National Safety and Quality
Health Service Standards

DRAFT
Guide for use in
Dental Practices

October 2011
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Introduction
This guide has been developed to assist dental practices meet the requirements of the National Safety and Quality Health Service (NSQHS) Standards.

It provides an overview of the relevant Standards and their purpose, examples of evidence that dental practices could use to demonstrate they meet the Standards, and a range of resources and additional information to clarify aspects of the requirements of the Standards and support implementation of safer systems.

National Safety and Quality Health Service Accreditation
Accreditation is a system to promote and support safe patient care and continuous quality improvement of health services through a process of regular assessment and review.

Accreditation is effective as part of an improvement system because it can verify that actions are being taken, that system data and information are being used to inform the analysis of issues and program solutions, and that safety and quality improvement is being achieved.

Roles and Responsibilities under an Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme
The role of the Commission under an AHSSQA scheme is to develop and maintain the NSQHS Standards, to approve or authorise accrediting agencies to assess performance and accredit health service organisations against the NSQHS Standards, and to provide national coordination.

The role of approved accrediting agencies is to assess the performance of health service organisations against the NSQHS Standards. Accrediting agencies may also offer a suite of other Standards against which organisations may chose to be assessed and accredited.

The role of dental practices is to choose an approved accrediting agency to undertake an assessment of their performance against the NSQHS Standards, and ensure their practice and services meet the requirements of the NSQHS Standards. Practices may also choose to seek accreditation against additional standards that may be specified under other requirements, or which the practice deems to be appropriate and valuable for its services, roles and responsibilities. A participating dental practice will be awarded full accreditation after demonstrating it meets Standards 1–6 of the NSQHS Standards.

The role of the Australian Dental Association (ADA) is to provide oversight and act as a quasi-regulator of an AHSSQA scheme for dental practices. The ADA will provide overall direction and support to participating dental practices.
About the NSQHS Standards
The NSQHS Standards aim to drive the implementation and use of safety and quality systems and to improve the quality of health service provision in Australia. The NSQHS Standards focus on areas that are essential to improving patient safety and quality of care and include:

1. Governance for Safety and Quality in Health Service Organisations
2. Partnering with Consumers
3. Preventing and Controlling Healthcare Associated Infections
4. Medication Safety
5. Patient Identification and Procedure Matching
6. Clinical Handover
7. Blood and Blood Products
8. Preventing and Managing Pressure Injuries
9. Recognising and Responding to Clinical Deterioration in Acute Health Care
10. Preventing Falls and Harm from Falls.

Please note that Standards 7–10 do not directly relate to dental practices and have not been included in this guide.

The first two Standards, ‘Governance for Safety and Quality in Health Service Organisations’ and ‘Partnering with Consumers’, set the overarching requirements for effective implementation of the remaining eight Standards, which address specific clinical areas of patient care.

The NSQHS Standards provide a nationally consistent statement of the level of care consumers should be able to expect from health services.

The NSQHS Standards were selected because they address areas where:

- the impact is on a large number of patients
- there is a known gap between the current situation and best practice outcomes, and
- improvement strategies exist that are evidence-based and achievable.

The Commission developed the NSQHS Standards to be applied across all settings of care. Health service organisations, such as hospitals and day procedure services, will be accredited against the NSQHS Standards. Other health services may choose to use the NSQHS Standards as part of their internal quality systems.

Structure and Content of the NSQHS Standards
Each NSQHS Standard includes a:

- description of the Standard
- statement of intent
- statement on the context in which the Standard must be applied
- list of key criteria, and
- series of items and actions relevant to each criterion.
Core and Developmental Actions

The NSQHS Standards apply to a wide variety of health service organisations, including hospitals, day procedure services and dental practices. Because of the variable 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 the NSQHS Standards is designated as either:

- **Core**, which are critical for safety and quality and must be met, or
- **Developmental**, which are areas where health service organisations can focus on activities or investments that improve patient safety and quality. Activity is required, but the action does not need to be fully met.

Core actions are considered fundamental to safe practice. Developmental actions identify areas where dental practices can focus their activities and/or investments to improve patient safety and quality. A review of all core and developmental actions will occur in 2015.

Ratings

Assessment will generally be against a three point rating scale:

- **Not Met (NM)** – the actions required have not been achieved.
- **Satisfactorily Met (SM)** – the actions required have been achieved.
- **Met with Merit (MM)** – 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 in relation to the action or Standard under review.

This rating system will be used at the level of individual actions in each Standard and can also be applied to the overall Standard.

Individual accrediting agencies may choose to apply additional items, such as partially met in the rating scale when carrying out assessments. Health services can discuss this with their accrediting agency.

Core, developmental and ‘not applicable’ actions are indicated using symbols and shading throughout the tables in the guide. Please refer to ‘Key to symbols used in the Guide for Dental Practices’ on page 8.

Not Applicable

In exceptional circumstances, a criterion, item or action may be rated as ‘not applicable’. ‘Not applicable’ items are those which are inappropriate in a specific service context and/or for which assessment would be meaningless. If an item is rated as ‘not applicable’ an explanation must be provided for this decision to the accrediting agency. Appendix 5 describes the proposed process to apply for ‘not applicable’ actions.

Structure and Components of the Guide for use in Dental Practices

The Commission has worked closely with dental practitioners and representatives of the Australian Dental Association to present the Standards in a way that is meaningful for dental practices. The NSQHS Guide for use in Dental Practices incorporates only those six Standards relevant to dental practices and services; four NSQHS Standards are not applicable.
Each Standard is presented in a separate section which details:

- the criteria, items and actions to meet each Standard
- reflective questions for each action to assist practices to consider actions in the context of their own practice
- examples of evidence that a health service organisation may use to demonstrate an action is being met, and
- a self assessment tool.

The evidence provided includes examples that can be used to demonstrate that an item is being met – but it is not a checklist. Furthermore, the examples or suggestions provided do not represent an exhaustive ‘list’ of possible evidence. The service type, size, nature and location will influence the types of evidence that are appropriate and available. Please note, however, that organisations must provide sufficient evidence that each core item is being addressed in order to meet the NSQHS Standards.

The self assessment section provides an opportunity for the practice to review performance against the actions required and determine if current systems and processes meet the requirements. Self assessment is an important component of an accreditation process as it allows services to identify areas or issues that require attention prior to assessment by an external accrediting body.

An action plan template is provided on page 89 to assist practices to plan the changes needed to meet the Standards. It also provides space to identify the potential risks and barriers to the actions; the strategies to be used to overcome these; the person responsible for the action; and the expected timeframes for completion.

Additional information that may assist in understanding and clarifying the Standards has been included for some actions and this is identified in the table with the symbol (i).

A list of additional information and resources is also included for each Standard. This provides details of resources and tools for the implementation of safer systems.

**Key to symbols used in the Guide for use in Dental Practices**

- **C** indicates that the action is core and therefore must be met
- **D** indicates that the action is developmental
- **N/A** indicates that the action is not applicable

(i) indicates there is additional information to assist in interpretation of the standards. Additional information specific to a particular action may be included immediately below the relevant action, while additional information related to the item or standard more broadly may be included in an ‘Information Box’.

- **MM** self assessment - ‘met with merit’.
- **SM** self assessment - ‘satisfactorily met’.
- **NM → add to action plan** self assessment - ‘not met’ and add action to ‘action plan’, template provided on page 89.
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
### Criterion: Governance and quality improvement systems

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

<table>
<thead>
<tr>
<th>C/D</th>
<th>This criterion will be achieved by:</th>
<th>Actions required</th>
<th>Reflective questions</th>
<th>Demonstrate you have met the action. This is not a checklist, but simply some examples. Use only the relevant evidence from your own organisation.</th>
<th>Self assessment</th>
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</thead>
</table>
| C   | 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 | 1.1.1 An organisation-wide management system is in place for the development, implementation and regular review of policies, procedures and/or protocols | How do we describe our decision making and management processes to an outsider?  
What documents do we use to meet laws, regulations, business and professional requirements? | - Policies, procedures and/or protocols that describe the management of patient safety and quality risks specified in Standard 1.1  
- Notes, memos, minutes or reports of meetings that review policies, procedure and/or protocols  
- Policies, procedures and/or protocols that are dated and note a timeframe for review  
- List or schedule of review of policies, procedures and/or protocols  
- Register or log of completed reviews including dates changes made and outcomes of changes | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 1.1.2 The impact on patient safety and quality of care is considered in business decision making | How do we show that our business decisions take into account safe practice and the quality of care for patients? | | □ MM  
□ SM  
□ NM → add to action plan |
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<thead>
<tr>
<th>C/D</th>
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<tr>
<td>C</td>
<td>workforce</td>
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<td>□ MM □ SM □ NM → add to action plan</td>
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<td></td>
<td>• undertaking regular clinical audits</td>
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<td>□ MM □ SM □ NM → add to action plan</td>
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<td>□ MM □ SM □ NM → add to action plan</td>
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<tr>
<td>C</td>
<td>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</td>
<td>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</td>
<td>How does our leadership take responsibility for safe practice and the quality of care for patients?</td>
<td>□ MM □ SM □ NM → add to action plan</td>
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<tr>
<td>D</td>
<td>1.2.2 Action is taken to improve the safety and quality of patient care</td>
<td>1.2.2 Action is taken to improve the safety and quality of patient care</td>
<td>What actions have our leadership taken to improve safe practice and the quality of care for patients?</td>
<td>□ MM □ SM □ NM → add to action plan</td>
<td></td>
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<tr>
<td>C</td>
<td>1.3 Assigning workforce roles, responsibilities and accountabilities to individuals for:</td>
<td>1.3.1 Workforce are aware of their delegated safety and quality roles and responsibilities</td>
<td>How do we inform each team member of their roles and responsibilities for safety and quality of care?</td>
<td>□ MM □ SM □ NM → add to action plan</td>
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<td></td>
<td>• patient safety and quality in their delivery of health care</td>
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<td>□ MM □ SM □ NM → add to action plan</td>
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<td>• the management of safety and quality specified in each of these Standards.</td>
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<td></td>
<td>□ MM □ SM □ NM → add to action plan</td>
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<tr>
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| C   | 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 | How do we support each team member to understand and perform their roles and responsibilities? | • Feedback to staff on their work performance  
• Feedback from staff on their understanding of their roles and responsibilities  
• Feedback from patients about staff performance  
• Review of incident reports and related comments | ☐ MM  
☐ SM  
☐ NM → add to action plan |
| C   | 1.3.3 Agency or locum workforce are aware of their designated roles and responsibilities | How do we inform each locum or agency team member of their roles and responsibilities for safety and quality of care? | • Position descriptions, duty statements and employment contracts that include safety and quality responsibilities  
• Notes, memos, minutes or reports of meetings or other forms of communication to staff about their responsibilities  
• Policies, procedures and/or protocols that outline roles and responsibilities for locum or agency staff  
• Education resources for orientation and ongoing training for staff roles and responsibilities  
• Attendance records of education and training by locum or agency staff in roles and responsibilities  
• Feedback from locum or agency staff on their understanding of their roles and responsibilities | ☐ MM  
☐ SM  
☐ NM → add to action plan |
| D   | 1.4 Implementing training in the assigned safety and quality roles and responsibilities | What training must a new team member do to start work? How do we provide a team member with the skills and information necessary for their roles and responsibilities? | • Orientation checklist  
• Current relevant guidelines available to staff  
• Orientation program content  
• Policies, procedures and/or protocols that outlines roles and responsibilities for staff positions  
• Education resources for orientation and ongoing training for staff roles and responsibilities  
• Attendance records of education and training of staff in roles and responsibilities  
• Feedback to staff on work performance  
• Individual professional development plan(s) | ☐ MM  
☐ SM  
☐ NM → add to action plan |
<table>
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<tr>
<th>C/D</th>
<th>This criterion will be achieved by:</th>
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<th>Reflective questions</th>
<th>Demonstrate you have met the action. This is not a checklist, but simply some examples. Use only the relevant evidence from your own organisation.</th>
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</table>
| D   |                                   | 1.4.2 Annual mandatory training programs meet the requirements of these Standards | What training must team members do each year? | • List of essential annual education and training  
• Review of staff education and training needs matched against the NSQHS Standard's requirements  
• Policy that outlines mandatory training requirements for staff  
• Education resources for orientation and ongoing training for mandatory training requirements  
• Attendance records of education and training of staff in mandatory training requirements | □ MM  
□ SM  
□ NM → add to action plan |
| D   |                                   | 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 | How do we provide a locum or agency team member with the skills and information necessary in their role and responsibilities? | • Education resources for orientation and ongoing training for locum and agency staff roles and responsibilities  
• Attendance records of education and training of locum or agency staff in roles and responsibilities  
• Locum and agency staff orientation resources and attendance records  
• Orientation handbooks or equivalent documents  
• Contracts, and/or position descriptions with locum and agency staff  
• Policies, procedures and/or protocols that are readily accessible to locum and agency workforce  
• Skills appraisals of locum and agency workforce  
• Records or register of locum and agency workforce credentials (qualifications)  
• Policy, procedures and/or protocols for clinical supervision  
• Internal communication system that is accessible to the locum and agency workforce which provides information about safety and quality (for example memos) | □ MM  
□ SM  
□ NM → add to action plan |
1.4.4 Competency-based training is provided to the clinical workforce to improve safety and quality

**Actions required**
- Education resources for orientation and ongoing training in competency based training to enhance safety and quality
- Attendance records of education and training of staff in competency based training to enhance safety and quality
- Staff orientation resources and attendance records
- Orientation handbooks or equivalent documents
- Contracts and/or position descriptions
- Policies, procedures and/or protocols that are readily accessible to the workforce
- Skills appraisals of the workforce
- Record or register of the workforce credentials (qualifications)
- Policy, procedures and/or protocols for clinical supervision
- Internal communication system that is accessible to the workforce and provides information about safety and quality (for example memos)

**Reflective questions**
- How do we provide competency based training to clinical team members to improve our safety and quality care in the practice?

