to patients or carers ☐ Audit of patient clinical records showing that patients are provided a current comprehensive list of medicines on discharge ☐ Observation of medicines list provided to patients on discharge ☐ Other_____	☐ No → further action is required ☐ Yes → list source of evidence

Continuity of medication management

The clinician provides a complete list of a patient's medicines to the receiving clinician and patient when handing over care or changing medicines.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.12 Ensuring a current comprehensive list of medicines, and the reason(s) for any change, is provided to the receiving clinician and the patient during clinical handovers (continued)				
4.12.3 A current comprehensive list of medicines is provided to the receiving clinician during clinical handover	**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	How do we provide a current list of medicines to the receiving clinician?	☐ Patient clinical records that show a current list of medicines, including the reason for change, was provided to the receiving clinician ☐ Audit of patient clinical records to identify the proportion of discharge summaries that contain a current comprehensive list of medicines, medication therapy changes and explanations for changes ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
4.12.4 Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover	**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	What action have we taken to improve the process for providing a current list of medicines to patients or receiving clinicians?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines ☐ Communication material developed for workforce and patients and carers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Communicating with patients and carers

The clinical workforce informs patients about their options, risks and responsibilities for an agreed medication management plan.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.13 The clinical workforce informing patients and carers about medication treatment options, benefits and associated risks				
4.13.1 The clinical workforce provides patients with patient-specific medicine information, including medical treatment options, benefits and associated risks	**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	How do clinicians inform patients about options for their care including the use of medicines?	☐ Policies, procedures and protocols that define the roles, responsibilities and accountabilities of the clinical workforce in informing patients and carers about medication treatment options, benefits and associated risks ☐ Patient's clinical record that shows patient-specific information such as consumer medicines information was provided to patients ☐ Records of patient education provided such as information on chemotherapy to oncology and haematology patients ☐ Patient and carer education material such as brochures, fact sheets, posters, links to trusted websites ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
4.13.2 Information that is designed for distribution to patients is readily available to the clinical workforce	No match to the *NSMHS*	What information do we provide to patients or carers about medication treatment options and risks?	☐ Observation that patient-specific medicines information (such as brochures and fact sheets, and including consumer medicines information) is available in the workplace ☐ Patient's clinical record shows the use of patient-specific medicines information such as consumer medicines information ☐ Results of patient experience survey on the provision of information on high-risk medicines such as warfarin, diabetes medicines, cardiac medicines ☐ Result of National Inpatient Medication Chart audit on patients prescribed warfarin documented as receiving warfarin information book ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Communicating with patients and carers

The clinical workforce informs patients about their options, risks and responsibilities for an agreed medication management plan.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.14 Developing a medication management plan in partnership with patients and carers				
4.14.1 An agreed medication management plan is documented and available in the patient's clinical record	**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 **10.5.10** The MHS ensures that medication and/or therapies when required, are only used as part of a documented continuum of treatment strategies	How is a medication management plan recorded in the patient clinical record? How do we know patients or carers have been involved in the development of their medication management plan?	☐ Policy and procedures are in place for documenting a medication management plan ☐ Audit of patient clinical records relating to patients with a completed medication management plan ☐ Patient clinical records that show written information was provided on new medicines and medicines to be continued by patients post-discharge ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
4.15 Providing current medicines information to patients in a format that meets their needs whenever new medicines are prescribed or dispensed				
4.15.1 Information on medicines is provided to patients and carers in a format that is understood and meaningful	**10.5.7** The MHS actively promotes adherence to evidenced-based treatments through negotiation and the provision of understandable information to the consumer	What information on medicines is provided to patients or carers on new medicines prescribed? How do we know if patients or carers understand this information?	☐ Patient clinical records that show patient and carer information was provided for any changes to medicines during the episode of care ☐ Records of consumer medicines information provided ☐ Results of patient experience survey on medicines information provided ☐ Patient and carer education resources available and education programs provided on medication such as cardiac rehabilitation programs, chemotherapy education sessions for oncology and haematology patients ☐ Record of patient and carer attendance at education sessions ☐ Other _____ **Links with Item 2.4 regarding consulting consumers on patient information distributed by the organisation**	☐ No → further action is required ☐ Yes → list source of evidence

Communicating with patients and carers

The clinical workforce informs patients about their options, risks and responsibilities for an agreed medication management plan.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.15 Providing current medicines information to patients in a format that meets their needs whenever new medicines are prescribed or dispensed (continued)				
4.15.2 Action is taken in response to patient feedback to improve medicines information distributed by the health service organisation to patients	**10.5.7** The MHS actively promotes adherence to evidenced-based treatments through negotiation and the provision of understandable information to the consumer	What action have we taken to ensure patient feedback is incorporated into the patient medicines information?	☐ Relevant documentation from committees that detail improvement actions taken ☐ Examples of improvement activities that have been implemented and evaluated to improve access to, and quality of, medicines information provided to patients and carers ☐ Communication material developed for workforce and patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Patient Identification and Procedure Matching

Standard 5

Standard 5: Patient Identification and Procedure Matching

Clinical leaders and senior managers of a health service organisation establish systems to ensure the correct identification of patients and correct matching of patients with their intended treatment. Clinicians and other members of the workforce use the patient identification and procedure matching systems.

The intention of this Standard is to:

Correctly identify all patients whenever care is provided and correctly match patients to their intended treatment.

Context:

It is expected that this Standard will be applied in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations* and *Standard 2: Partnering with Consumers*.

Criteria to achieve the Patient Identification and Procedure Matching Standard:

- Identification of individual patients
- Processes to transfer care
- Processes to match patients and their care

Identification of individual patients

At least three approved patient identifiers are used when providing care, therapy or services.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
5.1 Developing, implementing and regularly reviewing the effectiveness of a patient identification system, including the associated policies, procedures and/or protocols that: • **define approved patient identifiers** • **require at least three approved patient identifiers on registration or admission** • **require at least three approved patient identifiers when care, therapy or other services are provided** • **require at least three approved patient identifiers whenever clinical handover, patient transfer or discharge documentation is generated**			
5.1.1 Use of an organisation-wide patient identification system is regularly monitored	Do we have a system across the hospital that ensures consistent and correct identification of a patient at any point in their admission? Do we have a system that requires at least three approved patient identifiers to be used throughout the admission? How do we know if our workforce use our patient identification processes?	☐ Policies, procedures and protocols that require three patient identifiers to be recorded in the patient clinical records, including the Individual Healthcare Identifier ☐ Policy that specifies the approved patient identifiers for all clinical services ☐ Policy that describes the auditing process for monitoring compliance with the patient identification policy ☐ Relevant documentation from committees and meetings that demonstrate information about the patient identification system is routinely reported to and reviewed by management ☐ Schedule of routine policy reviews or review dates on policies ☐ Audit of patient clinical records for the use of three patient identifiers ☐ Other _____ **Links with Item 1.1 regarding governance systems that set out policies, procedures and protocols**	☐ No → further action is required ☐ Yes → list source of evidence

Identification of individual patients

At least three approved patient identifiers are used when providing care, therapy or services.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
5.1 Developing, implementing and regularly reviewing the effectiveness of a patient identification system, including the associated policies, procedures and/or protocols that: • **define approved patient identifiers** • **require at least three approved patient identifiers on registration or admission** • **require at least three approved patient identifiers when care, therapy or other services are provided** • **require at least three approved patient identifiers whenever clinical handover, patient transfer or discharge documentation is generated** (continued)			
5.1.2 Action is taken to improve compliance with the patient identification matching system	What action have we taken to improve the use of our processes for patient identification and procedure matching?	☐ Records of reviews of policies, procedures and protocols ☐ Documented strategies for minimising risks of misidentification, patient identification and procedure matching ☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to improve compliance with the patient identification matching system ☐ Education resources and records of attendance at training by the workforce on the organisation's patient identification and management protocols ☐ Communication material developed for workforce, patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Identification of individual patients

At least three approved patient identifiers are used when providing care, therapy or services.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
5.2 Implementing a robust organisation-wide system of reporting, investigation and change management to respond to any patient care mismatching events			
5.2.1 The system for reporting, investigating and analysis of patient care mismatching events is regularly monitored	How do we identify, record and manage patient mismatching events and near misses? How do we inform our workforce about patient care mismatching events and near misses?	☐ Relevant documentation from committees and meetings that demonstrate mismatch incidents are routinely reported to and reviewed by management ☐ Incident reporting management system or register of near misses and incidents of patient mismatching events ☐ Risk register that includes actions to address identified risks ☐ Root cause analysis of policy or protocol breaches that result in a serious incident or sentinel event ☐ Audit of patient clinical records that include the reporting and investigation of care mismatching events ☐ Other _____ **Links with Item 1.14 regarding incident management and investigation systems**	☐ No → further action is required ☐ Yes → list source of evidence
5.2.2 Action is taken to reduce mismatching events	What action have we taken to decrease the risk to patients of mismatching events and near misses?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to decrease the risk to patients of mismatching events and near misses ☐ Communication material developed for workforce, patients and carers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Identification of individual patients

At least three approved patient identifiers are used when providing care, therapy or services.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
5.3 Ensuring that when a patient identification band is used, it meets the national specifications for patient identification bands			
5.3.1 Inpatient bands are used that meet the national specifications for patient identification bands	How do we know that our patient bands meet the national specifications?	☐ Policies, procedures and protocols for patient identification and procedure matching that are consistent with the *Specifications for a Standard Patient Identification Band* ☐ Audit of patient identification bands compliance with the *Specifications for a Standard Patient Identification Band* ☐ Related policies, such as blood administration and medication administration policies, that have been amended based on audit results of the use of patient identification bands ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Processes to transfer care

A patient's identity is confirmed using three approved patient identifiers when transferring responsibility for care.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
5.4 Developing, implementing and regularly reviewing the effectiveness of the patient identification and matching system at patient handover, transfer and discharge			
5.4.1 A patient identification and matching system is implemented and regularly reviewed as part of structured clinical handover, transfer and discharge processes	How do we know if our processes for patient identification and matching are used during clinical handover, transfer and discharge?	☐ Policies, procedures and protocols on patient handover, transfer and discharge include the use of three patient identifiers, and the Individual Healthcare Identifier for electronically transferred information ☐ Audit of transfer or discharge summaries of patients transferred to another healthcare organisation for use of three patient identifiers ☐ Feedback to the workforce regarding results of audits on handover, transfer and discharge sheets, forms and summaries ☐ Relevant documentation from committees and meetings that include audit results of handover sheets, transfer forms and discharge summaries ☐ Report that provides results of audits on handover, transfer and discharge processes ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Processes to match patients and their care

Health service organisations have explicit processes to correctly match patients with their intended care.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
5.5 Developing and implementing a documented process to match patients to their intended procedure, treatment or investigation and implementing the consistent national guidelines for patient procedure matching protocol or other relevant protocols			
5.5.1 A documented process to match patients and their intended treatment is in use	Are our written processes for matching a patient and their intended care consistent with national guidelines?	☐ Policies, procedures and protocols that document specific patient identification procedures to be used by the workforce, including electronic systems which may include: – surgical safety checklist – handover checklists – medication management – discharge summaries – e-referrals – e-transfer of prescriptions – e-specialist letters ☐ Audits of compliance with policy, procedures and protocols ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
5.5.2 The process to match patients to any intended procedure, treatment or investigation is regularly monitored	How do we know if our patient identification and procedure matching processes are being used by our workforce?	☐ Audit of patient clinical records for patient and procedure, treatment and investigation matching (such as surgical, diagnostics, chemotherapy, renal dialysis) ☐ Relevant documentation from committees and meetings that include an analysis of incident data and trends ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
5.5.3 Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation	What action have we taken to improve our patient identification and procedure matching processes?	☐ Relevant documentation from committees that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to improve our patient identification and procedure matching processes ☐ Communication material developed for workforce, patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Clinical Handover

Standard 6

Standard 6: Clinical Handover

Clinical leaders and senior managers of a health service organisation implement documented systems for effective and structured clinical handover. Clinicians and other members of the workforce use the clinical handover systems.

The intention of this Standard is to:

Ensure there is timely, relevant and structured clinical handover that supports safe patient care.

Context:

It is expected that this Standard will be applied in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations* and *Standard 2: Partnering with Consumers*.

Criteria to achieve the Clinical Handover Standard:

- Governance and leadership for effective clinical handover
- Clinical handover processes
- Patient and carer involvement in clinical handover

Governance and leadership for effective clinical handover

Health service organisations implement effective clinical handover systems.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
6.1 Developing and implementing an organisational system for structured clinical handover that is relevant to the healthcare setting and specialities, including: • **documented policy, procedures and/or protocols** • **agreed tools and guides**				
6.1.1 Clinical handover policies, procedures and/or protocols are used by the workforce and regularly monitored	**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 **9.4** The MHS establishes links with the consumer's nominated primary healthcare provider and has procedures to facilitate and review internal and external referral processes **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	How do we describe our organisational processes for clinical handover resulting in a transfer of care and accountability to another healthcare practitioner or organisation? How do we know that our workforce use our clinical handover processes?	☐ Policies, procedures and protocols on structured clinical handover that include information for different situations, methods and venues relevant to the organisation ☐ Structured communication tools for use in clinical handover including handover checklists with minimum data set ☐ Schedule of routine policy reviews or review dates on policies ☐ Relevant documentation from committees and meetings that demonstrates information on clinical handover is routinely reported to and reviewed by management ☐ Education resources and records of attendance at training, orientation, in service by the workforce on the organisation's protocols for clinical handover ☐ Documentation recording feedback and communication to clinical workforce when changes to structured clinical handover occurs ☐ Audit of patient clinical records show that clinical handover has occurred, for example, patient care plans, discharge summary, operation reports, e-referrals ☐ Clinical handover records, for example, archived handover documentation, electronic tools, register, discharge summaries ☐ Discharge summary including minimum data set ☐ Transfer guidelines and forms for transferring patients within and between hospitals, at discharge for ongoing care or investigation that include structured format and minimum data set ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and leadership for effective clinical handover

Health service organisations implement effective clinical handover systems.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
6.1 Developing and implementing an organisational system for structured clinical handover that is relevant to the healthcare setting and specialities, including: • **documented policy, procedures and/or protocols** • **agreed tools and guides**				(continued)
6.1.2 Action is taken to maximise the effectiveness of clinical handover policies, procedures and/or protocols	**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	What action have we taken to improve policy and procedure surrounding clinical handover for our organisation?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to maximise the effectiveness of clinical handover ☐ Communication material developed for workforce, patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
6.1.3 Tools and guides are periodically reviewed	No match to the *NSMHS*	What tools and guides does our workforce use for structured clinical handover? How do we keep the tools and guides up to date?	☐ Structured communication tools which are based on the core principles for effective clinical handover and minimum datasets ☐ Schedule of policies, procedures and protocols updated in line with best practice or emerging information ☐ Tools and guides are updated in line with identified risks registers and relevant committee feedback ☐ Evidence of maintenance and evaluation plans for tools and guides ☐ Quality improvement plan that includes details of last review and schedule for future reviews ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Clinical handover processes

Health service organisations have structured and documented clinical handover processes in place.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
6.2 Establishing and maintaining structured and documented processes for clinical handover				
6.2.1 The workforce has access to documented, structured processes for clinical handover that include: • preparing for handover, including setting the location and time whilst maintaining continuity of patient care • organising relevant workforce members to participate • being aware of the clinical context and patient needs • participating in effective handover resulting in transfer of responsibility and accountability for care	No match to the *NSMHS*	What information do we give our workforce regarding clinical handover processes? Is this information suitable for local context and easily accessible? Does the workforce have sufficient resources to participate in effective clinical handover?	☐ Policies, procedures and protocols that describe a structured clinical handover process taking into account the setting, relevant workforce, patient needs and accountability for care ☐ Tools and resources for a structured clinical handover process that are accessible to the workforce. Examples include iSoBAR (identify–situation–observations–background–agreed plan–read back) and SHARED (Situation–History–Assessment–Risk–Expectation–Documentation) ☐ Transfer guidelines and forms for transferring patients between and within hospital, and at discharge, including e-discharge guides ☐ Observation that policies, procedures and protocols on clinical handover are posted on health service communication board or website and are easily accessible to the workforce ☐ Education resources and records of attendance at training, orientation, in service by the workforce on the organisation's protocols for clinical handover ☐ Documentation recording feedback and communication to clinical workforce when changes to structured clinical handover occurs ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Clinical handover processes

Health service organisations have structured and documented clinical handover processes in place.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
6.3 Monitoring and evaluating the agreed structured clinical handover processes, including: • **regularly reviewing local processes based on current best practice in collaboration with clinicians, patients and carers** • **undertaking quality improvement activities and acting on issues identified from clinical handover reviews** • **reporting the results of clinical handover reviews at executive level of governance**				
6.3.1 Regular evaluation and monitoring processes for clinical handover are in place	No match to the *NSMHS*	How do we monitor clinical handover to ensure that it is being conducted in the agreed structure? How do we evaluate if clinical handover processes are effective or improving?	☐ Policies and procedures identify a process for monitoring and evaluation of clinical handover ☐ Audit of patient clinical records show that clinical handover has occurred, for example patient care plans, discharge summary, operation reports, transfer forms ☐ Review of structured clinical handover tools ☐ Reports, investigations and feedback to the workforce on patient incidents involving clinical handover ☐ Results of patient experience surveys regarding clinical handovers ☐ Relevant documentation from committees and meetings that demonstrates information on clinical handover is routinely reported to, and reviewed by management ☐ Other_____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
6.3.2 Local processes for clinical handover are reviewed in collaboration with clinicians, patients and carers	No match to the *NSMHS*	How do we involve clinicians, patients and carers in the clinical handover process?	☐ Processes for clinical handover are reviewed in collaboration with clinicians, patients and carers ☐ Documentation of feedback, recommendations and action taken to reduce reoccurrence of clinical handover incidences ☐ Review of processes that includes the use of patient feedback data and/or focus groups ☐ Other_____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Clinical handover processes

Health service organisations have structured and documented clinical handover processes in place.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
6.3 Monitoring and evaluating the agreed structured clinical handover processes, including: • **regularly reviewing local processes based on current best practice in collaboration with clinicians, patients and carers** • **undertaking quality improvement activities and acting on issues identified from clinical handover reviews** • **reporting the results of clinical handover reviews at executive level of governance**				(continued)
6.3.3 Action is taken to increase the effectiveness of clinical handover	No match to the *NSMHS*	What action have we taken to improve clinical handover processes?	☐ Clinical handover tools and practices updated in line with review findings and risk register ☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to increase the effectiveness of clinical handover ☐ Communication material developed for workforce, patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
6.3.4 The actions taken and the outcomes of local clinical handover reviews are reported to the executive level of governance	No match to the *NSMHS*	What information do we provide the executive on our review of clinical handover processes?	☐ Results of audit of patient clinical records and action to address issued identified ☐ Reports on patient incidents involving clinical handover ☐ Relevant documentation from committees and meetings on clinical handover ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Clinical handover processes

Health service organisations have structured and documented clinical handover processes in place.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
6.4 Implementing a robust organisation-wide system of reporting, investigation and change management to respond to any clinical handover incidents				
6.4.1 Regular reporting, investigating and monitoring of clinical handover incidents is in place	No match to the *NSMHS*	How do we identify, record and respond to incidents relating to clinical handover? How do we inform our workforce of these incidents?	☐ Incident reporting forms and processes included in policies, procedures and protocols ☐ Reports on trends in clinical handover incidents ☐ Root cause analysis of clinical handover incidents and actions taken to address the issues identified ☐ Relevant documentation from committees and meetings that include information on clinical handover incidents ☐ Committee terms of reference outline the responsibilities of executives for clinical handover incidents ☐ Feedback provided to the workforce on clinical handover incidents and actions taken ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
6.4.2 Action is taken to reduce the risk of adverse clinical handover incidents	No match to the *NSMHS*	What action have we taken to reduce risks to patients during clinical handover periods? How do we use local feedback information to reduce clinical handover incidents?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to reduce the risk of adverse clinical handover incidents ☐ Communication material developed for workforce, patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Patient and carer involvement in clinical handover

Health service organisations establish mechanisms to include patients and carers in clinical handover processes.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
6.5 Developing and implementing mechanisms to include patients and carers in the clinical handover process that are relevant to the healthcare setting				
6.5.1 Mechanisms to involve a patient and, where relevant, their carer in clinical handover are in use	**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 **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)	How do we include patients and carers in the clinical handover processes?	☐ Information for patients and carers on their roles in handover such as access to a patient charter of rights ☐ Results of patient experience survey related to clinical handover ☐ Forms that patients review, sign and receive as a copy related to their clinical management and handover at discharge ☐ Audit of patient clinical records documenting involvement of consumers and carers in development of exit plans ☐ Procedure identifying mechanisms to deal with patient complaints surrounding clinical handover ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Blood and Blood Products

Standard 7

Standard 7: Blood and Blood Products

Clinical leaders and senior managers of a health service organisation implement systems to ensure the safe, appropriate, efficient and effective use of blood and blood products. Clinicians and other members of the workforce use the blood and blood product safety systems.

The intention of this Standard is to:

Ensure that the patients who receive blood and blood products do so appropriately and safely.

Context:

It is expected that this Standard will be applied in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations* and *Standard 2: Partnering with Consumers*.

Criteria to achieve the Blood and Blood Products Standard:

- Governance and systems for blood and blood product prescribing and clinical use
- Documenting patient information
- Managing blood and blood product safety
- Communicating with patients and carers

Governance and systems for blood and blood product prescribing and clinical use

Health service organisations have systems in place for the safe and appropriate prescribing and clinical use of blood and blood products

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
7.1 Developing governance systems for safe and appropriate prescription, administration and management of blood and blood products			
7.1.1 Blood and blood product policies, procedures and/or protocols are consistent with national evidence-based guidelines for pre-transfusion practices, prescribing and clinical use of blood and blood products	Are our blood and blood product policies consistent with national guidelines?	☐ Policies, procedures and protocols that adhere to national evidence-based guidelines where available and address areas such as: – prescription, administration and management of blood and blood products – pre-transfusion and sampling practices such as specimen collection – processes that relate to laboratory-hospital interface – consent and refusal procedure – ordering, receipting, storage and transportation of blood and blood products – risk assessment and management – Individual Healthcare Identifiers – wastage and discard of blood and blood products ☐ Education programs for the relevant workforce reflect national guidelines relating to blood and blood products management ☐ Other _____ **Links with Item 1.1 regarding governance systems that set out policies, procedures and protocols**	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
7.1.2 The use of policies, procedures and/or protocols is regularly monitored	How do we know our workforce are using our blood and blood product processes correctly and consistently?	☐ Relevant documentation from committee(s) that detail the development, implementation and monitoring of the use of policies, procedures and protocols ☐ Risk register that includes actions to address identified risks ☐ Audit of compliance with policies, procedures, guidelines and protocols, for example, clinicians' checklist for prescribing blood components to ensure blood products are only released for transfusion when guidelines have been satisfied ☐ Reports of vetting of transfusion requests ☐ Audit of accessibility and use of clinical guidelines in clinical areas ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and systems for blood and blood product prescribing and clinical use

Health service organisations have systems in place for the safe and appropriate prescribing and clinical use of blood and blood products

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
7.1 Developing governance systems for safe and appropriate prescription, administration and management of blood and blood products (continued)			
7.1.3 Action is taken to increase the safety and appropriateness of prescribing and clinically using blood and blood products	How do we make sure blood and blood products are prescribed properly and safely?	☐ Audit of patient clinical records that assesses compliance with evidence-based guidelines ☐ Feedback provided to clinicians on results of audits ☐ Education resources address safety and quality deficits in appropriate prescribing and clinical use of blood and blood products ☐ Peer review and self-audit tools and reports on outcomes ☐ Relevant documentation from committee(s) that detail improvement actions ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated ☐ Communication material developed for the workforce and patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
7.2 Undertaking a regular, comprehensive assessment of blood and blood product systems to identify risks to patient safety and taking action to reduce risks			
7.2.1 The risks associated with transfusion practices and clinical use of blood and blood products are regularly assessed	How do we ensure our risks related to blood and blood products are identified, reported and managed appropriately?	☐ Audit of compliance with policies, procedures and protocols ☐ Risk register that includes actions to address identified risks relating to non-compliance with policies, procedures and protocols, and the person responsible ☐ Process for addressing pathology laboratory documentation that identifies patient safety risks from the use of blood and blood products ☐ Relevant documentation from meetings confirming that data and other information on risks are regularly assessed ☐ Examples of data capture and analyses to identify risk associated with prescribing, handling and administration of blood and blood products ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and systems for blood and blood product prescribing and clinical use

Health service organisations have systems in place for the safe and appropriate prescribing and clinical use of blood and blood products

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
7.2 Undertaking a regular, comprehensive assessment of blood and blood product systems to identify risks to patient safety and taking action to reduce risks (continued)			
7.2.2 Action is taken to reduce the risks associated with transfusion practices and clinical use of blood and blood products	What do we do to manage the risks associated with our clinical use of blood and blood products? How do we tell the workforce about risks related to blood and blood products?	☐ Education resources and training attendance records related to the prescription and clinical administration of blood and risk assessment ☐ Quality improvement plan or risk register that includes actions to address identified risks and documents evidence for implementation of the actions ☐ Examples of modifications to policies, procedures and protocols to address issues of non-compliance ☐ Communication material developed for the workforce and patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
7.3 Ensuring blood and blood product adverse events are included in the incidents management and investigation system			
7.3.1 Reporting on blood and blood product incidents is included in regular incident reports	Where are incidents relating to blood and blood products reported?	☐ Policies, procedures and protocols for reporting and managing incidents relating to use of blood and blood products ☐ Incident reporting system, such as a register, which documents analysis, review and actions taken for incidents relating to the use of blood and blood products ☐ Relevant documentation that demonstrates incidents relating to use of blood and blood products are routinely reviewed ☐ Audits of patient clinical records that demonstrate reporting and investigation of incidents relating to use of blood and blood products ☐ Information relating to use of blood and blood products presented to the senior executive and relevant committees ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and systems for blood and blood product prescribing and clinical use

Health service organisations have systems in place for the safe and appropriate prescribing and clinical use of blood and blood products

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
7.3 Ensuring blood and blood product adverse events are included in the incidents management and investigation system (continued)			
7.3.2 Adverse blood and blood product incidents are reported to and reviewed by the highest level of governance in the health service organisation	How does our executive know about adverse blood and blood product incidents that occur?	☐ Reports of adverse blood and blood product incidents provided to relevant committees and senior executive ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
7.3.3 Health service organisations participate in relevant haemovigilance activities conducted by the organisation or at state or national level	Where do we report haemovigilance activities? How consistent is our reporting with state or national guidelines?	☐ Policies, procedures and protocols identifying all haemovigilance reporting obligations for the organisation ☐ Haemovigilance reports provided to the organisation or jurisdiction, for example, Serious Transfusion Incident Reporting (STIR) or Queensland incidents in Transfusion (QiiT) to national collation agencies such as the National Blood Authority ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
7.4 Undertaking quality improvement activities to improve the safe management of blood and blood products			
7.4.1 Quality improvement activities are undertaken to reduce the risks of patient harm from transfusion practices and the clinical use of blood and blood products	What do we do to improve the management of blood and blood products?	☐ Education resources on the prescription and clinical administration of blood and blood products for the workforce and patients and carers ☐ Risk register that includes actions taken in response to identified risks ☐ Quality improvement plan or risk register includes actions to address issues identified, including relating to patient identification, and blood product storage, handling, traceability and wastage ☐ Examples of quality improvement activities that have been implemented and evaluated ☐ Other _____ **Links with Action 7.2.2 regarding reducing the risks associated with transfusion practices and clinical use of blood and blood products**	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Documenting patient information