**Demonstrate you have met the action. This is not a checklist, but simply some examples. Use only the relevant evidence from your own organisation.**

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</table>
| D   | 1.4.4 Competency-based training is provided to the clinical workforce to improve safety and quality | How do we provide competency based training to clinical team members to improve our safety and quality care in the practice? | • Education resources for orientation and ongoing training in competency based training to enhance safety and quality | □ MM
□ SM
□ NM → add to action plan |
| C   | 1.5 Establishing an organisation-wide risk management system that incorporates identification, assessment, rating, controls and monitoring for patient safety and quality | How do we identify, record and manage risks to ensure safe dental practice? | • Notes, memos, minutes of meetings or other forms of communication to staff about risk matters | □ MM
□ SM
□ NM → add to action plan |
| C   | 1.5.2 Actions are taken to minimise risks to patient safety and quality of care | What action has been taken to reduce the risks to safe practice and quality of care for our patients? | • Register, log or other record of risk assessments and actions taken to mitigate risks | □ MM
□ SM
□ NM → add to action plan |
### C/D 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

<table>
<thead>
<tr>
<th>Actions required</th>
<th>Reflective questions</th>
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</thead>
</table>
| 1.6.1 An organisation-wide quality management system is in use and regularly monitored | How do we plan our work, measure our success against what we do and do it better? How do we use quality management methods in our practice? | • Policies, procedures and/or protocols that describe a quality approach in key areas such as:  
  o leadership  
  o planning activities and introduction of changes  
  o team members’ roles and responsibilities  
  o dissemination of information and documents  
  o work and administrative activities  
  o measuring and observation of performance  
  o review and improvement of activities  
  • Information on introduced changes in practice  
  • Evaluations and reports on the safety and quality of patient care  
  • Position descriptions or employment contracts that require participation in quality management systems  
  • Feedback on staff work performance in safety and quality matters  
  • Training resources on quality  
  • Documented quality management system | □ MM  
□ SM  
□ NM → add to action plan |

(i) A useful management tool is the Plan–Do–Check–Act (PDCA) cycle. The PDCA cycle is also known as the Plan–Do–Study–Act cycle, Deming’s cycle, Shewhart’s cycle and the Continuous Improvement cycle

| C | 1.6.2 Actions are taken to maximise patient quality of care | What actions have we taken to ensure the highest quality of care for our patients? | □ MM  
□ SM  
□ NM → add to action plan |
| C | 1.6.2 Actions are taken to maximise patient quality of care | What actions have we taken to ensure the highest quality of care for our patients? | □ MM  
□ SM  
□ NM → add to action plan |

Related actions and strategies include:

- List of improvement initiatives or improvement plan
- Policy, plans or other documents that describe improvements to safety and quality
- Policies, procedures and/or protocols that describe improvements to safety and quality
- Policies, procedures and/or protocols that identify and address deficiencies in care
- Register or log of adverse events, incidents and near misses, including actions to address issues identified
- Recorded outcomes of actions taken
- Patient satisfaction survey results
- Review of identified areas requiring action
- Review of implemented strategies
(i) **Information box**

‘Governance’ is the set of relationships established by a health service organisation between its executive, officers, stakeholders and consumers. Governance arrangements provide the structure through which the objectives of the health service organisation are set, the means by which the objectives are to be achieved and specify the mechanisms for monitoring performance.
### Criterion: Clinical practice

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

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</table>
| C   | 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 | Which clinical guidelines do we use, where do they come from and how do our team members access them? | • Review of the availability and currency of clinical guidelines to the clinical staff  
• Copies of printed or electronic guidelines  
• Policies, procedures and/or protocols for accessing clinical guidelines | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 1.7 The use of agreed clinical guidelines by the clinical workforce is monitored | 1.7.2 The use of agreed clinical guidelines by the clinical workforce is monitored | How do we find out if clinicians use agreed clinical guidelines? | • Affirmation of compliance by dental practitioners  
• Performance assessments of dental practitioners  
• Observation of clinical practice | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 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 | How do we identify those patients who are likely to have an increased risk of harm? | • Reviews of patient history and information  
• Risk profile of the dental practice that details the most likely risks and their potential impact  
• Completed risk assessments  
• Register or log of adverse events, incidents and near misses including actions to address issues identified  
• Reviews and analysis of adverse events, incidents and near misses  
• Review of patient complaints | □ MM  
□ SM  
□ NM → add to action plan |

<i>(I) Patient history and information includes relevant medical, social history, English Not First Language and significant disabilities are gathered by practices and documented in the dental record</i>
<table>
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<tr>
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</table>
| C   | 1.8.2 Early action is taken to reduce the risks for at-risk patients | What action have we taken to decrease the risk of harm to our vulnerable patients? | • Affirmation of compliance with measures and procedures by dental practitioners  
• Feedback on work performance of dental practitioners  
• Observation of clinical practice | □ MM  
□ SM  
□ NM → add to action plan | |
| C   | 1.8.3 Systems exist to escalate the level of care when there is an unexpected deterioration in health status | How do we respond to a person who needs immediate medical assistance? | • Policy, procedures and/or protocols that describe how to respond to a medical emergency  
• Signs, posters or stickers clearly visible regarding how to call for assistance  
• Information on medical emergency drills  
• Orientation and ongoing education resources relating to escalation of care  
• Attendance records of education and training of staff in medical emergency response  
• Education resources for medical emergency response | □ MM  
□ SM  
□ NM → add to action plan | |
| C   | 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  
How do we make our records available to dental practitioners when care is provided?  
How do we find out if our dental records are accurate? | • Reviews of the accuracy, integration and currency of clinical records  
• Policy, procedures and/or protocols for obtaining patient clinical records from storage or archive and other areas of the dental practice  
• Reviews of the accessibility of clinical records including paper-based and electronic archived patient records  
• Documented dental record management system | □ MM  
□ SM  
□ NM → add to action plan | |
| C   | 1.9.2 The design of the patient clinical record allows for systematic review of the contents against the requirements of these Standards | How do we find out if we are meeting the key parts of the Standards? | • Reports generated from dental records using survey methods | □ MM  
□ SM  
□ NM → add to action plan | |
**Criterion: Performance and skills management**
Managers and the clinical workforce have the right qualifications, skills and approach to provide safe, high quality health care.

<table>
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<tr>
<th>C/D</th>
<th>This criterion will be achieved by:</th>
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<th>Reflective questions</th>
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</table>
| C   | 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 | How do we know we have the right people doing the right job when providing clinical services? How do we come to a clear understanding of what services or professional practice each clinical team member may provide? | • Notes, memos, minutes meetings or other forms of communication relating to defining scope of clinical practice  
• Review of role descriptions, policies, procedures and/or protocols against jurisdictional requirements and recommendations of clinical practice and professional guidelines, such as evidence of training currency such as for Intravenous sedation administration  
• Procedures to undertake ‘credentialing’ and ‘defining scope of clinical practice’ for clinical team members  
• Review of policies, procedures and/or protocols against defined scopes of practice of clinical staff members  
• Feedback on work performance of clinical staff | □ MM  
□ SM  
□ NM → add to action plan |

(i) ‘Credentialing’ 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.

‘Defining the scope of clinical practice’ follows on from ‘credentialing’ and involves delineating the extent of an individual practitioner’s clinical practice within a particular organisation based on the individual’s credentials, competence, performance and professional suitability, and the needs and the capability of the organisation to support the practitioner’s scope of clinical practice. (The term ‘clinical privileging’ is also widely used.)

Dental practitioners include dental specialists, dentists, dental therapists, oral health therapists, and dental hygienists and dental prosthetists. Other clinical team members who may benefit from undergoing a defined scope of clinical practice process include dental assistants who expose radiographs or undertake other extended duties at the direction of a dental practitioner.
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<td>C</td>
<td>1.10.2 Mechanisms are in place to monitor that the clinical workforce are working within their agreed scope of practice</td>
<td>How do we know a clinical team member keeps within agreed boundaries when providing services or exercising their professional practice?</td>
<td>• Affirmation by dental practitioners of working within their defined scope of clinical practice • Register of staff and credentialed practice • Feedback on work performance of clinical staff • Observation and reviews of clinical workforce key performance measures • Peer review reports</td>
<td>□ MM □ SM □ NM → add to action plan</td>
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<td>C</td>
<td>1.10.3 Organisational clinical service capability, planning and scope of practice is directly linked to the clinical service roles of the organisation</td>
<td>How do we match: • what we can do • what we plan to do and • the agreed services and professional practice for our clinical team members against the services and care we provide?</td>
<td>• Plans or other documents that aim to improve safety and quality and establish the dental practice’s overall objectives and services provided • Register of workforce qualifications suitable for clinical service roles of the dental practice • Annual reports that detail the clinical service capability and clinical services provided • Evaluations of the dental practice in meeting its clinical services targets • Evaluations of the safety and quality of clinical services • Reports from clinical information systems • Clinical staff performance feedback • Clinical staff performance measures</td>
<td>□ MM □ SM □ NM → add to action plan</td>
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<td>C</td>
<td>1.10.4 The system for defining the scope of practice is used whenever a new clinical service, procedure or other technology is introduced</td>
<td>How do we assess a new clinical service, procedure or other technology before its introduction? How do we check if any new changes will affect the services or professional practice provided by clinical team members?</td>
<td>• Notes, memos, minutes, reports of meetings or other forms of communication relating to defining scope of clinical practice related to new services, procedures and technologies • Defined guidelines for clinical staff using new services, procedures and technology • Education resources for new services, procedures and technologies training • Attendance records of education and training of staff in new services, procedures and technologies • Procedure manuals, guidelines or similar documentation • Observation of practice on initial use and/or occupational health and safety checks • Policies, procedures and/or protocols that describe the process of defining scope of practice</td>
<td>□ MM □ SM □ NM → add to action plan</td>
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<td>1.10.5 Supervision of the clinical workforce is provided whenever it is necessary for individuals to fulfil their designated role</td>
<td>How do we provide the supervision to support clinical team members to keep within agreed boundaries when providing services or exercising their professional practice?</td>
<td>• Roles and responsibilities of designated principal dental practitioner&lt;br&gt;• Education resources for the supervision of other staff&lt;br&gt;• Attendance records of education and training for supervision of other staff by staff&lt;br&gt;• Observation and reviews of staff including those under probation&lt;br&gt;• Mentoring plan for a junior staff member or an observational review of a staff member under probation</td>
<td>□ MM&lt;br&gt;□ SM&lt;br&gt;□ NM → add to action plan</td>
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<tr>
<td>C</td>
<td>1.11 Implementing a performance development system for the clinical workforce that supports performance improvement within their scope of practice</td>
<td>1.11.1 A valid and reliable performance review process is in place for the clinical workforce</td>
<td>How do we develop and manage the performance of each of the clinical team members?</td>
<td>• Notes, memos or other communications relating to staff performance&lt;br&gt;• Performance reports&lt;br&gt;• Individual professional development plans&lt;br&gt;• Mentoring or peer review reports&lt;br&gt;• Documented performance review process</td>
<td>□ MM&lt;br&gt;□ SM&lt;br&gt;□ NM → add to action plan</td>
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<td>C</td>
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<td>1.11.2 The clinical workforce participates in regular performance reviews that support individual development and improvement</td>
<td>How often is the performance of each clinical team member reviewed?</td>
<td>• Performance reports&lt;br&gt;• Individual professional development plans&lt;br&gt;• Mentoring or peer review reports&lt;br&gt;• Clinical workforce performance appraisals&lt;br&gt;• Competency records&lt;br&gt;• Observation and reviews of clinical practice&lt;br&gt;• Staff development plans and programs</td>
<td>□ MM&lt;br&gt;□ SM&lt;br&gt;□ NM → add to action plan</td>
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</table>
| C   | 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 | What access do team members have to education and training in safe practice and quality care? | • Individual professional development plans  
• List of available education providers, courses and resources  
• Processes that describe access to ongoing training in safety and quality  
• Communication between practice principal and staff about education required  
• Education resources related to safety and quality training  
• Attendance records of education and training of staff in related to safety and quality training | □ MM  
□ SM  
□ NM → add to action plan |
| D   | 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 | How do we get feedback from team members on safety and quality matters to review their understanding and use of our processes? | • Notes, memos, minutes or reports of meetings or other communications relating to safety and quality matters  
• Staff communication books  
• Records of staff comments and suggestions | □ MM  
□ SM  
□ NM → add to action plan |
| D   | 1.13 Action is taken to increase workforce understanding and use of safety and quality systems | 1.13.2 Action is taken to increase workforce understanding and use of safety and quality processes by team members | What action has been taken to increase the use and understanding of our safety and quality processes by team members? | • Education resources in safety and quality  
• Attendance records of education and training of staff in safe practice and quality care by staff  
• Documented plans or approaches to increase knowledge | □ MM  
□ SM  
□ NM → add to action plan |

(i) Information box

1.10 Evidence could include staff training in specific procedures relevant to the practice, which is monitored, and reviewed as frequently as required to ensure safe practice. Performance reviews may be verbal, which may be reflected in practice improvement plan or staff personnel record. An example of performance management might include a performance plan for a new staff member under probation or existing staff member requiring additional supervision.
### Criterion: Incident and complaints management

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

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| C   | 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 | How do we identify, record and respond to incidents and near misses? | • Risk assessment forms  
• Adverse event, incident and near miss reporting forms  
• Guidelines for recognising and reporting adverse events, incidents and near misses  
• Register or log of adverse events, incidents and near misses including actions to address issues identified  
• Education resources for adverse events, incidents and near misses  
• Attendance records of education and training of staff in relation to adverse events, incidents and near misses  
• Material that demonstrates and supports promotion of incident reporting systems  
• Documented incident management system | □ MM  
□ SM  
□ NM → add to action plan |
|     |                                   | 1.14.2 Systems are in place to analyse incidents and near misses | What could we learn from incidents and near misses? | • Critical incidents register or log, including actions taken to address issues identified  
• Notes, memos, minutes or reports of meetings that relate to adverse events, incidents and near misses  
• Review of incident reports  
• Review of trends in adverse events, incidents, and near misses | □ MM  
□ SM  
□ NM → add to action plan |
|     |                                   | 1.14.3 Feedback on the analysis of reported incidents is provided to the workforce | How do we provide team members with feedback on our incidents and near misses? | • Notes, memos, minutes or reports of meetings  
• Record or report of initiated evidence-based interventions for identified risks  
• Completed risk assessments and action plans | □ MM  
□ SM  
□ NM → add to action plan |
|     |                                   | 1.14.4 Action is taken to reduce risks to patients identified through | How do we decrease the risk of an incident recurring? | • Material distributed to staff on incidents and trends  
• Incident reports accessible to staff  
• Staff meeting reports that contain a review of adverse events, incidents and near misses | □ MM  
□ SM |
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<td></td>
<td>the incident management system</td>
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<td>• Review of adverse events, incidents and near misses including actions taken to address issues identified</td>
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</table>
|     | 1.14.5 Incidents and analysis of incidents are reviewed at the highest level of governance in the organisation | How does our leadership review any incidents and near misses? | • Notes, memos and minutes or reports of meetings relating to adverse events, incidents and near misses  
• Plans or other documents that aim to improve safety and quality using information based on incident management processes  
• Communications including documents to team members, reports, updates of safety and quality plans and strategies | □ NM → add to action plan |
| C   | 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 | How do we identify, report and deal with our patient complaints? | • Patient feedback forms  
• Guidelines for recognising and reporting patient complaints  
• Register or list of complaints, including actions taken to address issues identified  
• Education resources in complaint management  
• Attendance records of education and training of staff in relation to complaint management  
• Documented complaint management processes  
• Secure patient comments and complaints ‘box’, or similar device, in publically accessible places  
• Patient brochure or information sheets, or equivalent, that outline internal and external complaints mechanisms | □ MM  
□ SM  
□ NM → add to action plan |