The clinical workforce accurately records a patient's blood and blood product transfusion history and indications for use of blood and blood products.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
7.5 As part of the patient treatment plan, the clinical workforce are accurately documenting: • relevant medical conditions • indications for transfusion • any special product or transfusion requirements • known patient transfusion history • type and volume of product transfusion • patient response to transfusion			
7.5.1 A best possible history of blood product usage and relevant clinical and product information is documented in the patient clinical record	How do we check that a comprehensive history of blood product use is documented in the patient's clinical record?	☐ Tools, forms and processes are available for taking a history of blood product usage ☐ Audit of patient clinical records for use of tools, forms and specified process ☐ Review of incidents related to poor patient records management ☐ Education resources and records of attendance at training by the workforce on prescription and clinical administration of blood and risk assessment ☐ Other _____ **Links with Action 1.9.1 regarding accurate, integrated and readily-accessible patient clinical records**	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
7.5.2 The patient clinical records of transfused patients are periodically reviewed to assess the proportion of records completed	What review processes do we use to test that patient clinical records are accurate?	☐ Audit of patient clinical records on the proportion of transfused patients with complete patient history ☐ Audit of patient clinical records on the use of tools, forms and specified processes ☐ Audit results provided to clinical workforce and relevant committees ☐ Review of incidents related to poor patient records management ☐ Other _____ **Links with Action 1.9.2 regarding the design of the patient clinical record**	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
7.5.3 Action is taken to increase the proportion of patient clinical records of transfused patients with a complete patient clinical record	What do we do to ensure the patient clinical records of all transfused patients are complete?	☐ Audit of patient clinical records for complete clinical records for transfused patients ☐ Risk register that includes actions taken in response to identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of quality improvement activities that have been implemented and evaluated ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Documenting patient information

The clinical workforce accurately records a patient's blood and blood product transfusion history and indications for use of blood and blood products.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
7.6 The clinical workforce documenting any adverse reactions to blood or blood products			
7.6.1 Adverse reactions to blood or blood products are documented in the patient clinical record	How do we know clinicians ask about adverse reactions to blood and blood products? How do we record adverse reactions to blood or blood products in the patient's clinical record?	☐ Policies, procedures and protocols on documentation and reporting of adverse reactions ☐ Education resources and records of attendance at training by the clinical workforce on adverse reaction documentation and reporting ☐ Audit of patient clinical records for information on adverse reactions ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
7.6.2 Action is taken to reduce the risk of adverse events from administering blood or blood products	What do we do to decrease the risk of adverse reactions to blood and blood products?	☐ Audit results of compliance with policies, procedures and protocols provided to clinicians and relevant committees ☐ Risk register that includes actions to address identified risks ☐ Education resources related to appropriate prescribing and administration of blood products ☐ Examples of improvement activities that have been implemented and evaluated such as changes to policies, procedures and protocols ☐ Posting of policy, procedures and protocols on notice board or website ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Documenting patient information

The clinical workforce accurately records a patient's blood and blood product transfusion history and indications for use of blood and blood products.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
7.6 The clinical workforce documenting any adverse reactions to blood or blood products			(continued)
7.6.3 Adverse events are reported internally to the appropriate governance level and externally to the pathology service provider, blood service or product manufacturer whenever appropriate	Where do we report adverse reactions to blood and blood products? How do we identify appropriate external organisations for reporting?	☐ Policies, procedures and protocols on identifying and reporting incidents, adverse events and near misses with blood transfusions ☐ Adverse reaction reports are included in relevant documentation of committees ☐ Reports from incident reporting and management systems that have been sent to external organisations, including pathology service providers and manufacturers ☐ Communication strategy includes requirements for reporting incidents, adverse events and near misses related to blood transfusions to internal stakeholders ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Managing blood and blood product safety

Health service organisations have systems to receive, store, transport and monitor wastage of blood and blood products safely and efficiently.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
7.7 Ensuring the receipt, storage, collection and transport of blood and blood products within the organisation are consistent with best practice and/or guidelines			
7.7.1 Regular review of the risks associated with receipt, storage, collection and transport of blood and blood products is undertaken	Are our process for the receipt, storage, collection and transport of blood and blood products consistent with best practice and national guidelines? How do we review these processes?	☐ Audit of the use of policies, procedures and protocols for the receipt, transportation, handling and storage of blood and blood products ☐ Register of blood and blood products maintained and reviewed ☐ Audit of documentation accompanying blood and blood products, delegation records, maintenance records and performance testing of refrigerators and freezers used for storing blood and blood products ☐ Audit of the use of checking processes for labels and dates when blood or blood products are handled ☐ Records provided to state, territory and national bodies on blood and blood products ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
7.7.2 Action is taken to reduce the risk of incidents arising from the use of blood or blood product control systems	What do we do to reduce the risk of incidents from storage, collection and/or transport of blood and blood products?	☐ Education resources and records of attendance at training by the workforce on receipt, storage, collection and transport of blood and blood products ☐ Risk register that includes actions taken in response to identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of quality improvement activities that have been implemented and evaluated to reduce the risks related to the use of blood control systems ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Managing blood and blood product safety

Health service organisations have systems to receive, store, transport and monitor wastage of blood and blood products safely and efficiently.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
7.8 Minimising unnecessary wastage of blood and blood products			
7.8.1 Blood and blood product wastage is regularly monitored	How do we monitor wastage of blood and blood products?	☐ Use of a wastage monitoring system such as BloodNet ☐ Reports from pathology laboratories regularly reviewed and reconciled by a clinician ☐ Audit of compliance of usage and disposal of blood and blood products against policies, procedures and/or protocols ☐ Records of disposal or discard rates of blood products are reviewed and actions taken ☐ Review of the reasons for the wastage of blood and blood products ☐ Reports on the usage and wastage of blood and blood products ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
7.8.2 Action is taken to minimise wastage of blood and blood products	What do we do to minimise waste of blood and blood products?	☐ Education resources on blood and blood product storage, handling, traceability and wastage for the workforce and patients and carers ☐ Risk register that includes actions taken in response to identified risks ☐ Quality improvement plan includes actions to address issues identified, including blood product storage, handling, traceability and wastage ☐ Examples of quality improvement activities that have been implemented and evaluated regarding minimisation of wastage of blood and blood products ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Communicating with patients and carers

Patients and carers are informed about the risks and benefits of using blood and blood products, and about available alternatives when a plan for treatment is developed.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
7.9 The clinical workforce informing patients and carers about blood and blood product treatment options, and the associated risks and benefits			
7.9.1 Patient information relating to blood and blood products, including risks, benefits and alternatives, is available for distribution by the clinical workforce	What information on blood and blood products (including the benefits, risks and alternatives) is available for clinicians to give to patients?	☐ Materials used in patient and carer education such as brochures, fact sheets and posters are provided in plain language ☐ Patient and carer information is available for distribution by the workforce ☐ Patient clinical records show that information was provided on the risks, benefits of, and alternatives to, blood and blood products ☐ Patient experience survey shows that patient and carer information was provided ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
7.9.2 Plans for care that include the use of blood and blood products are developed in partnership with patients and carers	How do we involve patients and carers in the development of their care plans?	☐ Information available to patients and carers on treatment options and use of blood and blood products ☐ A plan for care provided for patients to review, sign and receive as a copy related to the use of blood and blood products ☐ Patient clinical records indicate that patients and carers are informed of the risks and benefits of treatment options, and the use of blood and blood products ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Communicating with patients and carers

Patients and carers are informed about the risks and benefits of using blood and blood products, and about available alternatives when a plan for treatment is developed.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
7.10 Providing information to patients about blood and blood product use and possible alternatives in a format that can be understood by patients and carers			
7.10.1 Information on blood and blood products is provided to patients and carers in a format that is understood and meaningful	How do we identify and support patients that may not understand this information?	☐ Materials used in patient and carer education such as brochures, fact sheets, posters and websites ☐ Patient clinical records indicate that patient and carer information is provided ☐ Patient and carer feedback on the format and content of the information provided ☐ Reports from consumer focus groups on patient and carer information ☐ Patient experience survey results that show patient information has been understood by patients and carers ☐ Other _____ **Links with Item 2.4 regarding consulting consumers on patient information distributed by the organisation**	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
7.11 Implementing an informed consent process for all blood and blood product use			
7.11.1 Informed consent is undertaken and documented for all transfusions of blood or blood products in accordance with the informed consent policy of the health service organisation	How do we involve patients and carers in decisions about their care and confirm their consent to treatment? How do we document this?	☐ Policies, procedures and protocols on informed consent and refusal of consent ☐ Standardised consent form in use ☐ Patient clinical records indicate patients are informed of the risks and benefits of transfusion ☐ Materials used in patient and carer education include information on consent ☐ Audit of patient clinical records for compliance with informed consent policies, procedures and protocols ☐ Patient feedback on the process and materials used to obtain informed consent ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Preventing and Managing Pressure Injuries

Standard 8

Standard 8: Preventing and Managing Pressure Injuries

Clinical leaders and senior managers of the health service organisation implement evidence-based systems to prevent pressure injuries and manage them when they do occur. Clinicians and other members of the workforce use the pressure injury prevention and management systems.

The intention of this Standard is to:

Prevent patients from developing pressure injuries and effectively managing pressure injuries when they do occur.

Context:

It is expected that this Standard will be applied in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations* and *Standard 2: Partnering with Consumers*.

Criteria to achieve the Preventing and Managing Pressure Injuries Standard:

- Governance and systems for the prevention and management of pressure injuries
- Preventing pressure injuries
- Managing pressure injuries
- Communicating with patients and carers

Governance and systems for the prevention and management of pressure injuries

Health service organisations have governance structures and systems in place for the prevention and management of pressure injuries.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
8.1 Developing and implementing policies, procedures and/or protocols that are based on current best practice guidelines			
8.1.1 Policies, procedures and/or protocols are in use that are consistent with best practice guidelines and incorporate screening and assessment tools	Are our processes for preventing and managing pressure injuries consistent with best practice guidelines? Are our pressure injury screening and assessment tools consistent with best practice guidelines?	☐ Policies, procedures and protocols are evidence based, consistent with best practice guidelines and incorporate screening and assessment tools ☐ Audit of clinical practice and the tools and procedures used to identify individuals at risk ☐ Audit of use of policies, procedures and protocols for pressure injury prevention and management ☐ Other _____ **Links with Item 1.1 regarding governance systems that set out policies, procedures and protocols**	☐ No → further action is required ☐ Yes → list source of evidence
8.1.2 The use of policies, procedures and/or protocols are regularly monitored	How do we know the workforce is using our pressure injury prevention and control processes?	☐ Policies, procedures and protocols that are available to the workforce ☐ Relevant documentation from committees and meetings related to pressure injury prevention and control processes ☐ Results from audits, prevalence surveys and incident reporting that inform the organisation's prevention and management policies, protocols and procedures ☐ Reviews of patient clinical records against policies, procedures and protocols ☐ Reports from data systems related to pressure injury prevention and control ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Governance and systems for the prevention and management of pressure injuries

Health service organisations have governance structures and systems in place for the prevention and management of pressure injuries.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
8.2 Using a risk assessment framework and reporting systems to identify, investigate and take action to reduce the frequency and severity of pressure injuries			
8.2.1 An organisation-wide system for reporting pressure injuries is in use	How do we report data on pressure injuries across the organisation?	☐ Incident reporting forms and processes included in policies, procedures and protocols ☐ Reports on the prevalence and incidence of pressure injuries and interventions to manage pressure injuries ☐ Education resources and records of attendance at training by the workforce on pressure injury reporting systems ☐ Relevant documentation from committees and meetings that include data reports of pressure injuries ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
8.2.2 Administrative and clinical data are used to regularly monitor and investigate the frequency and severity of pressure injuries	What data is used to examine the frequency and severity of pressure injuries? How do we use administrative and clinical datasets?	☐ Documented process to extract data reports on pressure injuries from clinical and administrative data systems ☐ Regular reports on the review of pressure injury incidence, prevalence and management information ☐ Relevant documentation from committees and meetings used to monitor and investigate the frequency and severity of pressure injuries ☐ External reports to owners, regulators, insurers and departments on pressure injuries ☐ Feedback to clinical workforce on incidence and prevalence, monitoring forms, trends, changes to policy, procedure and protocols and review schedules ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
8.2.3 Information on pressure injuries is regularly reported to the highest level of governance in the health service organisation	What information do we provide to our executive on pressure injuries?	☐ Report on routine performance measures for pressure injuries, including frequency and severity ☐ Reports detailing changes from actions taken ☐ Relevant documentation from committees and meetings used to monitor and investigate the frequency and severity of pressure injuries ☐ Records of outcomes or plans following executive review of information provided ☐ Reports benchmarking performance in the management of preventable pressure injuries against high performing services ☐ Reports on usage rates of specified products and equipment ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Governance and systems for the prevention and management of pressure injuries

Health service organisations have governance structures and systems in place for the prevention and management of pressure injuries.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
8.2 Using a risk assessment framework and reporting systems to identify, investigate and take action to reduce the frequency and severity of pressure injuries (continued)			
8.2.4 Action is taken to reduce the frequency and severity of pressure injuries	What action is taken to reduce pressure injuries for our patients?	☐ Reports on analysis of pressure injury information ☐ Documentation from improvement activities that have been adapted and adopted locally to reduce the frequency and severity of pressure injuries ☐ Education resources and records of attendance at training by the workforce on pressure injury prevention and management ☐ Communication material developed for workforce and patients and carers ☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to reduce the frequency and severity of pressure injuries ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
8.3 Undertaking quality improvement activities to address safety risks and monitor the systems that prevent and manage pressure injuries			
8.3.1 Quality improvement activities are undertaken to prevent pressure injuries and/or improve the management of pressure injuries	What action have we taken to prevent or improve the management of pressure injuries?	☐ Data collected pre- and post-interventions ☐ Relevant documentation from committees and meetings that details improvement actions ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan that includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated ☐ Communication material developed for the workforce and patients on improvement activities and outcomes ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Governance and systems for the prevention and management of pressure injuries

Health service organisations have governance structures and systems in place for the prevention and management of pressure injuries.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
8.4 Providing or facilitating access to equipment and devices to implement effective prevention strategies and best practice management plans			
8.4.1 Equipment and devices are available to effectively implement prevention strategies for patients at risk and plans for the management of patients with pressure injuries	What equipment and devices are available for the management of patients at risk of, or patients with, pressure injuries?	☐ Register of equipment and devices ☐ Guidelines for the use and access to equipment to prevent pressure injuries ☐ Register of workforce training in the use and allocation of equipment and devices to manage pressure injuries ☐ Equipment utilisation reports ☐ Clinical audit of equipment use ☐ Register of equipment maintenance and safety checks ☐ Inventories of equipment or guidelines on how to access required equipment (for example rental options) ☐ Pressure redistribution and anti-shear equipment that is available and the maintenance and replacement schedules for this equipment ☐ Relevant documentation from committees and meetings on resource allocation and evaluation of the efficacy of products, equipment and devices ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Preventing pressure injuries

Patients are screened on presentation and pressure injury prevention strategies are implemented when clinically indicated.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
8.5 Identifying risk factors for pressure injuries using an agreed screening tool for all presenting patients within timeframes set by best practice guidelines			
8.5.1 An agreed tool to screen for pressure injury risk is used by the clinical workforce to identify patients at risk of a pressure injury	What tool is used to screen patients for pressure injury risk?	☐ Policies, procedures and protocols on screening for pressure injury risk accessible to the clinical workforce ☐ Audit of patient clinical records for documentation of screening ☐ Communication to workforce on the screening criteria and processes ☐ Pre-admission screening and/or assessment tool ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
8.5.2 The use of the screening tool is monitored to identify the proportion of at-risk patients that are screened for pressure injuries on presentation	How do we know if patients are screened for pressure injuries on presentation?	☐ Audit of patient clinical records demonstrate use of a screening tool and compliance with screening requirements ☐ Information from incident monitoring that captures data on screening of pressure injury risks ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
8.5.3 Action is taken to maximise the proportion of patients who are screened for pressure injury on presentation	What action have we taken to increase the proportion of patients screened for pressure injures on presentation?	☐ Reports on pressure injury risk and screening data quality ☐ Risk register that includes actions to address identified risks ☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to maximise the proportion of patients who are screened for pressure injury on presentation ☐ Communication material developed for workforce and patients and carers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Preventing pressure injuries

Patients are screened on presentation and pressure injury prevention strategies are implemented when clinically indicated.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
8.6 Conducting a comprehensive skin inspection in timeframes set by best practice guidelines on patients with a high risk of developing pressure injuries at presentation, regularly as clinically indicated during a patient's admission, and before discharge			
8.6.1 Comprehensive skin inspections are undertaken and documented in the patient clinical record for patients at risk of pressure injuries	What assessment tool is used by our workforce to complete a comprehensive skin inspection for at-risk patients?	☐ Policies, procedures and protocols that include an assessment tool ☐ Audit of patient clinical records shows that patients at risk of pressure injuries are being assessed in line with specified protocols ☐ Audit of patient clinical records for completed skin assessments and timing of assessments ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
8.6.2 Patient clinical records, transfer and discharge documentation are periodically audited to identify at-risk patients with documented skin assessments	How do we know if patients at risk of pressure injuries have a documented review before transfer or discharge?	☐ Reports or information on trends relating to pressure injuries ☐ Audit of patient clinical records, transfer and discharge documents for completed skin assessments and re-assessments ☐ Relevant documentation from committees and meetings that include information relating to the audit of patient clinical records ☐ Report to clinical workforce on the results of the audit and actions to address issues identified ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Preventing pressure injuries

Patients are screened on presentation and pressure injury prevention strategies are implemented when clinically indicated.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
8.6 Conducting a comprehensive skin inspection in timeframes set by best practice guidelines on patients with a high risk of developing pressure injuries at presentation, regularly as clinically indicated during a patient's admission, and before discharge (continued)			
8.6.3 Action is taken to increase the proportion of skin assessments documented on patients at risk of pressure injuries	What action have we taken to increase the proportion of at-risk patients with a documented skin assessment?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Infrastructure, instruments and other equipment necessary to comply with policies, procedures and protocols that are accessible to the workforce ☐ Education resources and records of attendance at training by the workforce on pressure injury assessment ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to increase the proportion of skin assessments documented on patients at risk of pressure injuries ☐ Communication material developed for workforce and patients and carers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
8.7 Implementing and monitoring pressure injury prevention plans and reviewing when clinically indicated			
8.7.1 Prevention plans for all patients at risk of a pressure injury are consistent with best practice guidelines and are documented in the patient clinical record	How do we know if prevention plans for patients at risk of a pressure injury are consistent with best practice guidelines?	☐ Policies, procedures and protocols reference sources that are evidence-based and consistent with national guidelines ☐ Templates for prevention plans ☐ Examples of patient clinical records with completed pressure injury prevention plans ☐ Audit of patient clinical records for use of policies, procedures and protocols ☐ Relevant documentation from committees and meetings reflect a multidisciplinary approach to pressure injury care ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Preventing pressure injuries

Patients are screened on presentation and pressure injury prevention strategies are implemented when clinically indicated.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
8.7 Implementing and monitoring pressure injury prevention plans and reviewing when clinically indicated			(continued)
8.7.2 The effectiveness and appropriateness of pressure injury prevention plans are regularly reviewed	How do we review our patients' pressure injury prevention plans?	☐ Audit of patient clinical records for re-assessment and review of an individual's pressure injury prevention plan ☐ Pressure injury management plans that describe consultation with relevant stakeholders and reflect a multidisciplinary approach to pressure injury care ☐ Documented review of policies and procedures ☐ Relevant documentation from committees and meetings where the effectiveness and appropriateness of pressure injury prevention plans are reviewed ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
8.7.3 Patient clinical records are monitored to determine the proportion of at-risk patients that have an implemented pressure injury prevention plan	How do we know that pressure injury prevention plans have been implemented by our workforce?	☐ Audit of patient clinical records identifies patients with a current injury prevention plan ☐ Report on patients with documented pressure injury prevention plans ☐ Feedback to the workforce on the results of audit and actions to address issues identified ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
8.7.4 Action is taken to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan	What action have we taken to increase the use of pressure injury prevention plans for at-risk patients?	☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan ☐ Communication material developed for workforce, patients and carers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Managing pressure injuries

Patients who have pressure injuries are managed according to best practice guidelines.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
8.8 Implementing best practice management and ongoing monitoring as clinically indicated			
8.8.1 An evidence-based wound management system is in place within the health service organisation	How do we describe our decision-making and management processes for pressure injuries? How do we ensure these evidence-based documents are updated and used by our workforce?	☐ Policies, procedures and protocols that are evidence-based and consistent with best practice guidelines ☐ Education resources and records of attendance at training by the workforce on managing pressure injuries ☐ Relevant documentation from committees and meetings with responsibilities for overseeing the wound management system ☐ Observation of evidence-based guidelines that are accessed by the clinical workforce ☐ Reports from clinical data systems that capture pressure injury wound progress or outcomes ☐ Audit of patient clinical records ☐ Feedback provided to the workforce on the results of audit and actions to address issues identified ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
8.8.2 Management plans for patients with pressure injury management plans are consistent with best practice and documented in the patient clinical record	Is our management of pressure injuries consistent with best practice guidelines?	☐ Templates for pressure injury management plans ☐ Policies, procedures and protocols for completing a pressure injury management plan for individuals at risk of pressure injury ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
8.8.3 Patient clinical records are monitored to determine compliance with evidence-based pressure injury management plans	How do we monitor the use of evidence-based pressure injury management plans?	☐ Report on patients with documented pressure injury prevention plans ☐ Audit of patient clinical records for pressure injury wound assessment and management plans that comply with policies, protocols and procedures ☐ Feedback provided to the workforce on the results of audit and actions to address issues identified ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Managing pressure injuries

Patients who have pressure injuries are managed according to best practice guidelines.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
8.8 Implementing best practice management and ongoing monitoring as clinically indicated			(continued)
8.8.4 Action is taken to increase compliance with evidence-based pressure injury management plans	What action has been taken to increase the use of evidence-based pressure injury management plans?	☐ Feedback provided to the workforce on the results of audit and actions to address issues identified ☐ Amended policies, procedures, protocols or work practices that address issues of non-compliance ☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to increase compliance with evidence-based pressure injury management plans ☐ Communication material developed for workforce and patients and carers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Communicating with patients and carers

Patients and carers are informed of the risks, prevention strategies and management of pressure injuries.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
8.9 Informing patients with a high risk of pressure injury, and their carers, about the risks, prevention strategies and management of pressure injuries			
8.9.1 Patient information on prevention and management of pressure injuries is provided to patients and carers in a format that is understood and is meaningful	What information do we give patients on prevention and management of their pressure injuries? How do we identify and support patients who may not understand this information?	☐ Materials used in patient and carer education such as brochures, fact sheets, posters, videos and trusted websites ☐ Patient information for distribution by the clinical workforce is available in a range of formats and language ☐ Results of patient experience survey and organisational responses recorded in relation to information provided on pressure injury prevention and management ☐ Other_____ **Links with Item 2.4 regarding consulting consumers on patient information distributed by the organisation**	☐ No → further action is required ☐ Yes → list source of evidence
8.10 Developing a plan of management in partnership with patients and carers			
8.10.1 Pressure injury management plans are developed in partnership with patients and carers	How do we know patients and carers are involved in the development of their pressure injury management plans?	☐ Pressure injury management plans that provide space for patient comment and signature ☐ Results of patient and carer experience surveys regarding pressure injury management ☐ Observation of patients and carers participating in making decisions about their care ☐ Audit of patient clinical records that shows the clinical workforce and patients collaborated in the development of pressure injury treatment plans and discharge summaries ☐ Other_____	☐ No → further action is required ☐ Yes → list source of evidence

Recognising and Responding to Clinical Deterioration in Acute Health Care

Standard 9

Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care

Health service organisations establish and maintain systems for recognising and responding to clinical deterioration. Clinicians and other members of the workforce use the recognition and response systems.

The intention of this Standard is to:

Ensure a patient's deterioration is recognised promptly, and appropriate action is taken.#

Context:

It is expected that this Standard will be applied in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations* and *Standard 2: Partnering with Consumers*.

Criteria to achieve the Recognising and Responding to Clinical Deterioration in Acute Health Care Standard:

- Establishing recognition and response systems
- Recognising clinical deterioration and escalating care
- Responding to clinical deterioration
- Communicating with patients and carers

This Standard does not apply to deterioration of a patient's mental state.

Criterion: Establishing recognition and response systems

Organisation-wide systems consistent with the National Consensus Statement are used to support and promote recognition of, and response to, patients whose condition deteriorates in an acute healthcare facility.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
9.1 Developing, implementing and regularly reviewing the effectiveness of governance arrangements and the policies, procedures and/or protocols that are consistent with the requirements of the National Consensus Statement				
9.1.1 Governance arrangements are in place to support the development, implementation and maintenance of organisation-wide recognition and response systems	No match to the *NSMHS*	Have we identified who is responsible for the governance of the organisation-wide recognition and response systems? How do we describe decision-making and management processes for recognising and responding to clinical deterioration in our organisation?	☐ Documentation identifying the individual or committee with oversight of the recognition and response system ☐ Documentation from meetings and reports prepared for the governance group ☐ Terms of reference and role descriptions describing the responsibilities of governance groups or individuals ☐ Reports on actions arising from review and evaluation of recognition and response systems ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
9.1.2 Policies, procedures and/or protocols for the organisation are implemented in areas such as: • measurement and documentation of observations • escalation of care • establishment of a rapid response system • communication about clinical deterioration	No match to the *NSMHS*	Are the policies, procedures, and protocols for our recognition and response systems consistent with the National Consensus Statement?	☐ Policies, procedures and protocols that are consistent with the National Consensus Statement and address items listed in Action 9.1.2 ☐ Examples of actions taken to implement policies throughout the organisation ☐ Audit of documents such as patient clinical records and observation charts that demonstrates correct use of policies, procedures and protocols ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Criterion: Establishing recognition and response systems

Organisation-wide systems consistent with the National Consensus Statement are used to support and promote recognition of, and response to, patients whose condition deteriorates in an acute healthcare facility.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
9.2 Collecting information about the recognition and response systems, providing feedback to the clinical workforce, and tracking outcomes and changes in performance over time				
9.2.1 Feedback is actively sought from the clinical workforce on the responsiveness of the recognition and response systems	No match to the *NSMHS*	What feedback do we collect from clinicians about our recognition and response system?	☐ Reports on the results of surveys of clinicians' views about the recognition and response system ☐ Feedback mechanisms for the clinical workforce who use the recognition and response system such as debriefs after individual events, peer review processes and clinical review committees ☐ Documentation showing that feedback from clinicians is reviewed by individuals or committees responsible for governance of the recognition and response system ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
9.2.2 Deaths or cardiac arrests for a patient without an agreed treatment-limiting order (such as 'not for resuscitation' or 'do not resuscitate') are reviewed to identify the use of the recognition and response systems, and any failures in these systems	No match to the *NSMHS*	How do we review the use of our recognition and response systems when a death or cardiac arrest occurs?	☐ Policies, procedures and protocols describe processes for collecting data on deaths and cardiac arrests ☐ Records of death reviews and reviews of cardiac arrests ☐ Relevant documentation demonstrating that failures of the recognition and response system are identified through processes such as morbidity and mortality meetings, death and cardiac arrest review committees, and serious adverse event reviews ☐ Documentation demonstrating that failures of the recognition and response system identified through mortality review are analysed and acted on by the group or individual with responsibility for the governance of the recognition and response system ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Criterion: Establishing recognition and response systems