(I) Examples of a feedback process may include mailing out a feedback brochure which the patients can return by mail, or patient feedback forms distributed on presentation associated with a feedback box and encouragement to provide comment before leaving the dental practice.
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| C   | 1.15.2 Systems are in place to analyse and implement improvements in response to complaints | 1.15.2 Systems are in place to analyse and implement improvements in response to complaints | What could we learn from complaints and patient feedback that will lead to better outcomes? | • Review of complaints and patient feedback  
• Review of trends in complaints and patient feedback  
• Reports or briefings on analysis of complaints  
• Complaints register or log with responses recorded and actions taken  
• Notes, memos, minutes and other papers from key people with responsibility for complaints and patient feedback management and outcomes  
• Data that report feedback and trends in complaints and patient feedback  
• Reports to owners, regulators, insurers and departments referring to complaints and patient feedback | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 1.15.3 Feedback is provided to the workforce on the analysis of reported complaints | 1.15.3 Feedback is provided to the workforce on the analysis of reported complaints | How do we keep team members informed of trends in reported complaints and patient feedback? | • Notes, memos, minutes or reports of meetings including documents to be provided to team members on complaints and trends in complaints  
• Record or report of initiated evidence-based interventions for identified risks  
• Completed risk assessments and action plans  
• Risk management processes that describe strategies for managing complaints  
• Review of trends in complaints and identified risks  
• Record of prompt and constructive responses to suggestions and complaints  
• Evaluations of the effectiveness of responses and improvements in services | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 1.15.4 Patient feedback and complaints are reviewed at the highest level of governance in the organisation | 1.15.4 Patient feedback and complaints are reviewed at the highest level of governance in the organisation | How does our leadership review complaints and patient feedback? | • Notes, memos, minutes or reports of meetings referring to complaint matters  
• Plans or other documents that intend to improve safety and quality using information based on patient feedback including complaint management processes  
• Review of complaint data such as staff meeting minutes or regular reports  
• Description of complaints and trend review in forums and formats such as presentations to staff or posters | □ MM  
□ SM  
□ NM → add to action plan |
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| D   | 1.16 Implementing an open disclosure process based on the national open disclosure standard | 1.16.1 An open disclosure program is in place that it is consistent with the national open disclosure standard | How could our open disclosure processes align with the national open disclosure standard? | • Policies, procedures and/or protocols that are consistent with the principles and processes outlined in the national open disclosure standard  
• Review of open disclosure processes used in the dental practice | □ MM  
□ SM  
□ NM → add to action plan |
| D   | 1.16.2 The clinical workforce are trained in open disclosure processes | How could we train team members in our open disclosure processes? | | • Notes, memos, minutes or reports of meetings or other communication to staff providing education and information on open disclosure processes  
• Attendance records of education and training of staff in open disclosure processes | □ MM  
□ SM  
□ NM → add to action plan |
## Criterion: Patient rights and engagement
Patient rights are respected and their engagement in their care is supported.

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| C   | 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 | How consistent is our approach to healthcare rights with the Australian Charter of Healthcare Rights? | • Documented charter of healthcare rights used by the practice  
• Review of the practice’s charter of healthcare rights against the Australian Charter of Healthcare Rights | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 1.17.2 Information on patient rights is provided and explained to patients and carers | How do we provide and explain information on healthcare rights? | | • Documented charter of healthcare rights used by the practice  
• Charter of healthcare rights displayed in reception and waiting areas  
• Brochures, information sheets or other documents given to patients that explain the charter of healthcare rights  
• Charter of healthcare rights in other appropriate languages  
• Patient registration checklist that includes provision and explanation of patient’s charter of rights | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 1.17.3 Systems are in place to support people at risk of not understanding their healthcare rights | How do we identify people who through disability, circumstance, age or culture may not understand their healthcare rights?  
How do we support people who may not understand their healthcare rights? | | • Identification and recording relevant patient medical and social history  
• Brochures and information sheets in languages other than English  
• Access to an interpreter services | □ MM  
□ SM  
□ NM → add to action plan |
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| C   | 1.18 Implementing processes to enable partnership with patients in decisions about their care, including informed consent to treatment | 1.18.1 Patients and carers are partners in the planning for their treatment | How do we involve our patient and carers in their care and seek and confirm their consent to treatment? | • Examples of written consent provided by patients  
• Observational reviews of obtaining patient consent  
• Feedback from patients and/or carers on treatment planning  
• Results of patient and carer satisfaction surveys | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 1.18.2 Mechanisms are in place to monitor and improve documentation of informed consent | How do we know our patient consent documentation and processes are being applied correctly?  
How do we improve our patient consent documentation and processes? | | • Notes, memos, minutes or reports from meetings or other forms of communication outlining the requirements for informed consent  
• Review of informed consent forms  
• Observational review of consent processes  
• Education resources on consent matters  
• Attendance records of education and training of staff in consent matters | □ MM  
□ SM  
□ NM → add to action plan |
<p>| N/A | 1.18.3 Mechanisms are in place to align the information provided to patients with their capacity to understand | | | | |
| N/A | 1.18.4 Patients and carers are supported to document clear advance care directives and/or treatment-limiting orders | | | | |</p>
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| C   | 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 | How do we know a patient’s dental record is available when care is provided? | • Policies, procedures and/or protocols that describe the retrieval of archived patient records  
• Observational reviews of dental record availability  
• Access to computer or paper-based patient records  
• Policies, procedures and/or protocols for retrieving archived patient records  
• Documented dental record management system | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 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 | How do we get patient feedback on care and services we provide?  
How do we use patient feedback to improve our performance in delivering care and services? | • Plans and other documents that aim to improve the safety and quality of care based on the results of patient feedback  
• Review of results of patient surveys and feedback including comments and complaints  
• Documented patient feedback system  
• Register of patient comments and complaints and improvement or action plans | □ MM  
□ SM  
□ NM → add to action plan |
### Additional information and resources


**National Safety and Quality Framework.** Australian Commission on Safety and Quality in Health Care: [www.safetyandquality.gov.au](http://www.safetyandquality.gov.au)


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
## Criterion: Consumer partnership in service planning

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

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| D   | 2.1. Establishing governance structures to facilitate partnerships with consumers and/or carers | 2.1.1 Consumers and/or carers are involved in the governance of the health service organisation | How could patients, their carers or other consumers have involvement with our leadership in decision making processes? | • Policies, procedures and/or protocols that describe the mechanisms for engaging patients  
• Avenues for representation from the community serviced by the practice | □ MM  
□ SM  
□ NM → add to action plan |
| D   | 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 that do not usually provide feedback | | How could we ensure that patients, their carers or other consumers have involvement with our leadership and reflects the broad range views of our patient population? | • Policies, procedures and/or protocols that detail how patients and carers are to be engaged, including those from diverse backgrounds  
• Documentation of review of patient demographics to ensure relevant minority groups are engaged  
• Examples of methods used to engage with people from diverse backgrounds and those people that do not usually provide feedback | □ MM  
□ SM  
□ NM → add to action plan |
| D   | 2.2 Implementing policies, procedures and/or protocols for partnering with consumers and/or carers in:  
• strategic and operational/services planning  
• decision making | 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 | How could patients, their carers or other consumers have involvement with our leadership in planning the delivery of care by the practice? | • Notes, memos, minutes or reports of meetings or other communications relating to engaging with patients and planning for delivery of care by the practice | □ MM  
□ SM  
□ NM → add to action plan |
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| D   | about safety and quality initiatives quality improvement activities | 2.2.2 Consumers and/or carers are actively involved in decision making about safety and quality | How could patients, their carers or other consumers have involvement with our leadership in decision making for safety and quality matters? | • Examples of decisions made with patients and/or carers  
• Consultation approaches and reports detailing involvement of patients in decision making | □ MM  
□ SM  
□ NM → add to action plan |
| D   | 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 | How could we assist or support a patient, their carer or other consumer to have an ongoing involvement with our leadership? | • Information brochure or sheet for patients or representatives (which outlines roles and responsibilities, key policies and other relevant information)  
• Orientation training for patients related to partnering with the organisation  
• Documentation of orientation and training for patients related to partnering with the organisation  
• Briefing and debriefing of patients and/or carers  
• Documented feedback of consumer training | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 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) | How do we get feedback on the written material we provide to our patients? | • Results and/or reports of patient feedback on patient information publications  
• Outcomes of focus groups of patients | □ MM  
□ SM  
□ NM → add to action plan |

(i) Evidence may include the example of new or revised information brochures that incorporate or are modified by consumer feedback. Brochures may be developed or amended by the practice or a peak body, state or national organisation
### Actions required

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.

### Reflective questions

What actions have we taken to include feedback we have received into the publications we provide to our patients?

### Demonstrate you have met the action. This is not a checklist, but simply some examples. Use only the relevant evidence from your own organisation.

- Examples of changes that have been made to patient information following feedback
- Consultation approaches and reports describing the feedback sought and how it has been used
- Notes, memos, minutes or reports of meetings or other communications relating to feedback and publications

### Self Assessment

- [ ] MM
- [ ] SM
- [ ] NM → add to action plan

### (i) Information box

Measuring and responding to patient feedback involves a number of complexities but it is an important component of improving both quality and health outcomes. The quality of patients’ experiences is central to a practice’s reputation and productivity, making it a major risk-management issue – and opportunity. Hence, senior managers and clinical leaders need to ensure that consumers are engaged in the governance of their organisations.
**Criterion: 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.

<table>
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</table>
| D   | 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 | How could patients, their carers or other consumers have involvement with our leadership in designing the delivery of care that accounts for patient needs and wants? | • Notes, memos, minutes or reports of meetings with patients, community groups or other parties, such as focus groups  
• Consultation approaches and reports detailing participation and contribution of patients and/or carers  
• Project planning and implementation reports detailing patient involvement.  
• Examples of new or revised clinical programs or policy, procedures and/or protocols based on patient feedback | □ MM  
□ SM  
□ NM → add to action plan |
| D   | 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 | What access do our leadership and team members have to training on patient-centre care and engagement with individuals? | • Individual professional development plans  
• List of available education providers, courses and resources  
• Processes to ensure access to ongoing training in patient centred care and engagement with individuals  
• Method of communication between practice principal and staff about education requirements  
• Education resources related to patient-centred care  
• Attendance records of education and training of staff related to patient-centred care | □ MM  
□ SM  
□ NM → add to action plan |
| D   | 2.6.2 Consumers and/or carers are involved in training the clinical workforce | How could we involve patients, their carers or other consumers in the training of our team members? | • Documentation or records regarding patient engagement in the staff training content  
• Feedback from patients and/or carers | □ MM  
□ SM  
□ NM → add to action plan |

(i) **Information box**
The consumer engagement/involvement may be done as part of a consultative process in creating national or state best practice guidelines that an organisation has adopted.
**Criterion: 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.

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| C   | 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 | How do we inform patients and community about our performance in safety and quality matters? | • Information sheets or other publications that list the results of performance measures of the practice  
• Feedback on distributed practice information for example, by focus groups or consumer surveys  
• List of safety and quality measures used by the practice | □ MM  
□ SM  
□ NM → add to action plan |
| D   | 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 | How could we engage with patients, their carers or other consumers in the review of our performance in safety and quality matters? | • Notes, memos, minutes or reports of meetings with patients, community groups or other parties for example, focus groups relating to the review of the practice’s performance | □ MM  
□ SM  
□ NM → add to action plan |
| D   | 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 | 2.8.2 Consumers and/or carers participate in the planning and implementation of quality improvements | How could we engage with patients, their carers and/or other consumers in the planning and undertaking of our quality improvement activities? | • Notes, memos, minutes or reports of meetings with patients, community groups or other parties relating to the quality improvement activities in the practice  
• List of examples of quality improvement activities | □ MM  
□ SM  
□ NM → add to action plan |
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| D   | 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 | How could we include patients, their carers or other consumers in the evaluation of our patient feedback? | • Consultation approaches and reports detailing patient involvement  
• Recommendations made to the principal dental practitioner | □ MM  
□ SM  
□ NM → add to action plan |
|     |                                  |                  |                     | (i) Measures may include the number of improvement opportunities that were put forward by consumers and subsequently tabled or added to a quality plan |
| D   |                                  | 2.9.2 Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data | How could we include patients, their carers or other consumers in undertaking improvement activities formed through the use of patient feedback information? | • Notes, memo, minutes or reports of meetings or other communications relating to improvement activities  
• Consultation approaches and reports detailing patient involvement in improvement activities  
• Project planning and implementation reports detailing patient involvement | □ MM  
□ SM  
□ NM → add to action plan |

(i) **Information box**

Clinical leaders and senior managers need to draw on a wide range of sources and types of information when involving patients in the dental practice’s processes to improve patient experience – formal and informal, real-time and periodic, quantitative and qualitative, ad hoc and systematic. The key is to compare information from various sources to assess the overall performance.

**Additional information and resources**

Involving patients in supporting quality improvement activities in healthcare organisations has been well documented. For example, in Australian general practice, there is a mandate to undertake a robust, valid and reliable patient survey on the quality of their services. Once this information is received, some practices are inviting patients to form a critical friends group (CFG). This group, which includes patients and staff, works together by reviewing the patient survey results and then suggesting appropriate actions in response to the results. In England, a randomised controlled trial (RCT) was undertaken to examine the impact of these CFGs. Findings showed that those practices with CFGs demonstrated higher performance in quality measures than those practices that did not have a CFG (Greco et al, 2006). The Australian Commission on Safety and Quality in Health Care Consumer Engagement Strategy: Consultation Report: http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/0EE542BF224D4227CA2574890019A935/$File/Consultation-Report.pdf


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 infection and communicate these to all 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 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
### Criterion: Governance and systems for infection prevention, control and surveillance

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

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</table>
| C   | 3.1 Developing and implementing governance systems for effective infection prevention and control to minimise the risks to patients of healthcare associated infections | 3.1.1 A risk management approach is taken in policies, procedures and/or protocols being implemented for:  
- standard infection control precautions  
- transmission-based precautions  
- aseptic non-touch 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 | How consistent are our infection prevention and related control measures with national guidelines?  
How have we applied a risk management approach within our policies, procedures and/or protocols for infection prevention and related control measures? | Policies, procedures and/or protocols that address items listed in 3.1.1  
Risk assessment tools used in the practice  
*Infection control manual* in accordance with jurisdictional requirements  
Policies, procedures and/or protocols that address the Standard's requirements | □ MM  
□ SM  
□ NM → add to action plan |

(i) Dental Board has *Australian Guidelines on Infection Control* found at: www.dentalboard.gov.au

The *Australian Guidelines for the Prevention and Control of Infections in Health Care* by the National Health and Medical Research Council (NHMRC) 2010. The NHMRC is Australia's peak body for supporting health and medical research; for developing health advice for the Australian community, health professionals and governments: www.nhmrc.gov.au
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<td>• Communicable infection&lt;br&gt; • Processing of reusable medical devices&lt;br&gt; • Single-use devices&lt;br&gt; • Surveillance and reporting of data where relevant&lt;br&gt; • Reporting of communicable and notifiable diseases&lt;br&gt; • Provision of risk assessment guidelines to workforce&lt;br&gt; • Exposure-prone procedures</td>
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<td>C</td>
<td>3.1.2 The use of policies, procedures and/or protocols is regularly monitored</td>
<td>How do we find out if our infection prevention and control measures are being used correctly?</td>
<td>• Affirmation by staff that they comply with infection control measures&lt;br&gt; • Note, memos, minutes or reports of meetings or other communications relating to monitoring of infection control measures&lt;br&gt; • Observational review of infection control measures in use&lt;br&gt; • Review checklist, or other documentation, that demonstrates monitoring practice compliance with the infection control policy on a periodic basis</td>
<td>□ MM&lt;br&gt;□ SM&lt;br&gt;□ NM → add to action plan</td>
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<td>C</td>
<td>3.1.3 The effectiveness of the infection prevention and control systems is regularly reviewed at the highest level of governance in</td>
<td>How does our leadership know about our performance in infection prevention and control measures?</td>
<td>• Notes, memos, minutes or reports of meeting or other communications to the practice owner and/or principal dental practitioner that relates to monitoring of infection prevention and control measures&lt;br&gt; • Review checklist, memos or other documentation that demonstrates a clinical leader or principal dental practitioner monitors and reviews the effectiveness of the practice’s systems</td>
<td>□ MM&lt;br&gt;□ SM&lt;br&gt;□ NM → add to action plan</td>
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| C   | 3.2 Undertaking surveillance of healthcare associated infections | 3.2.1 Surveillance systems for healthcare associated infections are in place | How do we know what changes are occurring in related healthcare infections matters in our workplace? | • Register or log of quality improvements actions and activities undertaken in infection control practices  
• Records of staff members attending update courses in infection control  
• Infrastructure (such as hand basins), instruments (such as sterile packs) and other equipment (such as solutions, sharp containers)  
• Policies, procedures and/or protocols available and accessible to the workforce  
• Reports of occupational exposure incidents, using occupational exposure indicators such as Healthcare Associated Infections Health Surveillance Indicators | □ MM  
□ SM  
□ NM → add to action plan |
|     |                                 |                 |                     |                                                                                                                                 |               |

(i) A practice should assess the opportunity and need to follow specific trends of indicators related to healthcare associated infections, for example the number of needle stack injuries reported over a period, dry sockets and post-operative infections

Central Line-Associated Blood Stream Infections – may be applicable in a dental practice that uses intravenous (IV) techniques

Non Line-Associated Blood Stream Infections – may be applicable in a dental practice, however the patient may need medical management in a hospital setting

Antibiotic resistant organisms – may be applicable in a dental practice and will require medical management

Occupational exposures to blood and/or body fluids – applicable
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<td>C</td>
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<td>3.2.2 Healthcare associated infection surveillance data are regularly monitored by the delegated workforce and/or committees</td>
<td>How does our leadership know about the changes to healthcare related infections matters in our workplace?</td>
<td>• Notes, memos, minutes or reports of meetings and other communications that relate to monitoring of healthcare associated infection surveillance &lt;br&gt; • Reports or reviews for the principal dental practitioner on the frequency of exposure incidents such as sharps injuries &lt;br&gt; • Records of practice staff meetings and/or occupational health and safety committee meetings &lt;br&gt; • Occupational exposures indicator reports that are reviewed by owners, principal dental practitioner and/or the practice occupational health and safety committee</td>
<td>□ MM &lt;br&gt; □ SM &lt;br&gt; □ NM → add to action plan</td>
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<td>3.3 Developing and implementing systems and processes for reporting, investigating and analysing healthcare associated infection, and aligning these systems to the organisation's risk management strategy</td>
<td>How do we identify, report and manage healthcare related infection risks or incidents? What could we learn from healthcare related infection incidents?</td>
<td>• Notes, memos, minutes or reports of meetings or other communications that relate to healthcare associated infection risks &lt;br&gt; • Current risk management plan and register that records action taken to address identified risks &lt;br&gt; • Access to relevant guidelines, standards policies, procedures and/or protocols for staff responsible for assessing risks &lt;br&gt; • Records of healthcare associated infection incidents collected and reviewed &lt;br&gt; • Completed risk assessment documents &lt;br&gt; • Accountability for risk assessment of healthcare associated infection in job descriptions</td>
<td>□ MM &lt;br&gt; □ SM &lt;br&gt; □ NM → add to action plan</td>
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<td>C</td>
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<td>3.3.2 Action is taken to reduce the risks of healthcare associated infection</td>
<td>How do we decrease the risks of healthcare related infections or stop incidents recurring? How do we inform team members of our healthcare related infection risks and incidents?</td>
<td>• Notes, memos, minutes or reports of meetings or other communications that relate to decreasing risk of healthcare associated infections &lt;br&gt; • Risk management and/or risk reduction plan that includes action to address issues identified &lt;br&gt; • Documented emergency plan for common healthcare associated infection outbreaks, for example respiratory diseases such as swine flu</td>
<td>□ MM &lt;br&gt; □ SM &lt;br&gt; □ NM → add to action plan</td>
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| D   | 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 | What improvement activities have we undertaken to reduce or prevent healthcare related infections? | • Notes, memos, minutes or reports of meetings or other communications that relate to preventing or decreasing the healthcare associated infections  
• Register or list of quality improvement activities relating to reduction of infection risks and improvement of control measures  
• Review of incidents related to risk of healthcare associated infections and any resultant actions taken | □ MM  
□ SM  
□ NM → add to action plan |
| D   | 3.4.2 Compliance with changes in practice are monitored | How could we find out if team members accept changes to our work practices? |  | □ MM  
□ SM  
□ NM → add to action plan |
| D   | 3.4.3 The effectiveness of changes to practice is evaluated | How could we know if any changes we make to processes or procedures are accepted and improve the outcome? |  | □ MM  
□ SM  
□ NM → add to action plan |
## Criterion: Infection prevention and control strategies

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

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| C   | 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 reviewed | How consistent is our hand hygiene program with national guidelines? How do we find out if team members comply with our hand hygiene program? | • Affirmation of compliance by staff  
• Observational review of hand hygiene by clinical leader equivalent or delegate  
• Reviews of the amounts of hand hygiene products used  
• Records of completed hand hygiene education and training consistent with guidelines such as the Australian Guidelines for the Prevention and Control of Infections in Health Care | □ MM  
□ SM  
□ NM → add to action plan |
|     |                                   |                  |                     | (i) Example: 5 Moments for Hand Hygiene found at: http://www.hha.org.au/home/5-moments-for-hand-hygiene.aspx | |
| D   | 3.5.2 Compliance rates from hand hygiene audits are regularly reported to the highest level of governance in the organisation | How could our leadership know our hand hygiene compliance rates? | • Observational reviews of hand hygiene performance  
• Notes, memos, minutes or reports of meetings or other communications relating reviews of hand hygiene matters  
• Affirmation of compliance by staff members  
• Documented process for reporting infection control breaches such as non-compliance with hand hygiene requirements | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 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 | What actions have we taken to improve compliance with the requirements of hand hygiene guidelines? | • Modifications to policies, procedures and/or protocols or work practices to address issues of non-compliance | □ MM  
□ SM  
□ NM → add to action plan |
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<td>C</td>
<td>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</td>
<td>3.6.1 A workforce immunisation program that complies with current national guidelines is in use</td>
<td>How do we protect team members through our immunisation program? How consistent is our immunisation program with the NHMRC immunisation guidelines?</td>
<td>• Policies, procedures and/or protocols that are consistent with national guidelines and jurisdictional legislation&lt;br&gt;• Record of healthcare workers’ immunisation status at commencement of employment and throughout their period of employment&lt;br&gt;• Record of immunisation refusals and the dental practice’s responses to refusals&lt;br&gt;• Documented risk assessment system for managing healthcare workers who do not meet immunisation requirements, for example within the practice’s infection control or occupational health and safety manuals</td>
<td>☐ MM&lt;br&gt;☐ SM&lt;br&gt;☐ NM → add to action plan</td>
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<td>C</td>
<td>3.7 Promoting collaboration with occupational health and safety programs to decrease the risk of infection or injury to healthcare workers</td>
<td>3.7.1 Infection prevention and control consultation related to occupational health and safety policies, procedures and/or protocols are implemented to address: communication disease status&lt;br&gt;• occupational management and prophylaxis&lt;br&gt;• work restrictions&lt;br&gt;• personal protective equipment&lt;br&gt;• assessment of</td>
<td>How well do our healthcare infection prevention and control measures align with our occupational health and safety measures?</td>
<td>• Policies, procedures and/or protocols for the management of occupational exposures (such as sharps injury, reporting communicable disease status) that address vaccination refusal and work placement or procedure restrictions&lt;br&gt;• Risk assessments for healthcare workers undertaking exposure prone procedures&lt;br&gt;• Occupational exposure data that is used to support the introduction of safety devices and equipment to minimise risks to the work force and patients&lt;br&gt;• Screening for skin conditions related to dermatitis or allergy to personal protective equipment or hand hygiene product&lt;br&gt;• Attendance record of staff who have completed training and competency assessments in the use of personal protective equipment which may include gloves, gowns, plastic aprons, face shields, protective eye wear and masks&lt;br&gt;• Monitoring and risk management of healthcare workers who may be infected or colonised with an infectious agent&lt;br&gt;• Record or reviews of the usage of personal protective equipment&lt;br&gt;• Vaccination policy and program consistent with current Australian immunisation guidelines</td>
<td>☐ MM&lt;br&gt;☐ SM&lt;br&gt;☐ NM → add to action plan</td>
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<td>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</td>
<td>3.8.1 Compliance with the system for the use and management of invasive devices is monitored</td>
<td>How do we know which invasive devices we use, and how consistent is their use and management with national guidelines?</td>
<td>• Protocol for post-exposure management and prophylaxis following blood borne virus parenteral exposures, Communicable Diseases Network Australia (CDNA) policy and National Health and Medical Research Council (NHMRC) guidelines</td>
<td>□ MM □ SM □ NM ➔ add to action plan</td>
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(i) The Commission’s definition of ‘invasive devices’: devices inserted through skin, mucosal barrier or internal cavity, including central lines, peripheral lines, urinary catheters, chest drains, peripherally inserted central catheters (PICC) and endotracheal tubes

Common invasive devices or instruments that may be found in a dental practice include:
- surgical instruments including scalpels, flap retractors, periosteal elevators, bone burs, elevators, sutures
- hypodermic needles
- implants
- scalers used in deep sub-gingival curettage
- endodontic instruments including hand files and reamers and rotary files
- tooth extraction forceps

Single-use or single-patient use invasive medical devices/instruments should be used whenever possible.

The use of a batch control number system is a useful means to link sterile instruments used...
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| D   | 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 | How could we educate and train team members in the use and management of our invasive devices? | • Orientation and ongoing education resources for use and management of invasive devices  
• Attendance records of education and training undertaken by staff related to the invasive devices | □ MM  
□ SM  
□ NM → add to action plan |
| D   | 3.10 Developing and implementing protocols for aseptic non-touch technique | 3.10.1 The clinical workforce is trained in aseptic non-touch technique | How could we train team members in aseptic technique? | • Education and training resources and attendance records of staff in relation to aseptic technique training | □ MM  
□ SM  
□ NM → add to action plan |
| D   | 3.10 Compliance with aseptic non-touch technique is regularly audited | 3.10.2 Compliance with aseptic non-touch technique is regularly audited | How could we know that team members comply with aseptic technique? | • Affirmation by dental practitioners and staff of complying with aseptic technique  
• Observational review of procedures of aseptic non-touch technique  
• Plans or reports detailing routine measures to review compliance  
• Records of annual assessment of compliance with aseptic non-touch technique  
• Policies, procedures and/or protocols on aseptic non-touch technique consistent with national and professional guidelines  
• Attendance records of education and training of staff in aseptic non-touch technique | □ MM  
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□ NM → add to action plan |
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</table>
| D   | 3.10.3 Action is taken to increase compliance with the aseptic non-touch technique protocols | How could we find out if team members correctly use aseptic technique and what action could we take to improve team members’ use of aseptic technique? | • Notes, memos, minutes and reports of meetings or other communications related to improvement of the use of aseptic non-touch technique  
• Education and training resources for use with aseptic non-touch technique  
• Attendance records of education and training by staff in aseptic non-touch technique  
• Reviews of accessibility of infrastructure, instruments, and other equipment necessary to comply with policies, procedures and/or protocol  
• Plans and outcomes for improving the use of aseptic non-touch technique | □ MM  
□ SM  
□ NM → add to action plan |
**Criterion: 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.

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| C   | 3.11 Implementing systems for using standard precautions and transmission-based precautions | 3.11.1 Standard precautions and transmission-based precautions consistent with the current national guidelines are in use | How consistent are the standard and transmission-based precautions we use with national guidelines? | • Policies, procedures and/or protocols for standard and transmission-based precautions based on current national guidelines  
• An infection control manual which is in accordance with the current jurisdictional requirements accessible to the staff  
• Observational reviews of workplace practices and equipments use  
• Education resources for use with standard and transmission-based precautions  
• Attendance records of education and training by staff in standard and transmission-based precautions  
• Standard and transmission-based precaution signage available and accessible to the staff | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 3.11.2 Compliance with standard precautions is monitored | 3.11.2 Compliance with standard precautions is monitored | How do we find out if team members correctly use standard precautions? | • Affirmation of compliance with standard precautions by staff members  
• Observational review of staff compliance with standard precautions  
• Annual assessments of clinical staff compliance with standard precautions  
• Inventory of equipment available for used in standard precautions | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 3.11.3 Action is taken to improve compliance with standard precautions | 3.11.3 Action is taken to improve compliance with standard precautions | What action has been taken to improve the use of standard precautions by team members? | • Notes, memos, minutes or reports of meetings or other communications with staff on approaches to improve the use of standard precautions  
• Educational materials such as brochures, pamphlets or posters and  
• Attendance record education and training by staff in standard precautions  
• Provision of infrastructure, instruments, and other equipment necessary to comply with policies, procedures and/or protocols | □ MM  
□ SM  
□ NM → add to action plan |
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| **C** | 3.11.4 Compliance with transmission-based precautions is monitored | How do we find out if team members correctly use transmission-based precautions? | • Affirmation of compliance with transmission-based precautions by staff members  
• Observational review of staff compliance with transmission-based precautions  
• Annual assessments of clinical staff compliance with transmission-based precautions  
• Inventory of equipment available for use in transmission-based precautions  
• Isolation policy for patients known to require transmission-based precautions |  | □ MM  
□ SM  
□ NM → add to action plan |
| **C** | 3.11.5 Action is taken to improve compliance with transmission-based precautions | What action has been taken to improve the use of transmission-based precautions by team members? | • Notes, memos, minutes or reports of meetings or other communications with staff on approaches to improve the use of transmission-based precautions  
• Educational materials such as brochures, pamphlets or posters  
• Attendance record of education and training by staff in the use of standard precautions  
• Provision of infrastructure, instruments, and other equipment necessary to comply with policies, procedures and/or protocols |  | □ MM  
□ SM  
□ NM → add to action plan |
| **D** | 3.12 Assessing the need for patient placement based on the risk of transmission of infection | How could we find out if we need to apply transmission-based precautions? | • Risk assessments for management of patients with known or suspected infectious diseases  
• Policies, procedures and/or protocols based on risk assessment, analysis and risk management processes  
• Access to an infection control manual that identifies the types of conditions and situations for which transmission-based precautions are required |  | □ MM  
□ SM  
□ NM → add to action plan |

(ii) Transmission of infectious agents can occur in a number of ways. Transmission-based precautions are applied to patients suspected or confirmed to be infected with agents transmitted by the contact, droplet or airborne routes: [www.nhmrc.gov.au/b2-transmission-based-precautions](http://www.nhmrc.gov.au/b2-transmission-based-precautions)
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| C   | 3.13 Developing and implementing protocols relating to 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 | How do we check the infectious status of a patient on presentation for care? | • Policies, procedures and/or protocols on identifying pre-existing healthcare associated infection or communicable disease
• Medical history form or equivalent document to assess the infection control risk of patients | □ MM □ SM □ NM → add to action plan |
|     | 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 | How do we alert others of the infectious status of a patient at handover or transfer of care? | • Policies, procedures and/or protocols requiring notification of communicable diseases at patient handover
• Handover sheets, discharge forms, referral forms or similar documents that require significant medical history findings, including infectious status
• Policies, procedures and/or protocols that meet mandatory notification requirements of communicable diseases | □ MM □ SM □ NM → add to action plan |
**Criterion: Antimicrobial stewardship**
Safe and appropriate antimicrobial prescribing is a strategic goal of the clinical governance system.