Organisation-wide systems consistent with the National Consensus Statement are used to support and promote recognition of, and response to, patients whose condition deteriorates in an acute healthcare facility.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
9.2 Collecting information about the recognition and response systems, providing feedback to the clinical workforce, and tracking outcomes and changes in performance over time (continued)				
9.2.3 Data collected about recognition and response systems are provided to the clinical workforce as soon as practicable	No match to the *NSMHS*	How do we inform our workforce about the performance of our recognition and response system?	☐ Reports on routinely collected performance data about recognition and response systems that are provided to clinicians ☐ Reports on failures of the recognition and response systems identified through serious adverse event or death reviews that are provided to clinicians ☐ Education and training resources that incorporate local data about the performance of recognition and response systems ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
9.2.4 Action is taken to improve the responsiveness and effectiveness of the recognition and response systems	No match to the *NSMHS*	What action has been taken to improve the effectiveness of our recognition and response systems?	☐ Education resources and records of attendance at training by the workforce on recognising and responding to clinical deterioration ☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk register that includes actions to address identified risks ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated ☐ Communication material developed for workforce, patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Recognising clinical deterioration and escalating care

Patients whose condition is deteriorating are recognised and appropriate action is taken to escalate care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
9.3 Implementing mechanism(s) for recording physiological observations that incorporates triggers to escalate care when deterioration occurs				
9.3.1 When using a general observation chart, ensure that it: • is designed according to human factors principles • includes the capacity to record information about respiratory rate, oxygen saturation, heart rate, blood pressure, temperature and level of consciousness graphically over time • includes thresholds for each physiological parameter or combination of parameters that indicate abnormality • specifies the physiological abnormalities and other factors that trigger the escalation of care • includes actions required when care is escalated	No match to the *NSMHS*	How do we record a patient's physiological observations? Are we using a general observation chart that is: • a state-wide chart or • one of the observation charts developed by the Australian Commission on Safety and Quality in Health Care or • has been tested to ensure it is safe for use from a human factors design perspective? Does our general observation chart include thresholds for physiological parameters that trigger escalation of care? Do we have a clear process in place for escalating care? Do we clearly describe the actions required in response to an escalation of care?	☐ Policies, procedures and protocols that describe how to use the observation chart ☐ General observation chart that has been agreed by the state or territory ☐ Observation and response chart that has been made available by the Australian Commission on Safety and Quality in Health Care ☐ Results of testing the locally-developed general observation chart that demonstrates it is safe from a human factors design perspective ☐ Policies, procedures and protocols that describe when and how to escalate care ☐ Policies, procedures and protocols that describe the actions required when care is escalated ☐ Audit of patient clinical records shows the use of a general observation chart and escalation process that meets the specifications outlined in 9.3.1 ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Recognising clinical deterioration and escalating care

Patients whose condition is deteriorating are recognised and appropriate action is taken to escalate care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
9.3 Implementing mechanism(s) for recording physiological observations that incorporates triggers to escalate care when deterioration occurs (continued)				
9.3.2 Mechanisms for recording physiological observations are regularly audited to determine the proportion of patients that have complete sets of observations recorded in agreement with their monitoring plan	No match to the *NSMHS*	What review processes do we use to test that observations recorded in the patient clinical record are consistent with monitoring plans? Does our audit schedule include regular audit of observation charts and monitoring plans?	☐ Policies, procedures and protocols that describe the frequency and processes for auditing observations charts and monitoring plans ☐ Results of audit of observation charts and monitoring plans that may be included as part of routine documentation audit ☐ Feedback to the clinical workforce on audit of observation charts ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
9.3.3 Action is taken to increase the proportion of patients with complete sets of recorded observations, as specified in the patient's monitoring plan	No match to the *NSMHS*	What do we do to increase the number of patients with complete sets of recorded observations?	☐ Education resources and records of attendance at training by the workforce on the requirements for taking and documenting observations in accordance with monitoring plans ☐ Risk register that includes actions to address identified risks ☐ Relevant documentation from committees that detail improvement actions taken ☐ Documentation from quality improvement processes detailing actions to address issues from observational audits ☐ Examples of improvement activities that have been implemented and evaluated to increase the proportion of patients with complete sets of recorded observations ☐ Communication material developed for workforce, patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Recognising clinical deterioration and escalating care

Patients whose condition is deteriorating are recognised and appropriate action is taken to escalate care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
9.4 Developing and implementing mechanisms to escalate care and call for emergency assistance where there are concerns that a patient's condition is deteriorating				
9.4.1 Mechanisms are in place to escalate care and call for emergency assistance	No match to the *NSMHS*	What is the mechanism we use to escalate care and call for emergency assistance?	☐ Policies, procedures and protocols that describe the process for escalation of care ☐ The use of mechanisms such as signs, posters or stickers describing how to call for assistance ☐ Orientation and ongoing education resources and records of attendance at training by the workforce ☐ Record of operational and mechanical call device testing ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
9.4.2 Use of escalation processes, including failure to act on triggers for seeking emergency assistance are regularly audited	No match to the *NSMHS*	How do we analyse and report on our escalation processes, including failure to act on triggers for seeking emergency assistance?	☐ Policies, procedures and protocols describe the frequency and processes for auditing escalation processes ☐ Feedback to the clinical workforce on the results of audit of escalation processes ☐ Documentation of reviews when failures to escalate are identified ☐ Results of audit of patient clinical records ☐ Results of audit of observation charts ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Recognising clinical deterioration and escalating care

Patients whose condition is deteriorating are recognised and appropriate action is taken to escalate care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
9.4 Developing and implementing mechanisms to escalate care and call for emergency assistance where there are concerns that a patient's condition is deteriorating (continued)				
9.4.3 Action is taken to maximise the appropriate use of escalation processes	No match to the *NSMHS*	What do we do to ensure the appropriate use of our escalation process?	☐ Data provided to relevant committees and the clinical workforce on escalation processes ☐ Reports or documentation from review of escalation processes ☐ Reports on workforce surveys relating to awareness and use of systems for escalating care ☐ Education resources and records of attendance at training by the workforce on escalation processes ☐ Risk register that includes actions to address identified risks ☐ Relevant documentation from committees that detail improvement actions taken ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to maximise the appropriate use of escalation processes ☐ Communication material developed for workforce, patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Responding to clinical deterioration

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

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
9.5 Using the system in place to ensure that specialised and timely care is available to patients whose condition is deteriorating				
9.5.1 Criteria for triggering a call for emergency assistance are included in the escalation policies, procedures and/or protocols	No match to the *NSMHS*	Are criteria for triggering a call for emergency assistance detailed in our policies, procedures and/or protocols?	☐ Escalation policies, procedures and protocols that include criteria for calling for emergency assistance ☐ Education resources and records of attendance at training by the workforce on the criteria for calling for emergency assistance for patients whose condition is deteriorating ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
9.5.2 The circumstances and outcome of calls for emergency assistance are regularly reviewed	No match to the *NSMHS*	How do we report data on the use and outcomes of emergency assistance calls?	☐ Records of audits, reviews and routine data collection about calls for emergency assistance ☐ Agenda papers, meeting minutes or reports of relevant committees related to escalation policy reviews and recommended changes ☐ Feedback to the clinical workforce on the process and outcome of calls for emergency assistance ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
9.6 Having a clinical workforce that is able to respond appropriately when a patient's condition is deteriorating				
9.6.1 The clinical workforce is trained and proficient in basic life support	No match to the *NSMHS*	What action have we taken to train clinicians in basic life support? Can we demonstrate that the clinical workforce is proficient in basic life support?	☐ Policies, procedures and protocols that describe the requirements and processes for providing basic life support interventions ☐ Education resources and records of attendance at training by the workforce on competencies in basic life support for the workforce ☐ Relevant documentation from committees relating to the assessment and maintenance of basic life support competency of the workforce ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Responding to clinical deterioration

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

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
9.6 Having a clinical workforce that is able to respond appropriately when a patient's condition is deteriorating (continued)				
9.6.2 A system is in place for ensuring access at all times to at least one clinician, either on-site or in close proximity, who can practise advanced life support	No match to the *NSMHS*	How do we provide access to a clinician who can provide advanced life support at all times? How do we ensure that clinicians maintain competency and currency in advanced life support skills?	☐ Policies, procedures and protocols that describe 24-hour per day access to a clinician who can practise advanced life support ☐ Delegation of roles and responsibilities to clinicians who can practise advanced life support ☐ Position descriptions, duty statements, employment contracts or other agreements that describe an individual clinician's delegated safety and quality roles and responsibilities ☐ Record of currency of advanced life support skills ☐ Rosters or evidence that demonstrates 24-hour access to at least one clinician or ambulance officer with advanced life support skills ☐ Audit of emergency calls and cardiac arrests that demonstrates timely access to a clinician with advanced life support skills regardless of the time of day ☐ Relevant documentation from committees that consider review findings and identify improvement actions ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Communicating with patients and carers

Patients, families and carers are informed of recognition and response systems and can contribute to the processes of escalating care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
9.7 Ensuring patients, families and carers are informed about, and are supported so that they can participate in, recognition and response systems and processes				
9.7.1 Information is provided to patients, families and carers in a format that is understood and meaningful. The information should include: • the importance of communicating concern, signs and symptoms of deterioration, which are relevant to the patient's condition, to the clinical workforce • local systems for responding to clinical deterioration, including how they can raise concerns about potential deterioration	No match to the *NSMHS*	What information is provided to patients and carers on how they can participate in our recognition and response processes?	☐ Written material is available for patients and carers about recognition and response systems ☐ Policies, procedures and protocols describe who is responsible for informing patients, families and carers about the recognition and response system ☐ Mechanisms such as signs, posters or stickers describe how patient, families and carers can participate in recognition and response systems and processes ☐ Audit of patient clinical records shows information on recognising and responding to clinical deterioration was provided to patients, families and/or carers ☐ Other_____ **Links with Item 2.4 regarding consulting consumers on patient information distributed by the organisation**	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Communicating with patients and carers

Patients, families and carers are informed of recognition and response systems and can contribute to the processes of escalating care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
9.8 Ensuring that information about advance care plans and treatment-limiting orders is in the patient clinical record, where appropriate				
9.8.1 A system is in place for preparing and/or receiving advance care plans in partnership with patients, families and 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	How do we provide patients, families and carers with the opportunity to prepare or provide advanced care plans? How do we ensure that advance care plans developed in the community or other health facilities are received and incorporated into the current plan of care?	☐ Appropriate templates are used in the patient clinical record ☐ Policies, procedures and/or protocols describe the process for preparing advanced care plans in partnership with patients, families and carers ☐ Policies, procedures and protocols describe the process of receiving advance care plans that have been developed in the community or other health service organisation ☐ Forms that provide instructions to assist with the preparation of advanced care plans ☐ Reviews of the use of advanced care plans ☐ Forms are accessible to the workforce for distribution to patients and/or carers to assist with the preparation of advanced care plans ☐ Audit of patient clinical records that shows patients, families and carers were involved in the preparation of advanced care plans ☐ Education resources and records of attendance at training by the workforce on preparing and documenting advance care plans in partnership with patients, families and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
9.8.2 Advance care plans and other treatment-limiting orders are documented in the patient clinical record	No match to the *NSMHS*	How do we document advanced care plans in the patient's clinical record?	☐ Audit of patient clinical records that show advance care plans and other treatment-limiting orders are documented in accordance with policies and procedures ☐ Forms for recording advanced care directives are accessible to the workforce in clinical areas ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Communicating with patients and carers

Patients, families and carers are informed of recognition and response systems and can contribute to the processes of escalating care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
9.9 Enabling patients, families and carers to initiate an escalation of care response				
9.9.1 Mechanisms are in place for a patient, family member or carer to initiate an escalation of care response	**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 • 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	What do we do to enable patients and carers to initiate escalation of care? Can patients and families escalate care independently of the team who are directly providing care to the patient?	☐ Policies, procedures and protocols describe the process for patient and family escalation ☐ Information that is provided to patients and families on escalation processes ☐ Data collection processes are in place to determine usage and performance of the patient and family escalation process ☐ Policies, procedures and protocols that have been amended to incorporate patient and carer feedback about the patient and family escalation process ☐ Crisis intervention plans ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Communicating with patients and carers

Patients, families and carers are informed of recognition and response systems and can contribute to the processes of escalating care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
9.9 Enabling patients, families and carers to initiate an escalation of care response				(continued)
9.9.2 Information about the system for family escalation of care is provided to patients, families and carers	No match to the *NSMHS*	What information do we provide to patients and carers about how to escalate care?	☐ Information resources on how to participate in recognition and response systems and processes are available for families when patients are admitted ☐ Mechanisms such as signs, posters or stickers on how to participate in escalation processes, including information about how to call for assistance ☐ Scripts and other resources for staff to use when explaining escalation processes to patients and families ☐ Information on the use of the recognising and responding system that is broadcast on patient television and audio services ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
9.9.3 The performance and effectiveness of the system for family escalation of care is periodically reviewed	No match to the *NSMHS*	What action have we taken to review the system for family escalation of care? How do we know that the system for family escalation of care is effective?	☐ Relevant documentation from committees and meetings that include information relating to the performance and effectiveness of the system for family escalation of care ☐ Documentation of outcomes of review of calls made by families ☐ Audit the frequency and type of calls made by families ☐ Qualitative data from communication with families about their understanding and experience of the system for family escalation ☐ Patient experience survey on family escalation of care ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Communicating with patients and carers

Patients, families and carers are informed of recognition and response systems and can contribute to the processes of escalating care.

Actions required	NSMHS	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
9.9 Enabling patients, families and carers to initiate an escalation of care response				(continued)
9.9.4 Action is taken to improve the system performance for family escalation of care	No match to the *NSMHS*	What action have we taken to improve the performance of the family escalation of care system?	☐ Risk register that includes actions to address identified risks ☐ Relevant documentation from committees that details improvement actions taken ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to improve the performance of the system for family escalation of care ☐ Communication material developed for workforce and patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Preventing Falls and Harm from Falls

Standard 10

Standard 10: Preventing Falls and Harm from Falls

Clinical leaders and senior managers of a health service organisation implement systems to prevent patient falls and minimise harm from falls. Clinicians and other members of the workforce use the falls prevention and harm minimisation systems.

The intention of this Standard is to:

Reduce the incidence of patient falls and minimise harm from falls.

Context:

It is expected that this Standard will be applied in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations* and *Standard 2: Partnering with Consumers*.

Criteria to achieve the Preventing Falls and Harm from Falls Standard:

- Governance and systems for preventing falls
- Screening and assessing risks of falls and harm from falling
- Preventing falls and harm from falling
- Communicating with patients and carers

Governance and systems for preventing falls

Health service organisations have governance structures and systems in place to reduce falls and minimise harm from falls.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.1 Developing, implementing and reviewing policies, procedures and/or protocols, including the associated tools, that are based on the current national guidelines for preventing falls and harm from falls			
10.1.1 Policies, procedures and/or protocols are in use that are consistent with best practice guidelines (where available) and incorporate screening and assessment tools	How do we describe our decision-making and management processes for preventing falls and harm from falls? Are our falls screening and assessment tools consistent with best practice guidelines?	☐ Policies, procedures and protocols are consistent with current *National Preventing Falls and Harm from Falls Best Practice Guidelines* ☐ Policies, procedures and protocols describe delegated roles, responsibilities and accountabilities of the workforce for falls management ☐ Relevant documentation from committees and meetings relating to falls and harm form falls ☐ The *Preventing Falls and Harm from Falls Best Practice Guidelines* are accessible to the workforce ☐ Other _____ **Links with Item 1.1 regarding governance systems that set out policies, procedures and protocols**	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
10.1.2 The use of policies, procedures and/or protocols is regularly monitored	How do we know if our processes for preventing falls and harm from falls are used by our workforce?	☐ Policies, procedures and protocols that are available to the workforce ☐ Relevant documentation from committees and meetings that include monitoring and review of the effectiveness of strategies for preventing falls and harm from falls ☐ Audits of patient clinical records against policies, procedures and protocols ☐ Analyses of reports relating to falls incidents resulting in harm ☐ Education resources and records of attendance at training by the workforce on the use of policies, procedures and protocols ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and systems for preventing falls

Health service organisations have governance structures and systems in place to reduce falls and minimise harm from falls.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.2 Using a robust, organisation-wide system of reporting, investigation and change management to respond to falls incidents			
10.2.1 Regular reporting, investigating and monitoring of falls incidents is in place	How do we report data on falls and the harm from falls incidents?	☐ Reports on causes of falls incidents across the organisation, including trends in falls incidents and causes, adverse events and near misses ☐ Minimum data sets for reporting and recording falls ☐ Benchmarking of falls incidents ☐ Relevant documentation from committees and meetings responsible for falls management ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
10.2.2 Administrative and clinical data are used to monitor and investigate regularly the frequency and severity of falls in the health service organisation	How do we use administrative and clinical datasets?	☐ Documented processes to extract data reports on falls from clinical and administrative data systems ☐ Regular reports on the review of falls incidence, prevalence and management information ☐ Relevant documentation from committees and meetings such as falls prevention, quality and safety, injury prevention or occupational health and safety committees ☐ Register of incidents and adverse events that includes data on types of injuries sustained ☐ Audit reports on patient clinical records of frequency and severity of falls ☐ Falls dataset reporting templates ☐ Trend analysis reports on falls incidence and near misses ☐ Reports to coroners, departments or other authorities ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
10.2.3 Information on falls is reported to the highest level of governance in the health service organisation	What information do we provide to our executive on falls incidents?	☐ Reports on routine performance measures for falls, including frequency and severity ☐ Reports detailing changes from actions taken ☐ Relevant documentation from committees and meetings of executive committees relating to falls and harm from falls ☐ Annual reports containing falls incidents information ☐ Clinical indicator reports to jurisdictional bodies, where applicable ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and systems for preventing falls

Health service organisations have governance structures and systems in place to reduce falls and minimise harm from falls.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.2 Using a robust, organisation-wide system of reporting, investigation and change management to respond to falls incidents (continued)			
10.2.4 Action is taken to reduce the frequency and severity of falls in the health service organisation	What action have we taken to reduce the frequency and severity of falls?	☐ Audit of patient clinical records for patients screened and identified as at risk of falls, for assessments and interventions in place ☐ Information provided to the workforce on falls risks and prevention strategies ☐ Education resources and records of attendance at training by the workforce on falls prevention and management ☐ Medication reviews for patients at risk of falls ☐ Referrals of at-risk patients to services to address identified risk factors , such as physiotherapist and occupational therapists, where available ☐ Audit of general environmental falls hazards ☐ Audit of patient clinical records for evidence of ongoing management of individual environmental risk factors ☐ Register of environmental and equipment falls hazards and actions taken ☐ Material provided to patients and their carers on preventing falls and harm from falls ☐ Relevant documentation from committees that detail improvement actions taken ☐ Quality improvement plan includes actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated ☐ Communication material developed for workforce and patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Governance and systems for preventing falls

Health service organisations have governance structures and systems in place to reduce falls and minimise harm from falls.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.3 Undertaking quality improvement activities to address safety risks and ensure the effectiveness of the falls prevention system			
10.3.1 Quality improvement activities are undertaken to prevent falls and minimise patient harm	What actions have we taken to prevent or improve the management of falls?	☐ Quality assurance and quality indicator reports ☐ Risk registers that include actions to address identified risks ☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Quality improvement plans including actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated ☐ Communication materials developed for the workforce and patients ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
10.4 Implementing falls prevention plans and effective management of falls			
10.4.1 Equipment and devices are available to implement prevention strategies for patients at risk of falling and management plans to reduce the harm from falls	What equipment and devices are available to prevent harm or manage patients at risk of falling?	☐ Inventories of equipment and audit of clinical use ☐ Maintenance logs of equipment and devices ☐ Policies, procedures and protocols for equipment procurement and provision ☐ Systems in place for review and future procurement of equipment and devices ☐ Relevant documentation from committees and meetings responsible for evaluating the efficacy of products, equipment and devices ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Screening and assessing risks of falls and harm from falling

Patients on presentation, during admission, and when clinically indicated, are screened for risk of a fall and the potential to be harmed from falls.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.5 Using a best practice-based tool to screen patients on presentation, during admission and when clinically indicated for the risk of falls			
10.5.1 A best practice screening tool is used by the clinical workforce to identify the risk of falls	How do we review patient clinical records to ensure patients are screened for falls risk?	☐ Policies, procedures and protocols accessible to the clinical workforce ☐ Audits of patient clinical records for compliance with screening (or assessment) requirements on admission and when clinically indicated ☐ Education resources and records of attendance at training by the relevant clinical workforce on falls risk screening (or assessment) ☐ Schedules of training for the relevant clinical workforce ☐ Pre-admission screening (or assessment) tools or processes including recording outcomes ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
10.5.2 Use of the screening tool is monitored to identify the proportion of at-risk patients that were screened for falls	How are patient clinical records reviewed to ensure patients are screened for falls risk?	☐ Audits of patient clinical records for compliance with screening requirement ☐ Observations of clinical practice ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Screening and assessing risks of falls and harm from falling

Patients on presentation, during admission, and when clinically indicated, are screened for risk of a fall and the potential to be harmed from falls.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.5 Using a best practice-based tool to screen patients on presentation, during admission and when clinically indicated for the risk of falls (continued)			
10.5.3 Action is taken to increase the proportion of at-risk patients who are screened for falls upon presentation and during admission	What action have we taken to increase the number of patients screened for falls risk?	☐ Evidence-based falls screening tools or details of falls screening (or assessment) processes, and process outcomes, are readily available to the clinical workforce at the point of patient presentation and during admission ☐ Risk registers that include actions to address identified risks ☐ Audit of clinical records to determine the completion of falls risk assessment for those identified as being at risk of falls following the falls risk screen ☐ Relevant documentation from committees that detail improvement actions taken as a result of assessments (or screenings) ☐ Quality improvement plans include actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to increase the proportion of at-risk patients who are screened for falls upon presentation ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
10.6 Conducting a comprehensive risk assessment for patients identified at risk of falling in initial screening processes			
10.6.1 A best practice assessment tool is used by the clinical workforce to assess patients at risk of falling	How do we review patient clinical records to ensure that patients' falls risks are identified?	☐ Policies, procedures and protocols that describe the assessment to be used, that is evidence based and consistent with national guidelines ☐ Audit of patient clinical records shows that patients at risk of falls are assessed (or screened) in line with specified protocols ☐ Education resources and records of attendance at training by the relevant clinical workforce on falls risk factors and assessment ☐ Falls history is recorded as part of the screening process on admission ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Screening and assessing risks of falls and harm from falling

Patients on presentation, during admission, and when clinically indicated, are screened for risk of a fall and the potential to be harmed from falls.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.6 Conducting a comprehensive risk assessment for patients identified at risk of falling in initial screening processes			(continued)
10.6.2 The use of the assessment tool is monitored to identify the proportion of at-risk patients with a completed falls assessment	How do we review patient clinical records to monitor assessment of patients at risk of falling?	☐ Reports provided to relevant committees detailing the number of patients screened who subsequently received a fall risk factor assessment ☐ Audit of patient clinical records that show patients identified at risk of falling who have a subsequent falls risk factor assessment ☐ Reports on the number of patients assessed and the incidence of falls ☐ Observational audits of the use of the assessment tool ☐ Audits of patient clinical records that show patients who have had a change in health status, a fall, significant change in medication or environment, and prior to discharge, are re-assessed for falls risk factors ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
10.6.3 Action is taken to increase the proportion of at-risk patients undergoing a comprehensive falls risk assessment	What action have we taken to increase the number of patients with a comprehensive falls risk assessment?	☐ Falls screening (or assessment) tools or processes are available to the clinical workforce at the point of patient presentation and during admission ☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Risk registers that include actions to address identified risks ☐ Quality improvement plans include actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to increase the proportion of at-risk patients undergoing a comprehensive falls risk assessment (or screening) ☐ Communication material developed for workforce, patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Preventing falls and harm from falling

Prevention strategies are in place for patients at risk of falling.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.7 Developing and implementing a multi-factorial falls prevention plan to address risks identified in the assessment			
10.7.1 Use of best practice multi-factorial falls prevention and harm minimisation plans are documented in the patient clinical record	Are our falls prevention and harm minimisation care plans consistent with best practice?	☐ Policies, procedures and protocols that describe best practice multi-factorial falls prevention plans and provide tools and detail of resources available ☐ Templates for prevention plans ☐ Audit of patient clinical records for the use of multi-factorial falls prevention plans ☐ Audit of patient clinical records with a multi-factorial falls prevention plan against care provided ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
10.7.2 The effectiveness and appropriateness of the falls prevention and harm minimisation plan are regularly monitored	How do we monitor the use of falls prevention and harm minimisation care plans?	☐ Audit of patient clinical records with a multi-factorial falls prevention plan against care provided ☐ Regular monitoring and review of patient functional status and incidents of falls and near misses pre and post implementation of the plan ☐ Root cause analyses of falls resulting in serious harm ☐ Reports from administration and clinical data that analyse trends in falls and near misses ☐ Falls indicator data ☐ Relevant documentation from committees and meetings that describe the effectiveness of falls and harm minimisation plans ☐ Observation that the multi-factorial action plan is communicated to all workforce concerned with the care of the patient ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
10.7.3 Action is taken to reduce falls and minimise harm for at-risk patients	What action have we taken to reduce falls and harm from falls for at-risk patients?	☐ Risk registers that include actions to address identified risks ☐ Relevant documentation from committees and meetings that detail improvement actions taken ☐ Quality improvement plans include actions to address issues identified ☐ Examples of improvement activities that have been implemented and evaluated to reduce falls and minimise harm for at-risk patients ☐ Communication material developed for workforce, patients and carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Preventing falls and harm from falling

Prevention strategies are in place for patients at risk of falling.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.8 Patients at risk of falling are referred to appropriate services, where available, as part of the discharge process			
10.8.1 Discharge planning includes referral to appropriate services, where available	How do we refer to other services, included in the discharge planning process, for patients at risk of falls?	☐ Audit of patient clinical records shows that falls risk is identified in the discharge plan and includes referrals to: – community health services – specialist medical practitioners such as geriatricians, ophthalmologists – continence consultants or nurses – allied health professionals such as physiotherapists, occupational therapists, podiatrists, dieticians, optometrists – general practitioners ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Communicating with patients and carers

Patients and carers are informed of the identified risks from falls and are engaged in the development of a falls prevention plan.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.9 Informing patients and carers about the risk of falls and falls prevention strategies			
10.9.1 Patient information on falls risks and prevention strategies is provided to patients and carers in a format that is understood and meaningful	What information do we provide to patients and carers on falls risk and prevention? How do we identify and support patients who may not understand this information?	☐ Materials used in patient and carer education such as brochures, fact sheets, posters and websites ☐ Patient information that is available for distribution by the clinical workforce in a range of formats and languages ☐ Audit of patient clinical records for evidence that patients have been provided with information on falls risks and prevention strategies ☐ Reports on patient feedback on information provided ☐ Analysis of consumer feedback relating to patient information on falls risks and prevention strategies ☐ Other_____ **Links with Item 2.4 regarding consulting consumers on patient information distributed by the organisation**	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
10.10 Developing falls prevention plans in partnership with patients and carers			
10.10.1 Falls prevention plans are developed in partnership with patients and carers	How do we include patients and carers in the development of their falls prevention plan?	☐ Audit of patient clinical records and care plans to ensure patient and carer input into falls prevention plans ☐ Case conference notes and reports are reviewed ☐ Other_____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Section B