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| C   | 3.14 Developing, implementing and regularly reviewing the effectiveness of the antimicrobial stewardship system | 3.14.1 An antimicrobial stewardship program is in place | How does our antimicrobial stewardship processes work and how consistent are they with national guidelines and jurisdictional requirements? | • Notes, memos, minutes or reports of meetings or other communications that relate to antimicrobial stewardship  
• Policies, procedures and/or protocols that relate to antimicrobial stewardship are based on national guidelines, jurisdictional legislation and codes, and health agencies’ directives | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 3.14.2 The clinical workforce prescribing antimicrobials have access to current endorsed therapeutic guidelines on antibiotic usage | How do we provide access to national therapeutic guidelines for our team members who prescribe antibiotics? | | □ MM  
□ SM  
□ NM → add to action plan |
| N/A | 3.14.3 Monitoring of antimicrobial usage and resistance is undertaken | | | |
| N/A | 3.14.4 Action is taken to improve the effectiveness of antimicrobial stewardship | | | |
### Criterion: Cleaning, disinfection and sterilisation

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

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| C   | 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 | How do we use risk management principles to maintain a clean and hygienic work place? |  
- Schedules related to cleaning of workplace rooms, areas and facilities  
- Communication book between cleaners and the practice  
- Notes, memos, minutes or reports of meetings or other communications relating to cleaning matters  
- Observational audit of cleaning services and standards  
- Policies, procedures and/or protocols that relate to environmental cleaning are consistent with current guidelines  
- Register or log of improvement for building and infrastructure maintenance  
- Infection control manual that includes information on environmental cleaning  
- Manuals, guidelines or policies, procedures and/or protocols for cleaning  
- Material safety data sheets or chemical register of cleaning resources utilised  
- Waste management plan that conforms to local state or territory regulations and standards | ☑ MM  
☐ SM  
☐ NM → add to action plan |
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|     | Management within the clinical environment  
• Laundry and linen transportation, cleaning and storage  
• Appropriate use of personal protective equipment | How and when do we review our cleaning procedures and contracts? | Notes, memos, minutes or reports of meetings or other communications relating to cleaning matters  
• Sign-off list or register of completed reviews by principal dental practitioner or clinical leader  
• Documented schedule of reviews  
• Regular reviews and updates of policies, procedures and protocols and/or practice and infection control manuals | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 3.15.2 Policies, procedures and/or protocols for environmental cleaning are regularly reviewed | How do we use checks to ensure cleaning standards and services are maintained? | Cleaning schedules that are consistent with current guidelines, for example, Australian Guidelines for the Prevention and Control of Infections in Health Care: Section B5.1  
• Work instructions and job descriptions  
• Cleaning contracts and schedule  
• Environmental cleaning review results  
• Reviews of schedule compliance | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 3.15.3 An established environmental cleaning schedule is in place and environmental cleaning reviews are undertaken regularly | How do we find out if team members are reprocessing reusable medical devices in accordance with national standards and | Notes, memos, minutes or reports of meetings or other communications relating to cleaning and processing of instruments  
• Records of sterilisation verifying reprocessing is consistent with jurisdictional requirements  
• Maintenance schedules for sterilising equipment | □ MM  
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□ NM → add to action plan |
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|    | accordance with relevant national or international standards and manufacturers’ instructions | manufacturer’s instructions for cleaning, disinfection and sterilisation of reusable instruments and devices is regularly monitored | standards and manufacturer’s instructions? | • Reviews of monitoring systems for sterilisers  
• Attendance records of education and training by staff in the cleaning and reprocessing of instruments  
• Risk assessments where there are deviations in the requirements of relevant standards and the manufacturer’s instructions  
• Observational reviews of cleaning, disinfection and sterilisation processes  
• Review results for sterile stock integrity and supply | plan |
| D  | 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 | How could we link reusable instruments or other devices that need to be sterile at use with the patient they have been used on?  
How could we know our process to link instruments and patients is consistent with national and professional guidelines? | • Policies, procedures and/or protocols that require a batch control number system for reusable sterile medical devices used on a patient at a critical (sterile) site for dental surgery, where this is a requirement by the manufacturer or by relevant national guidelines or standards.  
• Batch control numbers that link the batch of sterile instruments used in invasive procedures are recorded in patient dental records | MM  
SM  
NM → add to action plan |
| D  | 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 | How could we train team members to correctly perform decontamination of our reusable instruments and devices? | • Numbers or proportion of staff who have completed orientation programs and ongoing education and training in decontamination of reusable instruments  
• Numbers or proportion of the staff who completed competency based training in decontaminating of reusable instruments  
• Attendance record of education and training by staff who undertake competency based training  
• Schedule of competency based training and targets  
• Relevant current standards and guidelines | MM  
SM  
NM → add to action plan |
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<td>Relevant Guides may include AS/NZS 4815 (Office-based health care facilities – Reprocessing of reusable medical and surgical instruments and equipment, and maintenance of the associated environment) or AS/NZS 4187 (Cleaning, disinfecting and sterilizing reusable medical and surgical instruments and equipment, and maintenance of associated environments in health care facilities) and the Australian Guidelines for the Prevention and Control of Infections in Health Care (2010) are accessible to relevant staff</td>
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Criterion: Communicating with patients and carers
Information on healthcare associated infection is provided to patients, carers, consumers and service providers.

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| D   | 3.19 Ensuring 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 consumers and/or carers | How could we tell patients, their carers or other consumers about our work to decrease infection risks to patients? | • Risk alert information and materials provided to patients and their carers, for example respiratory precautions during influenza season  
• Public health risk alert material placed on display in public places  
• Information sheets, posters and pamphlets that inform patients about infection control precautions used at the practice, such as hand hygiene  
• Information on practice emergency plans and procedures during influenza or influenza-like outbreaks in the community  
• Patient education materials and information translated into languages other than English | □ MM □ SM □ NM → add to action plan |
| D   | 3.19.2 Patient infection prevention and control information is evaluated to determine if it meets the needs of the target audience | How could we find out what patients think of our infection prevention and control information? | | • Patient information that has been subjected to consumer consultation processes and evaluation provided to the practice by professional Dental Associations or other relevant bodies  
• Commercially available patient information that has had consumer input and evaluation  
• Analysis of patient comments, suggestions and complaints  
• Feedback from patient surveys results | □ MM □ SM □ NM → add to action plan |

Additional information and resources

Healthcare Associated Infection (HAI) Program, Commission on Safety and Quality in Health Care (ACSQHC)  
Dental Board of Australia, Guidelines on Infection Control. (Current version) www.dentalboard.gov.au
Australian Dental Association, Guidelines for Infection Control. (Current version): www.ada.org.au
National Health and Medical Research Council, Therapeutic Guidelines: Antibiotic: www.nhmrc.gov.au
National Health and Medical Research Council, Therapeutic Guidelines: Oral and Dental Antibiotic: www.nhmrc.gov.au
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 consumers 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

Communicating with patients and carers
**Criterion: Governance and systems and 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.

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<td>C</td>
<td>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</td>
<td>4.1.1 Governance arrangements are in place to support the development, implementation and maintenance of organisation-wide medication safety systems</td>
<td>How does our leadership take responsibility for the safe and legal use of medicines?</td>
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- Notes, memos, minutes or reports of meetings or other communications relating to medication safety processes
- Documented consideration of the business changes necessary to support the development, implementation and maintenance of practice-wide medication safety systems
- Designated responsibility for the support of the development, implementation and maintenance of practice-wide medication safety systems at all levels of the practice
- Identifying patient safety and quality risks, reviewing information or data on them, and taking appropriate action to improve the development, implementation and maintenance of practice-wide medication safety systems
- Staff are trained and supported to ensure competency in the performance of their role and duties in the medication management system

□ MM
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| C   | 4.1.2 Policies, procedures and/or protocols are in place that are consistent with legislative requirements, national, jurisdictional and professional guidelines | How consistent is the way we order, store prescribe, administer, supply and dispose of medicines with regulations and professional guidelines? | Policies, procedures and/or protocols that:  
- are based on best practice and identify legislative requirements, including Australian Pharmaceutical Advisory Council, Commonwealth Department of Health and Ageing, Therapeutic Goods Authority and state health department Acts or regulations, nursing, medical and pharmacy professional guidelines  
- include the date the policy was implemented and scheduled review date  
- provide links to relevant resource material  
- incorporates approved policy, procedure and/or protocol amendments following review of incidents, and national changes in guidelines or policy  
- specify the mechanism for checking compliance with medication policy | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 4.2 Undertaking a regular, comprehensive assessment of medication use systems to identify risks to patient safety and | 4.2.1 The medication management system is regularly assessed | How do we find out the risks associated with medication management for a patient and the medicines used in our work place? | Notes, memos, minutes or reports of meetings or other communications relating to medication safety processes  
- Risk assessment tool such as the Medication Risk Identification section of National Medication Management Plan (MMP) is in use throughout the dental practice.  
- Separate risk assessments, registers and/or action plans have been completed for each unit or service area  
- Reports or data from internal review undertaken in areas of high risk, for example medication reconciliation practice | □ MM  
□ SM  
□ NM → add to action plan |
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| C   | implementing system changes to address the identified risks                           | 4.2.2 Action is taken to reduce the risks identified in the medication management system                   | What action have we taken to reduce the risks associated with medication management for patients and medicines used in our work place? | • Risk register or individual action plans to reduce risks  
• Progress and final reports are available, known to the dental staff, and have been presented to key executive or practice principal.  
• A uniform medication documentation process has been implemented or is being implemented throughout the dental practice  
• Data from the incidence reporting system is analysed and actions taken  
Response to errors, adverse events, incidents and near misses are recorded  
• An antibiotic stewardship program in use | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 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 | How do team members find out who has authority to prescribe, administer or supply medicines? | • Credentialing records and a list of staff with authority to prescribe, administer, and/or supply medicines, are available  
• Policies, procedures and/or protocols incorporating scope of practice exist and are reviewed in line with current legislation  
• Review of incident reporting system and compliance monitoring system to verify compliance with authorisations | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 4.3.2 The use of the medication authorisation system is regularly monitored            |                                                                                                           | How do we find out if the medication authority system is used? | • Notes, memos, minutes or reports of meetings or other communications relating to medication authorisation processes | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 4.3.3 Action is taken to increase the effectiveness of the medication authority system |                                                                                                           | What action have we taken to improve the usefulness and reliability of our medication authority system? | • Notes, memos, minutes or reports of meetings or other communications relating to improving the medication authorisation processes | □ MM  
□ SM  
□ NM → add to action plan |
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| C   | 4.4 Utilising a robust organisation-wide system of reporting, investigation and change management to respond to adverse medicines incidents | 4.4.1 Adverse medication incidents are regularly monitored, reported and investigated | How do we identify and respond to an adverse medicines incident? How could we learn from an adverse medicines incident? How do we decrease the risk of an adverse medicines incident recurring? How do we keep team members informed of our adverse medicines incidents? | • Notes, memos, minutes or reports of meetings or other communications relating to medicines incidents  
• Incident reporting form including use for adverse medicines incidents | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 4.4.2 Action is taken to reduce the risk of adverse medication incidents | What action have we taken to decrease the risk of adverse medicines incidents? | | • Notes, memos, minutes or reports of meetings or other communications relating to action taken to reduce the risk of an adverse medicines incidents  
• Review of compliance with policies, procedures and/or protocols  
• Education resources on changes to policy, procedures, and documentation processes  
• Attendance records of education and training by staff on changes to policy, procedures and documentation processes  
• Access to online and/or hard copies of relevant resources, for example, MIMS, Therapeutic Guidelines, and/or Injectable Guidelines | □ MM  
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<td>D</td>
<td>4.5 Undertaking quality improvement activities to enhance the safety of medicines use</td>
<td>4.5.1 The performance of the medication management system is regularly assessed</td>
<td>How could we find out about the performance of our medication safety processes?</td>
<td>• Notes, memos, minutes or reports of meetings or other communications relating to the performance of the medication safety processes&lt;br&gt;• Observational review of dental practitioner performance&lt;br&gt;• Medication improvement activities are documented in action plans, risk register or log, dental practice plan or equivalent documents&lt;br&gt;• Reporting on actions taken following review of risks or internal reviews in areas of high risk included in executive meeting papers and/or memos&lt;br&gt;• Data is available to demonstrate improvements in the dental practice&lt;br&gt;• The dental practice has established key performance indicators (KPIs) for safe medication management that are known to the staff and are routinely monitored&lt;br&gt;• Key performance indicator reports</td>
<td>□ MM&lt;br&gt;□ SM&lt;br&gt;□ NM → add to action plan</td>
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<tr>
<td>D</td>
<td>4.5.2 Quality improvement activities are undertaken to reduce the risk of patient harm and increase the quality and effectiveness of medicines use</td>
<td>What action could we take to improve our medication safety processes?</td>
<td>• Notes, memos, minutes or reports of meetings or other communications relating to decreasing the risk of harm to patients and improve the use of medicines&lt;br&gt;• Education resources which incorporate information and skills to enable the quality management of medications and the implementation of improvement strategies&lt;br&gt;• Attendance records of education and training of staff in medication safety training&lt;br&gt;• Documentation from medication safety reviews, such as reports, papers and/or minutes for key executive meetings, that include rates of medication adverse events, incidents and near misses demonstrated</td>
<td>□ MM&lt;br&gt;□ SM&lt;br&gt;□ NM → add to action plan</td>
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(i) **Information box**

An antibiotic stewardship program is in place which includes:

- Minutes of meetings and/or memos, and reports
- Dental practice wide antimicrobial prescribing guidelines and policies that are consistent with guidelines such as *Therapeutic Guidelines: Antibiotic*
- Educational programs addressing antimicrobial usage, development of resistance, and judicious prescribing
- Reviews of antimicrobial usage
- Restriction/approval or review systems to guide the use of broad spectrum antimicrobials.
**Criterion: Documentation of patient information**
The clinical workforce accurately records a patient’s medication history and this history is available throughout the episode of care.

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| C   | 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 | How do we record the medication history for each patient in their dental record? | • Notes, memos, minutes or reports of meetings or other communications relating to the documentation of medication history for patients  
• Reviews are conducted including history and medication reconciliation documentation to assist in assessment and care delivery  
• Use of medication history  
• Medication assessment is documented as part of the patient’s visit  
• A section for medication history to be completed by the dentist  
• Medical record review, reviewing patient records for a standardised system, and legibility | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 4.6 The medication history and current clinical information is available at the point of care | 4.6.2  
Medication history is accessible at the point of care  
Medication history recorded in the dental record  
Documented dental record system | How do we make available a patient’s dental record where care is provided? | • Policies, procedures and/or protocols on the management of dental records and medication history  
• Medication history is accessible at the point of care  
• Medication history recorded in the dental record  
• Documented dental record system | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 4.7 The clinical workforce documenting the patient’s previously known adverse medicine reactions on initial presentation and updating this if another adverse reaction to a medicine | 4.7.1 Known medication allergies and adverse drug reactions are documented in the patient clinical record | How do we record our patient’s allergy and adverse drug status in their dental record?  
How do we know dental practitioners ask about allergy and adverse drug reactions and record the results? | • Policies, procedures and/or protocols on documentation of allergies and adverse drug reactions  
• Review of patient records for recording of allergy status and adverse drug reactions and actions taken | □ MM  
□ SM  
□ NM → add to action plan |
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| C   | occurs during the episode of care | 4.7.2 Action is taken to reduce the risk of adverse reactions | What action have we taken to decrease the risk of adverse reactions? | • Notes, memos, minutes or reports of meetings or other communications related to action taken to decrease the risk of adverse reactions  
• Review undertaken of medication documentation to determine the number of patients administered a medication to which they have had an allergy or previous adverse drug reaction  
• Adverse drug reactions reporting mechanisms are in use  
• Documentation of adverse drug reactions in patient records  
• Review of adverse drug reactions data on a systematic basis by a specified group or people with recommendations for system improvement where appropriate  
• Policies, procedures and/or protocols are in place to identify adverse drug reactions  
• Review of reports on adverse events, incidents and near misses  
• Attendance records of education and training of staff in orientation and ongoing training in allergies and adverse reactions  
• Education resources for informing staff about adverse drug reactions  
• Recommendations for system improvement where appropriate may include:  
  o patient records are updated on presentation  
  o review of dental records and action taken | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 4.7.3 Adverse drug reactions are reported within the organisation and to the Therapeutic Goods Administration | How do we report adverse drug reactions?  
How consistent is our reporting of adverse drug reactions with Therapeutic Goods Administration (TGA) guidelines? | Policies, procedures and/or protocols for identifying, recording and reporting adverse drug reactions | □ MM  
□ SM  
□ NM → add to action plan |
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| D   | 4.8 The clinical workforce reviewing the patients’ current medication orders against their medication history and prescriber’s medication plan, and reconciling any discrepancies | 4.8.1 Current medicines are documented and reconciled at admission and transfer of care between healthcare settings | How could we find out if dental practitioners, who may prescribe, administer or supply medicines record that information and consider their actions with regard to the patient’s medication history and reconcile any discrepancies? | • Notes, memos, minutes or reports of meetings or other communications relating to current medications are documented and reconciled at admission and transfer of care between healthcare settings  
• Review of percentage of patients whose current medicines are reconciled on admission and/or discharge. Focus on high-risk patients such as 65 years and over  
• Documentation and review undertaken, including action plans formulated and implemented  
• Use of a modified medication management plan  
• Medication history is reconciled with current medicines | □ MM  
□ SM  
□ NM → add to action plan |
## Criterion: Medication management processes

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

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| C   | 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 | What support tools for information and decision making in medication management do we need? How do dental practitioners access our support tools where care is provided? | • List of information and support tools for use with medications management  
• Notes, memos, minutes or reports of meetings or other communications relating to support tools for information and decision making in medication management  
• Observation review of the use of information and decision support tools  
• Information and support tools readily accessible to the clinical workforce  
• Review of medication history in patient’s records  
• Reports or other data related to patient education sessions  
• Dentist’s documentation on medication prescribing and administration  
• Results of patient focus group elicit ing information on their understanding of the information provided on their medications | □ MM  
□ SM  
□ NM → add to action plan |

| C   | 4.9.2 The use of the information and decision support tools is regularly reviewed | How do know our information and support tools are current and useful to dental practitioners and patients? |  | • Notes, memos, minutes or reports of meetings or other communications relating to support tools for information and decision making in medication management  
• Observational review of the use of decision support tools  
• Feedback from patients and dental practitioners on the value of the support tools  
• Policy, procedures and/or protocols on prescribing within the practice  
• Restriction, approval or review systems to guide the use of restricted medications | □ MM  
□ SM  
□ NM → add to action plan |

(i) The structure and composition of this team or group of people will vary depending on the dental practice. Allocated time for these staff to undertake these activities will depend on practice size
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| C   | 4.9.3 Action is taken to improve the availability and effectiveness of information and decision support tools | What action have we taken to improve the availability and effectiveness of our support tools for information and decision making in medication management? | • Notes, memos, minutes or reports of meetings or other communications relating to support tools for information and decision making in medication management  
• Feedback from dental practitioners and patients regarding the accessibility and effectiveness of the support tools and action taken  
• Review of clinical resources by relevant staff with appropriate changes in line with feedback, legislation and best practice | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 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 | How do we identify, report and manage risks associated with the storage of medicines in our workplace? | • Notes, memos, minutes or reports of meetings or other communications relating to risks of storage and distribution of medicines | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 4.10.2 Action is taken to reduce the risks associated with storage and distribution of medicines | What action have we taken to decrease the risks associated with the storage of medicines in our workplace? | • Notes, memos, minutes or reports of meetings or other communications relating to actions taken to decrease the risks of storage and distribution of medicines  
• Systems to record those who access medication supply areas and record the removal of medications  
• Policies, procedures and/or protocols on storage and distribution of medicines | □ MM  
□ SM  
□ NM → add to action plan |
<p>| N/A | 4.10.3 The storage of temperature-sensitive medicines is monitored | | | |</p>
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| C   | 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 | How consistent are our processes for disposal of unwanted medicines with jurisdictional requirements and the manufacturer’s instructions? | • Notes, memos, minutes or reports of meetings or other communications relating to disposal of unused, unwanted or expired medicines  
• Policies, procedures and/or protocols are in place for:  
  o the disposal of unused, unwanted or expired medications  
  o hazard management  
  o management of patients’ own medications for example, narcotics  
  o education resources for orientation and ongoing education resources in disposal of unused, unwanted or expired medicines  
  o attendance records of education and training of staff in disposal of unused, unwanted or expired medicines | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 4.10.5 The system for disposal of unused, unwanted or expired medications is regularly monitored | How do we find out if the disposal of medicines is being done correctly? | • Observational review of the disposal of unused, unwanted or expired medicines  
• Affirmation or certification by team members of the compliance with correct disposal methods of unwanted medicines | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 4.10.6 Action is taken to increase compliance with the system for disposal of unused, unwanted or expired medications | What action have we taken to support team members in the correct disposal of medicines? | • Notes, memos, minutes or reports of meetings or other communications-related compliance issues in the disposal of unused, unwanted or expired medicines  
• Education resources for orientation and ongoing education resources on disposal of unused, unwanted or expired medicines  
• Attendance records of education and training of staff in disposal of unused, unwanted or expired medicines | □ MM  
□ SM  
□ NM → add to action plan |
### C/D

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| **C**                             | 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 administering of high-risk medicines are regularly reviewed | - Notes, memos, minutes or reports of meetings or other communications relating to the review risks storage, prescribing, administering or supplying of high-risk medicine  
- Review of compliance with prescribing, administering and supplying high-risk medications policy  
- List of dental practitioners in the practice and their prescribing authority  
- Review, in conjunction with occupational health and safety policies, procedures and/or protocols, the risks of storage, prescribing, administering or supplying of high-risk medicine  
- Review of incident reports identifying trends and the implementation of appropriate responses | ☐ MM  
☐ SM  
☐ NM → add to action plan |

(i.) *High risk medications* are those medications that may have a high risk of causing serious injury or death to a patient if they are misused. Examples of high risk medications and additional information may be found at the Institute for Safe Medication Practices (ISMP) website at: [www.ismp.org](http://www.ismp.org)

| **C**                             | 4.11.2 Action is taken to reduce the risks of storing, prescribing, dispensing and administering high-risk medicines | What action have we taken to decrease the risks associated with our high-risk medicines? | - Notes, memos, minutes or reports of meetings or other communications relating to actions taken to decrease risks storage, prescribing, administering or supplying of high-risk medicine  
- Education resources for orientation and ongoing education resources to decrease risks storage, prescribing, administering or supplying of high-risk medicine  
- Attendance records of education and training of staff to decrease risks storage, prescribing, administering or supplying of high-risk medicine  
- System for separation of look-alike sound-alike medications | ☐ MM  
☐ SM  
☐ NM → add to action plan |
**Criterion: 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.

<table>
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<tr>
<td>N/A</td>
<td>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 any clinical handovers</td>
<td>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</td>
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<td>N/A</td>
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<td>N/A</td>
<td>4.12.3 A current comprehensive list of medicines is provided to the receiving clinician during clinical handover</td>
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<td>N/A</td>
<td>4.12.4 Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current and comprehensive list of medicines during clinical handover</td>
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</table>
**Criterion: Communicating with patients and carers**

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

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| C   | 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 medication treatment options, benefits and associated risks | How do we inform our patients about their care options including the use of medicines? | • Notes, memos, minutes or reports of meetings or other communications relating on the provision of patient-specific medicine information, including medication treatment options, benefits and associated risks  
• Medication history taken and updated as required  
• Feedback from patients on the provision of patient-specific medicine information, including medication treatment options, benefits and associated risks  
• Medication material provided to patients by staff  
• Review documentation, for example, patient notes, computer systems | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 4.13.2 Information that is designed for distribution to patients is readily available to the clinical workforce | 4.13.2 Information that is designed for distribution to patients is readily available to the clinical workforce | How do we make available information to a patient about their care options? | • Education materials and resources provided to patients by staff such as brochures, handouts and fact sheets  
• Observational review of the availability patient information material  
• Feedback from patients on the suitability of patient information provided by the practice  
• Education resources for orientation and ongoing education on patient information material  
• Attendance records of education and training of staff in patient information material | □ MM  
□ SM  
□ NM → add to action plan |
| N/A | 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 |  |  |  |
## Additional information and resources

*Guiding principles for medication management in the community.* Australian Pharmaceutical Advisory Council, Canberra: Commonwealth of Australia 2006

*Guiding principles to achieve continuity in medication management.* Australian Pharmaceutical Advisory Council, Commonwealth of Australia. (APAC)

*Indicators for Quality Use of Medicines in Australian Hospitals.* NSW Therapeutic Advisory Group

*Medication Safety Self Assessment for Antithrombotic Therapy in Australian Hospitals.* Clinical Excellence Commission and NSW Therapeutic Advisory Group

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 the 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
Criterion: Identification of individual patients
At least three approved patient identifiers are used when providing care, therapy or services.

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| C   | 5.1 Developing, implementing and regularly reviewing the effectiveness of a patient identification system including the associated policies, procedures and/or protocols that: | 5.1.1 Use of an organisation-wide patient identification system is regularly monitored | How consistent are our documented patient identification processes with national guidelines? How do we find out if team members correctly use our patient identification processes? | • List the practice’s approved patient identifiers  
• Statement of the use of at least three approved patient identifiers on registration or admission  
• Statement of the use of at least three approved patient identifiers when care, therapy or other services are provided  
• Statement of the use of at least three approved patient whenever clinical handover, patient transfer or discharge documents are generated  
• Identify appropriate protocols for identification and procedure matching including the use of ‘time-out’ techniques  
• Observational reviews of patient identification procedures  
• Affirmation by team members of complying with patient identification and procedure matching requirements | □ MM  
□ SM  
□ NM → add to action plan |

(i.) Time out is the last patient safety check immediately prior to commencing a procedure to ensure, correct patient, correct site, and correct procedure. The time is used to confirm that medications have been taken, for example, prophylactic antibiotics, correct prostheses or appliances are present such as immediate dentures. A silent time-out may be used for routine dental procedures that are not undertaken using conscious sedation or general anaesthetic techniques.
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<td>C</td>
<td>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</td>
<td>5.1.2 Action is taken to improve compliance with the patient identification matching system</td>
<td>What action have we taken to improve team members’ compliance with our patient identification matching processes?</td>
<td>• Record/s of regularly reviewed policies, procedures and/or protocols and the date disseminated to staff, for example, sign off sheet for all staff that they have read and understood the policy and will enforce it • Education resources for orientation and ongoing training in patient identification and procedure matching matters • Attendance records of education and training of staff in patient identification and procedure matching matters • List of training that specifies training for patient identification and procedure matching processes</td>
<td>☐ MM ⊗ SM ⊗ NM → add to action plan</td>
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| C   | 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 the analysis of patient care mismatching events is regularly monitored | How do we identify, record and deal patient mismatching events and near misses?  
What could we learn from patient care mismatching events and near misses?  
How do we decrease the risk of patient care mismatching events recurring?  
How do we keep team members informed of patient care mismatching events and near misses? | • The practice uses a mechanism or method to record incidents of mismatching and wrong site practice (for example, incidents and adverse event register, log, or journal is kept of incidents in general where any incidents of mismatching can be recorded. This should also include what action is taken to prevent the incident occurring again, with a sign off column for the staff member who has committed the breach and has been counselled)  
• Notes, memos, minutes or reports of meetings or other communications that relate to incidents of mismatching and wrong site practice are routinely reported and reviewed  
• Register of log of safety and quality risk register  
• Incident reporting form  
• Safety and quality risk register or log that is reviewed and amended as necessary following mismatching incident  
• Open disclosure policies, procedures and/or protocols when a patient is harmed following a mismatching incident.  
• Open disclosure notations in patient records where applicable (for example, incident discussed with patient)  
• Root cause analysis of serious mismatching events including sentinel events  
• Adverse events, incidents and near misses of mismatching and wrong site practice are routinely reported and reviewed | □ MM  
□ SM  
□ NM → add to action plan |

(i) A method to record incidents of mismatching and wrong site practice may include an incident and adverse event register, log, or journal, where any incidents of mismatching can be recorded. This may also include what action is taken to prevent the incident occurring again, with a sign off column for the staff member who has committed the breach and has been counselled.
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| C   |                                   | 5.2.2 Action is taken to reduce mismatching events. | What action have we taken to decrease the number of mismatching events and near misses and the risk of these recurring? | • Information material distributed to staff on incidents and trends  
• Incident reports accessible to staff  
• Staff meeting reports containing review of adverse events, incidents and near misses  
• Review of incidents and trends on display in staff accessible areas  
• Safety and quality risk register that is reviewed and amended as necessary following a mismatching incident  
• Reviews of medical records for open disclosure of mismatching incidents and associated actions | ☐ MM  
☐ SM  
☐ NM → add to action plan |
| N/A | 5.3 Ensuring that when a patient identification band is used, it meets the national specification for patient identification bands | 5.3.1 Inpatient bands are used that meet the national specifications for patient identification bands |                        |                                                                                                                                                  |                 |

(i) **Information box**

Examples of approved patient identifier list are:
- full name (family and given names) stated by the patient
- date of birth stated by the patient
- gender
- home address in full as stated by the patient
- identified and recognised by sight by the practice staff member
- photographic image of the patient attached to the patient file
- appointment day or date and time correctly stated by the patient
- treating oral health practitioner’s name correctly stated by the patient
- a valid card or document stating the patient’s family name
- the patient’s personal identifier stated by the patient.
## Criterion: Processes to transfer care
A patient’s identity is confirmed using three approved patient identifiers when transferring responsibility for care.