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

Section B presents the remaining criteria in the *NSHMS* where no overlap or matching action occurs in the *NSQHS Standards*. The tables contain reflective questions and examples of evidence, consistent with the *Implementation Guidelines for Public Mental Health Services and Private Hospitals*.[3]

National Standards for
Mental Health Services

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
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	How do we use existing environments in ways that are least restrictive? How do we design and plan environments to meet needs for safety and security?	☐ Policies, procedures and protocols that align with legislation regarding voluntary and involuntary consumers ☐ Evidence in the clinical documentation that consumers have been offered least restrictive options before restrictive measures employed ☐ Audits of clinical records documenting regular review of leave status ☐ Developed standards and audit tools for culturally informed design of buildings and standards for culturally informed design and operation of inpatient units ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.15 The MHS upholds the right of the consumer to access advocacy and support services	How do we ensure consumers know about what advocacy and support is available to them?	☐ Policies, procedures and protocols that align with legislation regarding voluntary and involuntary consumers ☐ Documentation that consumers have been provided with written information concerning their rights and responsibilities ☐ Evidence in the clinical documentation that consumers have been offered access to advocacy and support services ☐ Evidence of provision of access to consumer consultants across health settings ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
1.17 The MHS upholds the right of the consumer, wherever possible, to access a staff member of their own gender	How do we tailor our services to offer this option?	☐ Documentation that consumers have been provided with written information concerning their rights and responsibilities ☐ Audits of rosters showing mix of genders in staff on shift ☐ Evidence of flexible processes for allocation of staff, e.g. gender preference taken into account as well as catchment area, or level of acuity ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
2.1 The MHS promotes the optimal safety and wellbeing of the consumer in all mental health settings and ensures that the consumer is protected from abuse and exploitation	What do we do to promote the safety of consumers? How do we prevent exploitation and abuse of consumers? How do we make sure we are delivering culturally appropriate care?	☐ Policies, procedures and protocols that describe how the service implements the *National Safety Priorities in Mental Health: a national plan for reducing harm*[55] (2005) ☐ Risk management plans ☐ Risk register and evidence of action on recommendations from safety reviews ☐ Staff training records in cultural sensitivity ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
2.2 The MHS reduces and where possible eliminates the use of restraint and seclusion within all MHS settings	What steps are we taking to reduce restraint and seclusion rates?	☐ Evidence of staff training in de-escalation techniques and other alternatives to restraint and seclusion (2.9) ☐ Review of audits of restraint and seclusion registers at executive level, and actions taken ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
2.5 The MHS complies with relevant Commonwealth and state/territory transport policies and guidelines, including the current National Safe Transport Principles	How do we ensure transport arrangements are safe for consumers, staff and the community?	☐ Policies, procedures and protocols that describe how the service ensures transport arrangements are safe and comply with relevant legislation ☐ Evidence of collaborative arrangements with other agencies involved in transporting consumers, including ambulance and police services ☐ Logs or maintenance records of vehicles ☐ Risk register and actions taken ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

Standard 3: Consumer and Carer Participation

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
3.4 Consumers and carers have the right to independently determine who will represent their views to the MHS	How do we ensure consumers and carers have access to independent representation, and information on how to achieve this?	☐ Written information about access to a range of independent advocacy services available in brochures and on posters ☐ Job descriptions for consumer and carer consultants clearly outlining accountabilities to service users and to the mental health service ☐ Documents to outline role of advocate and to appoint an advocate ☐ Records in client files ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Standard 4: Diversity Responsiveness

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	How do we identify the diverse population in our defined community, and ensure our service is culturally responsive and appropriate for them?	☐ Evidence of analysis of census data and relevant research on CALD mental health issues ☐ Evidence of collaboration with expert individuals and organisations such as the Transcultural Mental Health and Refugee Centres and networks to gain knowledge of the diversity in its community ☐ Evidence of collaboration with Aboriginal and Torres Strait Islander elders and peak groups ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
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	What data do we use to identify the diverse needs in our community, and how do we evaluate it?	☐ The provision of training to all staff, including management, on the diversity of needs within its catchment and on culturally competent service delivery ☐ Evidence of seeking input from cultural informants, bilingual workers or relevant others ☐ Evidence that complaints, dispute and grievance resolution procedures address diversity factors ☐ Service profile and analysis of patient population ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
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	What links do we have to other agencies to ensure our consumers have access to a range of suitable services?	☐ Policies, procedures and protocols for the use of professional interpreters ☐ Service level agreements with other providers such as Aboriginal and Torres Strait Islander medical services, divisions of general practice or Royal Flying Doctor Service ☐ Evidence of referrals to appropriate services ☐ Evidence of consultation ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
4.5 Staff are trained to access information and resources to provide services that are appropriate to the diverse needs of its consumers	How do we ensure staff are aware of how to access information on resources for consumers?	☐ Evidence of percentage of staff who have completed cultural competency training ☐ Contemporary resources available to staff ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
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	How do we monitor and manage sources of potential discrimination against our consumers by our own staff? How do we feedback to consumers that identified issues have been addressed?	☐ Evidence of integration of culturally and linguistically diverse and Aboriginal and Torres Strait Islander liaison staff into service delivery ☐ External monitoring of non-discriminatory practice by carers and consumers and Aboriginal and Torres Strait Islander community groups ☐ A current complaints register which includes responses and actions to address identified issues ☐ Feedback from service users ☐ Feedback from workforce ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
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 responsive to the needs of its community, by establishing and sustaining partnerships with consumers, carers, other service providers and relevant stakeholders	What partnerships do we build to address local mental health and promotion needs? How do we sustain these partnerships?	☐ Policies, procedures and protocols covering promotion and prevention ☐ Partnership agreements with relevant service providers ☐ Delivery of, or participation in education to targeted communities, e.g. Mental Health First Aid workshops in schools and workplaces ☐ Range of strategies targeted to specific groups ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
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	What steps do we take to identify the mental health promotion and prevention needs of our particular communities?	☐ Evidence of mechanisms for consumers and carers to participate in the development, implementation and evaluation of promotion and prevention activities ☐ MHS participation in local activities building on national and international campaigns, e.g. Schizophrenia Awareness Week, Mental Health Month ☐ Reports on evaluation of activities undertaken ☐ Development, review and evaluation of strategic plans ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
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	How do we work in partnerships to support mental health consumers and carers to be included in activities that promote health and wellbeing beyond mental health services?	☐ Evidence of MHS representation on external committees and boards involved in promotion and prevention activities ☐ Programs that promote social inclusion and healthy lifestyles, such as links with sporting and recreation clubs – records of attendance by consumers, transport bookings, payment etc. ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
5.4 The MHS evaluates strategies, implementation plans, sustainability of partnerships and individual activities in consultation with their partners. Regular progress reports on achievements are provided to consumers, carers, other service providers and relevant stakeholders	What processes do we have in place to evaluate our strategies and partnerships? How are consumers/carers engaged in this process? How do we report on these evaluations to consumers, carers, partners and other service providers?	☐ Partnership agreements with other service providers ☐ Reports documenting coordinated evaluations of partnership activities, e.g. in annual reports ☐ Dissemination of these evaluations in varied media, e.g. online, in forums for community members, in local newspapers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
5.5 The MHS identifies a person who is accountable for developing, implementing and evaluating promotion and prevention activities	Have we appointed a key person or team to coordinate promotion and prevention activities and given them adequate resources?	☐ Identified position(s) responsible for promotion and prevention ☐ Budget planning for adequate resources for promotion and prevention activities ☐ Job description including promotion and prevention role ☐ Activity reports ☐ Evaluation reports/feedback from consumers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
5.6 The MHS ensures that its 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	What training do we provide our staff on the principles of mental health promotion and prevention? What supports do we provide for staff to implement these principles?	☐ Policies, procedures and protocols covering workforce training programs, and mentoring and supervision ☐ Time sequestered for clinical staff to participate in promotion and prevention activities ☐ Participation in promotion and prevention noted in performance reviews ☐ Staff training attendance records ☐ Job description includes roles and responsibilities regarding health promotion and prevention ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

Standard 6: Consumers

Consumers have the right to comprehensive and integrated mental health care that meets their individual needs and achieves the best possible outcome in terms of their recovery.

Note: The consumer standard is not assessable, as it contains criteria that are all assessable within the other standards.

National Standards for Mental Health Services

Standard 7: Carers

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
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	How do we identify carers? How is this information documented?	☐ Policies, procedures and protocols for prompt identification and prominent documentation of carers ☐ Audit of forms completed in clinical record ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
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	How do we engage carers in planning and evaluating care? How do we ensure carers understand information we are providing?	☐ Documentation in progress notes that staff have involved carers in care-planning meetings ☐ Written information available to enable informed participation by carers ☐ Availability of Aboriginal and Torres Strait Islander or CALD carer advocates where appropriate ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
7.3 In circumstances where a consumer refuses 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	Do we have a mechanism to regularly review our information after initial refusal by a consumer to nominate a carer?	☐ Audits of clinical records that reflect regular efforts to identify carers ☐ Staff training re the importance of engaging carers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
7.6 The MHS considers the special needs of children and aged persons as carers, and makes appropriate arrangements for their support	What processes do we have in place to support children and aged persons who are carers?	☐ Policies, procedures and protocols in place regarding the special needs of children and aged persons as carers ☐ Documented needs assessment and actions taken to address these needs ☐ Written information about the availability of services like Children of Parents with a Mental Illness (COPMI) and the Association of Relatives and Friends of People with Mental Illness (ARAFMI) available in waiting rooms and clinical settings ☐ An identified position or team within the MHS dedicated to meeting these carers' specific needs ☐ Records of staff attendance at training programs on identifying specific carers and offering them targeted support ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
7.8 The MHS ensures information regarding carers is accurately recorded in the consumer's health record and reviewed on a regular basis	How do we ensure our information on carers and their views is current?	☐ The consumer's health record should show when a nominated carer seeks information. All liaisons with carers should be documented in the health record ☐ Evidence of regular review ☐ Schedule for review is maintained and implemented ☐ Evidence of updates according to need/change of status ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
7.9 The MHS provides carers with non-personal information about the consumer's mental health condition, treatment, ongoing care and if applicable, rehabilitation	How do we provide comprehensive information to carers to enable them to participate in care planning, while maintaining our practice in accordance with Commonwealth, state and territory privacy laws?	☐ Information on rights and responsibilities is available ☐ Staff training programs in relevant privacy legislation ☐ Information about mental health conditions and treatments available in forms which reflect varieties in carer language and health literacy ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
7.11 The MHS actively encourages routine identification of carers in the development of relapse prevention plans	Do we effectively engage carers in relapse prevention planning?	☐ Consumer files indicate use of relapse prevention plans that include clear space to identify carers and their role in relapse prevention planning ☐ Audit of relapse prevention plans to reflect identification of carers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
7.13 The MHS provides information about and facilitates access to services that maximise the wellbeing of carers	How do we support carers to maintain their own wellbeing?	☐ Posters and brochures with information on respite services, carer respite centres, resource centres and counselling programs should be prominently displayed in every facility of the MHS and made available on the MHS website and via email, fax or post on request ☐ Workforce refer carers to carer consultants and/or carer support groups and document this in file ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