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| C   | 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 find out if our patient identification and matching processes are working and improving? How do we know patient identification and matching processes are used at handovers, transfers and discharges? | • Policies, procedures and/or protocols for patient handover, transfer and discharge that include:  
  o the use of three patient identifiers  
  o requirement for all team members to reconfirm the three patient identifiers whenever a practitioner takes on clinical care  
 • Require regular file reviews to confirm three patient identifiers are being used | ☐ MM  
 ☐ SM  
 ☐ NM → add to action plan |
**Criterion: Processes to match patients and their care**
Health service organisations have explicit processes to correctly match patients with their intended care.

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| C   | 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 | How consistent are our written processes for matching a patient and their intended care with the national guidelines? | • Policies, procedures and/or protocols when a specific patient identification procedure is to be used by team members. This may include:  
  o correct site, correct patient, correct procedure protocols surgical safety checklist  
  o handover checklists  
  • Reviews of treatment records | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 5.5 The process to match patients to any intended procedure, treatment or investigation is regularly monitored | 5.5.2 The process to match patients to any intended procedure, treatment or investigation is regularly monitored | How do we find out if our patient identification and procedure matching processes are being followed? | • Affirmation of compliance by dental practitioners to matching processes  
  • Observation of team members in the clinical setting  
  • Policy and strategies to ensure routine site marking where there is the potential for error involving left/right distinction  
  • Patients are involved in identifying correct site for the procedure | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 5.5.3 Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation | 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 has been taken to improve our patient identification and procedure matching processes? | • Record or system to demonstrate policy is routinely reviewed and kept current  
  • Register or record of quality improvement activities  
  • Register of safety and quality action plans | □ MM  
□ SM  
□ NM → add to action plan |

**Additional information and resources**
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
**Criterion: Governance and leadership for effective clinical handover**

Health service organisations implement effective clinical handover systems.

<table>
<thead>
<tr>
<th>C/D</th>
<th>This criterion will be:</th>
<th>Actions required</th>
<th>Reflective questions</th>
<th>Demonstrate you have met the action. This is not a checklist, but simply some examples. Use only the relevant evidence from your own organisation.</th>
<th>Self assessment</th>
</tr>
</thead>
</table>
| C   | 6.1 Developing and implementing an organisational system for structured clinical handover that is relevant to the healthcare setting and specialities, including: | 6.1.1 Clinical handover policies, procedures and/or protocols are used by the workforce and regularly monitored. | How do we refer or transfer our patient’s care to another healthcare practitioners or other organisation? How do we know that our patient referrals or care transfers are being done correctly? | • Policies, procedures and/or protocols for handover which occurs between practitioners within the practice and referral outside of the practice  
• Review of the use of handover tools such as:  
  o checklists, transfer forms  
  o handover proforma documents  
  o database entries | □ MM  
□ SM  
□ NM → add to action plan |
| C   | • documented policy, procedures and/or protocols  
• agreed tools and guides | 6.1.2 Action is taken to maximise the effectiveness of clinical handover policies, procedures and/or protocols | What action have we taken to improve the guidance to team members on referral or transfer of patient care? | • Notes, memos, minutes or reports of meetings or other communications to team members of handover matters  
• Education and training sessions on handover matters | □ MM  
□ SM  
□ NM → add to action plan |
| C   | 6.1.3 Tools and guides are periodically reviewed | What tools and guides do we use to assist in the referral or transfer of patient care and how often do we review them? | | • Tools and guides are reviewed and updated or modified as indicated | □ MM  
□ SM  
□ NM → add to action plan |
**Criterion:** Clinical handover processes

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

<table>
<thead>
<tr>
<th>C/D</th>
<th>This criterion will be:</th>
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<th>Reflective questions</th>
<th>Demonstrate you have met the action. This is not a checklist, but simply some examples. Use only the relevant evidence from your own organisation.</th>
<th>Self assessment</th>
</tr>
</thead>
</table>
| D   | 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: | What could be the best clinical handover processes to use for our patients? How could we document and keep our clinical handover processes current? | • Displaying the clinical handover policy/guideline on a visible surface  
• Clinical handover policy/guideline documentation in orientation resources or manuals  
• Education resources on clinical handover matters  
• Attendance records of education and training of staff in clinical handover  
• Demonstrated availability of tools and resources associated with the structured clinical handover process, for example, handover sheets in patient notes | □ MM  
□ SM  
□ NM → add to action plan |
<table>
<thead>
<tr>
<th>C/D</th>
<th>This criterion will be:</th>
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<th>Demonstrate you have met the action. This is not a checklist, but simply some examples. Use only the relevant evidence from your own organisation.</th>
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</tr>
</thead>
</table>
| D   | 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 | 6.3.1 Regular evaluation and monitoring processes for clinical handover are in place | How could we find out if our clinical handover processes are working and improving? | • Notes, memos, minutes or reports of meetings or other communications to team members on clinical handover matters  
• Observation of team member’s compliance with clinical handover processes  
• Review of clinical handover incidents and reporting of relevant findings  
• Affirmation of compliance by dental practitioners with clinical handover processes  
• Review of dental records for compliance with clinical handover processes | □ MM  
□ SM  
□ NM → add to action plan |
| N/A |                       |                 |                     | (I) Executive level of governance may be for a service, facility or broader dental practice of a health service, whichever is the most appropriate to take action on the results | |
| D   |                       | 6.3.2 Local processes for clinical handover are reviewed in collaboration with clinicians, patients and carers |                     | | |
| D   |                       | 6.3.3 Action is taken to increase the effectiveness of clinical handover | What action could we take to improve our clinical handover processes? | • Review of documents and procedures for clinical handover and any action taken | □ MM  
□ SM  
□ NM → add to action plan |
| D   |                       | 6.3.4 The actions taken and the outcomes of local clinical handover reviews are reported to the executive level of governance | How could our leadership know about our clinical handover actions, incidents and reviews? | • Notes, memos, minutes or reports of meetings or other communications confirming reviews of clinical handover actions, reviews and outcomes | □ MM  
□ SM  
□ NM → add to action plan |
<table>
<thead>
<tr>
<th>C/D</th>
<th>This criterion will be:</th>
<th>Actions required</th>
<th>Reflective questions</th>
<th>Demonstrate you have met the action. This is not a checklist, but simply some examples. Use only the relevant evidence from your own organisation.</th>
<th>Self assessment</th>
</tr>
</thead>
</table>
| **D** | 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 | How do we identify, record and respond to clinical handover incidents?  
What could we learn from clinical handover incidents?  
How do we decrease the risk of clinical handover incidents?  
How do we keep team members informed of clinical handover incidents? | • Notes, memos, minutes or reports of meetings or other communications relating to clinical handover adverse events, incidents and near misses  
• Incident and near-miss reporting forms  
• Guidelines for recognising and reporting adverse events, incidents and near misses  
• Register or list of the most common adverse events, incidents and near misses  
• Education resources in handover adverse events, incidents and near misses  
• Attendance records of education and training of staff in clinical handover adverse events and incident reporting systems  
• Material that demonstrates and supports promotion of clinical handover adverse events and incident reporting systems  
• Documented incident management system | ☐ MM  
☐ SM  
☐ NM → add to action plan |
| **D** | 6.4.2 Action is taken to reduce the risk of adverse clinical handover incidents | What action could we take to decrease the risk of clinical handover incidents recurring? | | • Notes, memos, minutes or reports of meetings or other communications relating to decreasing the risks clinical handover incidents or near misses  
• Material distributed to staff on incidents and trends  
• Incident reports accessible to staff  
• Staff meeting reports containing review of adverse events, incidents and near misses  
• Review of trends in adverse events, incidents and near misses on display in staff accessible areas | ☐ MM  
☐ SM  
☐ NM → add to action plan |
**Criterion: Patient and carer involvement in clinical handover**
Health service organisations establish mechanisms to include patients and carers in clinical handover processes.

<table>
<thead>
<tr>
<th>C/D</th>
<th>This criterion will be achieved by:</th>
<th>Actions required</th>
<th>Reflective questions</th>
<th>Demonstrate you have met the action. This is not a checklist, but simply some examples. Use only the relevant evidence from your own organisation.</th>
<th>Self assessment</th>
</tr>
</thead>
</table>
| D   | 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 | How could we include a patient or their carer in the clinical handover processes? | • Notes, memos, minutes or reports of meetings or other communications confirming reviews of clinical handover actions, reviews and outcomes  
• Observation review of clinical handovers  
• Consumer feedback on clinical handover processes  
• Information and leaflets for patients and/or carers on their roles in handover consistent with the Australian Charter of Healthcare Rights  
• Patient and carer views or input on health status and treatment plan | □ MM  
□ SM  
□ NM → add to action plan |

**Additional information and resources**
Charter
Glossary

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. ²

Acute health care facility: A hospital or other health care facility providing healthcare services to patients for short periods of acute illness, injury or recovery. ³

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). ³

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. ³

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.⁴

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).⁵

Antibiotic: A substance that kills or inhibits the growth of bacteria.⁶

Antimicrobial: A chemical substance that inhibits or destroys bacteria, viruses and fungi, including yeasts or moulds.⁶

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.⁶

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.

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.⁷

Blood: Includes homologous and autologous whole blood. Blood includes red blood cells, platelets, fresh frozen plasma, cryoprecipitate and cryodepleted plasma.⁸
Blood products: Plasma derivatives and recombinant products excluding medication products. 

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. Carers include parents and guardians caring for children.

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).

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.

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.

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.

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.

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.

Consumer (health): Patients and potential patients, carers and organisations representing consumers’ interests.

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.

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

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.

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.
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. 3

Fall: An event that results in a person coming to rest inadvertently on the ground or floor or another lower level. 17

Guidelines: Clinical practice guidelines are ‘systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific circumstances’.18

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.

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. 19

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).

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.20

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.\(^{21}\)

**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.

**Infection:** The invasion and reproduction of pathogenic or disease causing organisms inside the body. This may cause tissue injury and disease.\(^{6}\)

**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.\(^{6}\)

**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.\(^{22}\) 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.\(^{23}\)

**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.

**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.\(^{24}\)

**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.\(^{25}\)

**Medication incident:** See *Adverse medicines event*.\(^{24}\)

**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.\(^{26}\)

**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’.\(^3\)

**Near miss:** An incident that did not cause harm, but had the potential to do so.\(^{27}\)

**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.\(^{26}\)

**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.\(^{28}\)

**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).

**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.

**Patient information:** Formal information that is provided by health services to a patient. Patient information to 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.\(^{29}\)
**Patient master index:** An organisation’s permanent listing or register of health information on patients who have received or are scheduled to receive services.\(^{30}\)

**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.\(^{31}\)

**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.

**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.\(^{3}\)

**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.\(^{3}\)

**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.

**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.

**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.

**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.

**Training:** The development of knowledge and skills.
**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'.

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


### Appendix 1 - Decision Support Tool for determining the level of performance to meet the NSQHS Standards

<table>
<thead>
<tr>
<th>Issue</th>
<th>Satisfactory Performance</th>
<th>Unsatisfactory Performance</th>
</tr>
</thead>
</table>
| 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 know the documents exist, can access them, and know and use the contents  
• Include the tools, forms and processes referenced in the Standards | 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  
• 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  
• 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 |
| Action is taken to improve | • The action being taken:  
  o is applicable broadly across the health service, and/or  
  o is readily transferable across the organisation, and/or  
  o focuses on key risks or priority areas identified by the health service  
• Action outcomes will inform future improvement plans across the | • 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
<table>
<thead>
<tr>
<th>Issue</th>
<th>Satisfactory Performance</th>
<th>Unsatisfactory Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>health service or target specific risks</td>
<td>action being taken, and/or</td>
</tr>
<tr>
<td></td>
<td>• Action outcomes are, or will be, communicated to the workforce, patients, and governance committees</td>
<td>• Action is disparate and not coordinated, duplicated across the organisation</td>
</tr>
<tr>
<td></td>
<td>• Action is timely and responsive to issues as they arise, and/or</td>
<td></td>
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<tr>
<td></td>
<td>• Action is coordinated</td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>• Training provided or accessed is matched to workforce training needs;</td>
<td>• Training does not address safety and quality of care needs, or workforce training needs</td>
</tr>
<tr>
<td></td>
<td>• A system, such as a register, is in place to track staff participation in training and qualifications, and/or</td>
<td>• The workforce are not aware of training</td>
</tr>
<tr>
<td></td>
<td>• Training programs are evaluated</td>
<td>• The workforce are not able to access training, and/or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The workforce are not given the opportunity to provide feedback on training</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>• Clear and agreed processes exist to identify risks for the organisation and for individual service areas</td>
<td>• There is no formal process for identifying and rating of risk, or where risk exists, the formal process is not applied, and/or</td>
</tr>
<tr>
<td></td>
<td>• A scale to rate risk is consistently applied</td>
<td>• Risks are identified and rated at an organisational level, not at an individual service level</td>
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<tr>
<td></td>
<td>• The risks are reviewed on a regular basis, and/or</td>
<td></td>
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<tr>
<td></td>
<td>• Risks are assessed at all levels of an organisation</td>
<td></td>
</tr>
<tr>
<td>Regular review</td>
<td>• Review occurs across the relevant organisation or a representative sample that is appropriate for the issue under review;</td>
<td>• Frequency of review is insufficient in providing information that can be used to introduce change</td>
</tr>
<tr>
<td></td>
<td>• Risk assessment is used as the basis to determine the location and size of the sample, and/or</td>
<td>• Size of the review is too small or limited to provide meaningful information</td>
</tr>
<tr>
<td></td>
<td>• Frequency and timing of the review is both organisationally appropriate and consistent with the level of risk of the issue.</td>
<td>• Data collected is not current</td>
</tr>
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<td></td>
<td></td>
<td>• Reviewed data is not representative of all areas where the issue occurs</td>
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<tr>
<td></td>
<td></td>
<td>• The review inappropriately excludes consumers</td>
</tr>
<tr>
<td>Evidence base or best practice</td>
<td>• Reference is current and source is accepted as reputable and authoritative, and may include professional body, published articles, published research</td>
<td>• Material or resources are not referenced, or source is not clear,</td>
</tr>
<tr>
<td></td>
<td>• May be peer reviewed, and/or</td>
<td>• Reference material is out of date, and/or</td>
</tr>
<tr>
<td></td>
<td>• Where possible or appropriate, are consistent with national specifications or standards.</td>
<td>• Inconsistencies are apparent in the material or resources.</td>
</tr>
</tbody>
</table>
| Processes and/or systems are in place | • Processes/systems:  
  o are responsive in their ability to address issues  
  o clearly delineate roles and responsibilities  
  o interface with risk management, governance, operational | • Workforce are not aware of the processes/systems, and/or                                     |
<p>|                            |                                                                                          | • Processes/systems are cumbersome and/or not adhered to                                       |</p>
<table>
<thead>
<tr>
<th>Issue</th>
<th>Satisfactory Performance</th>
<th>Unsatisfactory Performance</th>
</tr>
</thead>
</table>
| 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 in place for routinely distributing relevant communication materials are in place;  
• The effectiveness of the communication strategy is evaluated and/or  
• The needs of culturally and linguistically diverse populations are taken into consideration  
• Communication strategies are evaluated and modified accordingly | • Format is inappropriate for purpose  
• Communication is not adapted for the target audience, and/or  
• Key pieces of communication do not reach the target audience  
• 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 |
## Appendix 2 - Summary table of items and actions in the NSQHS Standards to be audited or reviewed by health services