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	Have we appointed a key person or team to coordinate promotion and prevention activities and given them adequate resources?	☐ Identified position(s) responsible for promotion and prevention ☐ Budget planning for adequate resources for promotion and prevention activities ☐ Monitoring, evaluation and reporting to executive ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
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	Can our consumers and carers identify one person responsible for coordination of their care?	☐ Audit results indicating documentation in clinical records of individual responsible for coordinating a consumer's care ☐ Survey feedback from consumers and carers that they are able to identify person responsible for coordinating care ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
9.2 The MHS has formal processes to support and sustain interdisciplinary care teams	How do we support our clinicians to work together in true interdisciplinary ways?	☐ Audit results of treatment, care and recovery plans indicating interdisciplinary involvement ☐ Minutes of interdisciplinary team meetings ☐ Training programs that reflect benefits of interdisciplinary practice, and strategies to improve this ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
9.5 The MHS has formal processes to develop inter-agency and intersectoral links and collaboration	What links have we developed with other agencies to ensure our consumers and carers have access to the full range of appropriate services?	☐ Discharge summaries routinely supplied to primary healthcare providers ☐ Evidence of shared care arrangements in patient's clinical record ☐ Formal partnership agreements, e.g. with Drug and Alcohol services, housing and employment providers ☐ Minutes of intersectoral and interagency meetings ☐ Participation of MHS staff in key committees of related agencies ☐ Participation of staff from related agencies in key meetings within MHS ☐ Links to other agencies in MHS websites ☐ Links to MHS in other agencies' websites ☐ Joint participation of MHS and other agencies staff in public settings, e.g. community stall during Mental Health Month ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.1 Supporting recovery			
10.1.1 The MHS actively supports and promotes recovery oriented values and principles in its policies and practices	How does our organisation reflect recovery values?	☐ A mission statement identifying recovery processes and outcomes ☐ Policies, procedures and protocols providing recovery-based principles for service delivery ☐ Evidence that staff selection, training and supervision is according to recovery values and occurs with consumer and carer involvement ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
10.1.3 The MHS recognises the lived experience of consumers and carers and supports their personal resourcefulness, individuality, strengths and abilities	How do we practically acknowledge the lived experience of consumers and carers?	☐ Survey feedback from consumers and carers ☐ Documented involvement of consumers and carers in delivery of care plans ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
10.1.4 The MHS encourages and supports the self-determination and autonomy of consumers and carers	How do we support our consumers' autonomy and self-determination? Do we actively use advanced care directives and consumer driven recovery plans to support self-determination?	☐ Information provided on mental health and recovery in language appropriate to consumer's health literacy and language ☐ Evidence that treatment, care and recovery plans reflect consumer and carer involvement ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.1 Supporting recovery			(continued)
10.1.5 The MHS promotes the social inclusion of consumers and advocates for their rights of citizenship and freedom from discrimination	What actions has our MHS taken to promote social inclusion of consumers? What steps has our MHS taken to reduce discrimination?	☐ Programs that promote social inclusion and healthy lifestyles, such as links with sporting and recreation clubs ☐ Information about protections afforded under disability and mental health legislation available in language consumers can understand ☐ External monitoring of non-discriminatory practice by carers and consumers and Aboriginal and Torres Strait Islander community groups ☐ Feedback from consumers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
10.1.7 The MHS supports and promotes opportunities to enhance consumers' positive social connections with family, children, friends and their valued community	How do we support consumers to build or rebuild their social connectedness?	☐ A mission statement identifying recovery processes and outcomes ☐ Evidence of access to consumer-run groups ☐ Education provided to staff and consumer and carer advocates about the range of support networks that are available in the community such as local civic and volunteer groups, faith communities and educational institutions ☐ Evidence of care plan including actions to increase social connection ☐ Provision of appropriate, flexible access to visitors ☐ Organised calendar of social events ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
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	Do we maintain up-to-date information about relevant community resources? How do we enable consumers to access relevant services?	☐ Maintenance of a database, available to consumers in hard or soft copy, of local resources and services they may access ☐ Where available, linkage of consumers with support coordinators, e.g. PHAMS ☐ Direct links between MHS and local community services, including advocacy for inclusion of mental health consumers ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.1 Supporting recovery			(continued)
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	How do we ensure carers are genuinely included in the consumer's recovery plan (with informed consent from consumers), and supported in this role?	☐ Policies, procedures and protocols covering working with carers ☐ Attendance at education sessions ☐ Evidence in treatment and recovery plans of carer involvement (with informed consent from consumers) ☐ Local links between MHS and carer support services, including ARAFMI, COPMI ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
10.2 Access			
10.2.1 Access to available services meets the identified needs of its community in a timely manner	Are we meeting the diverse needs of our local community? Are we meeting these needs in a timely manner?	☐ Evidence of formal links with relevant community groups and service providers to facilitate access to services ☐ Staff orientation and ongoing training that includes information about the access process ☐ Data on waiting times to access the MHS should be analysed and strategies should be developed and implemented to reduce the number of consumers on the waiting lists ☐ Use of technology to improve access (such as Telehealth) ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
10.2.2 The MHS informs its community about the availability, range of services and methods for establishing contact with its service	How do we communicate to the community about our service?	☐ Brochures, posters describing the service available in GP waiting rooms, other community agencies, local libraries ☐ Clear and informative signage on exterior and interior of buildings ☐ Record of health promotion activities ☐ A webpage with links to prominent local and national organisations ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.2 Access			(continued)
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	How do we arrange for consumers to access care 24 hours a day? Do we provide information for consumers and carers about how to access after-hours care?	☐ 24 acute service is provided by the service itself, or by an identified partner organisation ☐ Brochures and posters with information about how to contact services are available in community languages ☐ Information about 24 hour access included on MHS website, with links to relevant options ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
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	What steps can we take to make sure access is physically easy, and appropriate to the local community?	☐ Clear signage, accessible physical entry points ☐ Consideration of cultural factors in the built, clinical environment ☐ Transport options provided, e.g. on MHS website ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
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	Is the entry process to our service clearly documented, as well as our inclusion and exclusion criteria?	☐ Policies, procedures and protocols covering the referral process, triage, inclusion and exclusion criteria ☐ Written information on the entry process to the service ☐ Evidence of referral on to other services if the particular MHS is not appropriate to the consumer needs ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.3 Entry			(continued)
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	What steps have we taken to ensure information about entry to the MHS is widely known in our local community?	☐ Written information on the entry process and criteria for access to the service ☐ Evidence of dissemination of this information ☐ Brochures and posters available within the service and in local referring agencies ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
10.3.3 The MHS had 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	Do we have a clear system for prioritising referrals? Do we communicate this system effectively?	☐ Policies, procedures and protocols covering prioritisation of referrals and effective risk management ☐ Documented entry criteria and process for assessing priority ☐ Minutes of intake meetings ☐ Prioritised waiting list ☐ Referrals to other service providers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
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	Is there a clear point of entry to our MHS?	☐ Policies, procedures and protocols covering entry pathways to the services ☐ Evidence of coordination with other sites ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.3 Entry			(continued)
10.3.5 Entry to the MHS minimises delay and the need for duplication in assessment, treatment, care and recovery planning and care delivery	How do we ensure entry to the MHS is a smooth process without undue duplication of assessment and planning?	☐ Policies, procedures and protocols covering efficient assessment treatment and care planning ☐ Audit of assessment documentation and review of assessment ☐ Audit of care plans ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
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	Have we developed processes to ensure involuntary admission and transport of consumers is effective, safe and complies with legislation?	☐ Policies, procedures and protocols covering involuntary admission, and safe transport in these circumstances, including reference to relevant legislation ☐ Memoranda of understanding with relevant agencies, including police and ambulance ☐ Evidence of early liaison with carers where possible to facilitate the process ☐ Consumer/carer feedback ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
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	Can our consumers and carers identify one person responsible for coordination of their care?	☐ Protocol for allocation of responsible staff member, e.g. roster for care coordination ☐ Audit results indicating documentation in clinical records of individual responsible for coordinating a consumer's care ☐ Survey feedback from consumers and carers that they are able to identify person responsible for coordinating care ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.4 Assessment and review			
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	Do we have appropriately trained staff available to conduct comprehensive psychosocial assessments? Do we make efforts to ascertain the consumer's preferred setting for the initial assessment? Is our risk assessment procedure rigid or flexible regarding assessment setting?	☐ Staff have appropriate qualifications to conduct psychosocial assessments, and access to consultation with senior clinicians ☐ Comprehensive assessment information is documented in consumer's health record ☐ Use of standardised assessment documentation, including prompts for key information e.g. risk assessment, nominated carer ☐ Evidence of corroborative information documented ☐ Policies and staffing levels that support choice re preferred assessment setting being available ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of 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	Do we routinely begin discharge planning early in an admission? Do we foster engagement with carers by providing information offering flexible times to participate?	☐ Documentation in the individual health record of discharge planning discussions ☐ Evidence of involvement of multidisciplinary team in discharge planning ☐ Evidence of consumer and (with consent) carer involvement in discharge planning ☐ Evidence of engagement with other service providers (GP, CMO) prior to discharge ☐ Evidence that discharge plan realistic – accommodation, finances, capacity to adhere to recommended treatment all confirmed prior to discharge ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.4 Assessment and review			(continued)
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 stated in criteria 10.4.5 above)	Do we have a mechanism to ensure that every consumer's care is reviewed at least every three months?	☐ Tracking of review through National Outcomes and Casemix Collection (NOCC) system, or local database if NOCC not used in the particular MHS ☐ Evidence of regular assessment and review should be recorded in the consumer's individual health record ☐ Crisis intervention should be included in treatment, care and recovery plans both for this episode and for future presentations ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
10.4.7 The MHS has a procedure for appropriate follow-up of those who decline to participate in an assessment	What steps do we take to ensure appropriate follow-up if a consumer declines to participate in an assessment with our MHS?	☐ Risk assessment is conducted and documented for people who decline to participate in an assessment. Action is taken consistent with mental health legislation ☐ An appropriate form of contact is planned with the referring agent and support is offered to carers where relevant ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
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	Are our treatment, care and recovery plans interdisciplinary? Can we demonstrate consultation with consumers and carers in the development of their treatment, care and recovery plans?	☐ Policies, procedures and protocols covering the development of treatment, care and recovery plans ☐ Consultation with carers and cultural brokers should be documented in the care plan ☐ Record of case management meetings ☐ The plan should complement plans developed by other service providers the consumer accesses ☐ The MHS should be able to provide evidence that the consumer and their carer have received a copy of the current treatment, care and recovery plan and that steps have been taken to ensure that the content of the treatment, care and recovery plan is understood by the consumer and their carer. ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.5 Treatment and support			
10.5.4 Any participation of the consumer in clinical trials and experimental treatments is subject to the informed consent of the consumer	Do we ensure ethical overview of treatment trials? Do our staff understand the difference between informed consent for treatment, and informed consent for clinical trials?	☐ The service has a Human Research Ethics Committee, or access to one ☐ The service provides training to staff on ethical human research practices ☐ Documentation regarding HREC approval, and informed consent practices is available ☐ Consumers are comprehensively informed of their capacity to withdraw from a clinical trial without adverse outcomes ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
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	What steps do we take to ensure care is delivered in the least restrictive way? How do we assess consumer needs and preferences? Do we engage actively to seek out other treatment modalities for consumers regarding the use of restrictive practices? Do we engage recovery principles at such times?	☐ Policies, procedures and protocols covering consent ☐ Completed consent forms/ consumer signatures on treatment plans ☐ Access to, and availability of, evidence-based guidelines ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.5 Treatment and support			(continued)
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	What links have we made with other agencies to facilitate participation by consumers in a range of activities?	☐ Evidence in clinical records of referral to relevant programs or interventions, with follow-up if indicated ☐ Documented capacity to provide joint case management, e.g. with alcohol and other drug services ☐ Joint care planning reviews (with informed consent from consumers) ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
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	Do we have understandable information available about how consumers can build on their self-care competencies?	☐ Brochures and posters about available services in a range of community languages ☐ Policies, procedures and protocols covering comprehensive assessment of consumers current level of self-care, and identification of specific skills for development ☐ Client notes indicate discussion to ensure understanding ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence
10.5.14 The setting for the learning or the re-learning of self-care activities is the most familiar and/or the most appropriate for the skills acquired	Can we demonstrate consideration of the most appropriate setting when delivering self-care activities?	☐ Policies, procedures and protocols covering provision of services beyond healthcare settings, including resourcing and workplace health and safety considerations ☐ Individual treatment plans and clinical records detailing location of self-care activity service provision, e.g. consumer's home, local supermarket, public transport ☐ Physically appropriate environments ☐ Other _____	☐ No → further action is required ☐ Yes → list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.5 Treatment and support			(continued)
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	Do we have a range of formats for delivering information to consumers and carers about self-care programs, to increase their capacity to understand, and access services?	☐ Brochures and posters on service options in various community languages ☐ Links to other services through MHS website ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
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	Are our accommodation services appropriate to the needs of the diverse range of consumers in our community? Do we have effective liaison models with other accommodation services accessed by our consumers?	☐ Supported accommodation programs run by the MHS ☐ Referrals to other agencies providing diverse accommodation services ☐ Joint contracts with other services re provision of comprehensive support ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
10.5.17 The MHS promotes access to vocational support systems, education and employment programs	Do we actively engage with consumers in accessing vocational, education and training opportunities?	☐ Appointment of a Vocational, Education, Employment and Training (VEET) officer ☐ Evidence of links with other service providers, e.g. disability officers at TAFE ☐ Evidence of training of staff in benefits of meaningful activity in recovery process ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
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	What steps do we take to ensure consumers have access to recovery focused services post discharge? Do we assist consumers with recovery plans and active engagement to supportive services and lifestyle?	☐ Information provided in the form of a booklet in a language understood by the consumer and carer ☐ Referrals and follow-up appointments ☐ Evidence of links with other relevant service providers ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
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	What information do we provided to consumers and carers about local services? How do we ensure consumers and carers understand this information?	☐ Written information on services provided in a range of community languages ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
10.6.3 The MHS has a process to commence development of an exit plan at the time the consumer enters the service	Do our care plans incorporate the idea of consumers leaving the service at an appropriate time?	☐ Policies, procedures and protocols covering exit planning ☐ Audits of case review notes, treatment plans detailing discussion of exit strategy ☐ Relapse prevention plans which include participants and services outside the MHS, which will be involved after exit from the service ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.6 Exit and re-entry			(continued)
10.6.5 The MHS provides consumers, their carers and other service providers involved in follow-up with information on the process for re-entering the MHS if required	What information do we provide consumers exiting the service, and their carers and service providers about how to re-engage with the service?	☐ Policies, procedures and protocols covering communication of exit and re-entry processes ☐ Exit plans that include this information in clear language ☐ Information on MHS website about re-entry process ☐ Timely discharge summaries provided to shared care general practitioners about re-engaging with MHS ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
10.6.6 The MHS ensures ease of access for consumers re-entering the MHS	How do we adapt our triage and assessment processes to enable consumers to re-enter the service smoothly?	☐ Policies, procedures and protocols covering re-entry to the service ☐ Evidence of access, where possible, to previous designated contact person and other key clinicians ☐ Evidence of modification to assessment process to reflect previous contact ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence
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	Do we evaluate effectiveness of the intervention and outcomes with the consumer prior to discharge? Do we review this info and evaluate on individual basis?	☐ The exit plan should contain details of: – the change in the consumer's health status – the consumer's satisfaction with the service – perception of quality of life – a review of the goals in individual treatment, care and recovery plans ☐ Other _____	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards

NSMHS criterion	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
10.6 Exit and re-entry			(continued)
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	Do we have an operative procedure for ensuring all consumers discharged from hospital are followed up within 7 days?	☐ Policies, procedures and protocols covering follow-up of consumers within 7 days of discharge from inpatient care ☐ Risk assessments detailing what time frame an individual consumer should be seen within ☐ Discharge summaries detailing discharge address, consumer readiness for follow-up, potential risks for visiting clinicians. Evidence of direct clinical contact with service receiving handover should be documented. ☐ Audits of clinical records detailing follow-up of consumers, including date, time, location ☐ Monitoring process and actions for those who don't attend appointments ☐ Other _____ NB. For the purposes of criterion 10.6.8, discharge is defined as discharge from an inpatient unit or discharge from an episode of care. The criterion does not apply to final discharge of the consumer from the mental health service.	☐ No ➔ further action is required ☐ Yes ➔ list source of evidence

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Notes

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