<table>
<thead>
<tr>
<th>Number</th>
<th>Item or action</th>
<th>Audit of clinical information</th>
<th>Review of process</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Standard 1: Governance for safety and quality in health service organisations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.1</td>
<td>An organisation-wide management system is in place for the development, implementation and regular review of policies, procedures and/or protocols</td>
<td>✓</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>1.6.1</td>
<td>An organisation wide quality management system is in use and regularly monitored.</td>
<td>✓</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>1.10.1</td>
<td>A system is in place to define and regularly review the scope of practice for the clinical workforce</td>
<td>✓</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>1.11.2</td>
<td>The clinical workforce participates in regular performance reviews that support individual development and improvement</td>
<td>✓</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>1.13.1</td>
<td>Feedback from the workforce on their understanding and use of safety and quality systems is analysed.</td>
<td>✓</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>1.15.3</td>
<td>Feedback is provided to the workforce on the analysis of reported complaints.</td>
<td>✓</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>1.15.4</td>
<td>Patient feedback and complaints are reviewed by the highest level of governance in the organisation.</td>
<td>✓</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>1.18.2</td>
<td>Mechanisms are in place to monitor and improve documentation of informed consent</td>
<td>✓</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td><strong>Standard 2: Partnering with consumers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4.1</td>
<td>Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation</td>
<td>✓</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Number</td>
<td>Item or action</td>
<td>Audit of clinical information</td>
<td>Review of process</td>
<td>Completed</td>
</tr>
<tr>
<td>--------</td>
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</tr>
<tr>
<td>2.9.2</td>
<td>Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Standard 3: Preventing and controlling healthcare associated infections**

| 3.1.2  | The use of policies, protocols and procedures is regularly monitored                                                                                                                                   | ✓                             |                 |           |
| 3.1.3  | The effectiveness of the infection prevention and control systems is regularly reviewed at the highest level of governance in the organisation                                              | ✓                             |                 |           |
| 3.5    | Developing, implementing and auditing a hand hygiene program consistent with the current national hand hygiene initiative                                                                                 | ✓                             |                 |           |
| 3.8.1  | Compliance with the system for the use and management of invasive devices is monitored                                                                                                                | ✓                             |                 |           |
| 3.10.2 | Compliance with aseptic non-touch technique is regularly audited                                                                                                                                           | ✓                             |                 |           |
| 3.11.2 | Compliance with standard precautions is monitored                                                                                                                                                           | ✓                             |                 |           |
| 3.11.4 | Compliance with transmission-based precautions is monitored                                                                                                                                                 | ✓                             |                 |           |
| 3.14   | Developing, implementing and regularly reviewing the effectiveness of the antimicrobial stewardship system                                                                                              | ✓                             |                 |           |
| 3.15.2 | Policies, procedures and/or protocols for environmental cleaning are regularly reviewed                                                                                                                   | ✓                             |                 |           |
| 3.15.3 | An established environmental cleaning schedule is in place and environmental cleaning audits are undertaken regularly                                                                                       | ✓                             |                 |           |
| 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 | ✓                             |                 |           |

**Standard 4: Medication safety**

<p>| 3.15.2 | Policies, procedures and/or protocols for environmental cleaning are regularly reviewed                                                                                                                   | ✓                             |                 |           |
| 3.15.3 | An established environmental cleaning schedule is in place and environmental cleaning audits are undertaken regularly                                                                                       | ✓                             |                 |           |
| 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 | ✓                             |                 |           |</p>
<table>
<thead>
<tr>
<th>Number</th>
<th>Item or action</th>
<th>Audit of clinical information</th>
<th>Review of process</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2</td>
<td>Undertaking a regular, comprehensive assessment of medication use systems to identify risks to patient safety and implementing system changes to address the identified risks</td>
<td>✓</td>
<td></td>
<td>□ □</td>
</tr>
<tr>
<td>4.3.2</td>
<td>The use of the medication authorisation system is regularly monitored</td>
<td>✓</td>
<td></td>
<td>□ □</td>
</tr>
<tr>
<td>4.4.1</td>
<td>Adverse medicines incidents are regularly monitored, reported and investigated</td>
<td>✓</td>
<td></td>
<td>□ □</td>
</tr>
<tr>
<td>4.5.1</td>
<td>The performance of the medication safety system is regularly assessed</td>
<td>✓</td>
<td></td>
<td>□ □</td>
</tr>
<tr>
<td>4.9.2</td>
<td>The use of the information and decision support tools is regularly reviewed</td>
<td>✓</td>
<td></td>
<td>□ □</td>
</tr>
<tr>
<td>4.10.1</td>
<td>Risks associated with secure storage and safe distribution of medicines are regularly reviewed</td>
<td>✓</td>
<td></td>
<td>□ □</td>
</tr>
<tr>
<td>4.10.3</td>
<td>The storage of temperature-sensitive medicines is monitored</td>
<td>✓</td>
<td></td>
<td>□ □</td>
</tr>
<tr>
<td>4.10.5</td>
<td>The system for disposal of unused, unwanted or expired medications is regularly monitored</td>
<td>✓</td>
<td></td>
<td>□ □</td>
</tr>
<tr>
<td>4.11.1</td>
<td>The risks for storing, prescribing, dispensing and administration of high-risk medicines are regularly reviewed</td>
<td>✓</td>
<td></td>
<td>□ □</td>
</tr>
</tbody>
</table>

**Standard 5: Patient identification and procedure matching**

<table>
<thead>
<tr>
<th>Number</th>
<th>Item or action</th>
<th>Audit of clinical information</th>
<th>Review of process</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1.1</td>
<td>Use of an organisation-wide patient identification system is regularly monitored</td>
<td>✓</td>
<td></td>
<td>□ □</td>
</tr>
<tr>
<td>5.2.1</td>
<td>The system for reporting, investigation and analysis of patient care mismatching events is regularly monitored</td>
<td>✓</td>
<td></td>
<td>□ □</td>
</tr>
<tr>
<td>5.4.</td>
<td>Developing, implementing and regularly reviewing the effectiveness of the patient identification and matching system at patient handover, transfer and discharge</td>
<td>✓</td>
<td></td>
<td>□ □</td>
</tr>
<tr>
<td>5.5.2</td>
<td>The process to match patients to any intended procedure, treatment or investigation is regularly monitored</td>
<td>✓</td>
<td></td>
<td>□ □</td>
</tr>
<tr>
<td>Number</td>
<td>Item or action</td>
<td>Audit of clinical information</td>
<td>Review of process</td>
<td>Completed</td>
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<td>-----------</td>
</tr>
<tr>
<td>6.1.1</td>
<td>Clinical handover policies, procedures and/or protocols are used by the workforce and regularly monitored</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1.3</td>
<td>Tools and guides are periodically reviewed</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>6.3</td>
<td>Monitoring and evaluating the agreed structured clinical handover processes, including&lt;br&gt;- regularly reviewing local processes based on current best practice in collaboration with clinicians, patients and carers&lt;br&gt;- undertaking quality improvement activities and acting on issues identified from clinical handover reviews&lt;br&gt;- reviewing the results of clinical handover reviews at executive level of governance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.4.1</td>
<td>Regular reporting, investigating and monitoring of clinical handover incidents is in place</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Standard 7: Blood and Blood Products**

<table>
<thead>
<tr>
<th>Number</th>
<th>Item or action</th>
<th>Audit of clinical information</th>
<th>Review of process</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1.2</td>
<td>The use of policies, procedures and/or protocols is regularly monitored</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.2.1</td>
<td>The risks associated with transfusion practices and clinical use of blood and blood products are regularly assessed</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.5.2</td>
<td>The patient clinical records of transfused patients are periodically reviewed to assess the proportion of records completed</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.7.1</td>
<td>Regular review of the risks associated with receipt, storage and transport of blood and blood products is undertaken</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.8.1</td>
<td>Blood and blood product wastage is regularly monitored</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Standard 8: Preventing and managing pressure injuries**

<table>
<thead>
<tr>
<th>Number</th>
<th>Item or action</th>
<th>Audit of clinical information</th>
<th>Review of process</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1.2</td>
<td>The use of policies, procedures and/or protocols are regularly monitored.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>Item or action</td>
<td>Audit of clinical information</td>
<td>Review of process</td>
<td>Completed</td>
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<td>-----------</td>
</tr>
<tr>
<td>8.2.2</td>
<td>Administrative and clinical data are used to regularly monitor and investigate the frequency and severity of pressure injuries</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.3</td>
<td>Undertaking quality improvement activities to address safety risks and monitor the systems that prevent and manage pressure injuries</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>8.5.2</td>
<td>The use of the screening tool is monitored to identify the proportion of at risk patients that are screened for pressure injuries on presentation</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.6.2</td>
<td>Patient clinical records, transfer and discharge documentation are periodically audited to identify the proportion of at risk patients with documented skin assessments</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.7</td>
<td>Implementing and monitoring pressure injury prevention plans and reviewing when clinically indicated</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.8.3</td>
<td>Patient clinical records are monitored to determine compliance with evidence-based pressure injury management plans</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Standard 9: Recognising and responding to clinical deterioration in acute health care**

<table>
<thead>
<tr>
<th>Number</th>
<th>Item or action</th>
<th>Audit of clinical information</th>
<th>Review of process</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.2.2</td>
<td>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</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.3.2</td>
<td>Mechanisms for recording physiological observations are regularly audited to determine the proportion of patients with complete sets of observations recorded in accordance with the monitoring plan for that patient</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.5.2</td>
<td>The circumstances and outcome of calls for emergency assistance are regularly reviewed</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.9.3</td>
<td>The performance and effectiveness of the system for family escalation of care is periodically reviewed</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Standard 10: Preventing falls and harm from falls**

<table>
<thead>
<tr>
<th>Number</th>
<th>Item or action</th>
<th>Audit of clinical information</th>
<th>Review of process</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Item or action</td>
<td>Audit of clinical information</td>
<td>Review of process</td>
<td>Completed</td>
</tr>
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<td>-----------</td>
</tr>
<tr>
<td>10.1</td>
<td>Developing, implementing and reviewing policies, procedures and/or protocols, including the associated tools, are based on the current national guidelines for preventing falls and harm from falls</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>10.2.1</td>
<td>Regular reporting, investigation and monitoring of falls incidents is in place</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.5.2</td>
<td>Use of the screening tool is monitored to identify the proportion of at risk patients that were screened for falls</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.6.2</td>
<td>The use of the assessment tool is monitored to identify the proportion of at risk patients with a completed falls assessment</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.7.2</td>
<td>The effectiveness and appropriateness of the falls prevention and harm minimisation plan are regularly monitored</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 3 - NSQHS Standards actions that require workforce training

<table>
<thead>
<tr>
<th>Item or Action</th>
<th>Standard</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard 1: Governance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4.2</td>
<td>Annual mandatory training programs to meet the requirements of these Standards 2 - 10</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>1.4.4</td>
<td>Competency-based training is provided to the clinical workforce to improve safety and quality</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>1.12</td>
<td>Ensuring that systems are in place for ongoing safety and quality education and training</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>1.16.2</td>
<td>The clinical workforce are trained in open disclosure processes</td>
<td>☐ ☐</td>
</tr>
<tr>
<td><strong>Standard 2: Partnering with Consumers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>Facilitating access to relevant orientation and training for consumers and/or carers partnering with the organisation</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>2.6.2</td>
<td>Consumers and/or carers are involved in training the clinical workforce</td>
<td>☐ ☐</td>
</tr>
<tr>
<td><strong>Standard 3: Health Associated Infection</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9.1</td>
<td>Education and competency-based training in invasive devices protocols and use is provided for the workforce who perform procedures with invasive devices</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>3.10.1</td>
<td>The clinical workforce is trained in aseptic non-touch technique</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>3.18.1</td>
<td>Action is taken to maximise coverage of the relevant workforce trained in a competency-based program to decontaminate reusable medical devices</td>
<td>☐ ☐</td>
</tr>
<tr>
<td><strong>Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.6.1</td>
<td>The clinical workforce is trained and proficient in basic life support</td>
<td>☐ ☐</td>
</tr>
</tbody>
</table>
Appendix 4 - Steps in determining not applicable actions

During the accreditation process, there may be instances where individual health service organisations decide that a Standard or action is ‘not applicable’. The proposed process for identifying additional ‘not applicable’ actions is as follows:

1. A health service assesses an action as ‘not applicable’ and applies to the accrediting agency providing evidence / arguments for the action to be rated as not applicable.

2. The accrediting agency confirms that an action is ‘not applicable’ for the purpose of accreditation of that facility based on the evidence, context and precedence.

Assessment of submissions for ‘not applicable’ actions will be against agreed criteria. The decisions of an Accrediting Agency can be appealed by health services.

All actions that are confirmed as ‘not applicable’ and the basis for the decision is provided to the surveyor, regulator and national coordinator.

3. The surveyor assesses the evidence and makes a recommendation to the accrediting agency making the decision on compliance.

4. The national coordinator assesses ‘not applicable’ actions to determine national trends with a view to:
   - Clarifying the requirements of the action
   - Providing additional tools and resources for health services to met the Standard
   - Makes amendment to the Guides
   - Considers amendments to the Standards.

Draft criteria for determining not applicable items

- The health service organisation demonstrates an action, criteria or Standard is not applicable because a particular service or product is not provided by the health service organisation for example, Blood and blood products, wrist bands.
- The health service demonstrates an action, criteria or Standards has limited applicability to the health service organisation eg Standard 9 Recognising and responding to clinical deterioration is not be applicable in non-acute health care setting.

If a health service organisation changes the types of services offered and an action, criteria or Standard that was previously assessed is no longer applicable.