# Table of Contents: A Guide for Dental Practices Part A

Introduction ..................................................................................................................2  
How to use this Guide ..................................................................................................3  
Types of dental practices to be accredited .................................................................8  
Accreditation ..............................................................................................................9  
Resources in the Guide............................................................................................13  
Terms and Definitions ..............................................................................................14  
Appendix 1: Developmental actions for Dental Practices ........................................24  
Appendix 2: Non-applicable actions for Dental Practices ........................................25  
Appendix 3: Steps in applying for ‘not applicable’ actions ........................................26  
Appendix 4: Decision Support Tool for determining the level of performance to meet the NSQHS Standards .......................................................................................27  
Appendix 5: Summary of actions for policies, protocols and procedures ...............30  
Appendix 6: Summary of training actions ..................................................................33  
Appendix 7: Summary of actions related to the patient clinical record .....................34  
Appendix 8: Summary of actions that require data collection for audit or review ....35  
References ...............................................................................................................37
Introduction

The ten National Safety and Quality Health Service (NSQHS) Standards were endorsed by Australian Health Ministers in 2011. They provide a clear statement about the level of care consumers can expect from health service organisations and a framework for implementing safety and quality improvements. They also play an essential part in new accreditation arrangements under the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme that will come into place from January 2013.

The introduction of the NSQHS Standards and the AHSSQA Scheme has implications for dental practices nationally, as they may be participating in accreditation of their practice for the first time.

Generally the process for private dental practices will be established as a voluntary, self-regulated scheme overseen by the Australian Dental Association Inc (ADA). However, in the ACT, licensed dental practices undertaking sedation may be required to meet the NSQHS Standards through accreditation.

A dental practice can be awarded full accreditation after demonstrating it meets Standards 1–6 of the NSQHS Standards. Standards 7–10 do not directly relate to care provided in dental practices and are therefore not required for accreditation.

This Guide has been developed by the Australian Commission on Safety and Quality in Health Care (the Commission) to assist dental practices assess their compliance with the NSQHS Standards. It primarily focuses on the process of accreditation and:

- highlights the key steps in an accreditation process
- provides examples of evidence that could be used to demonstrate the NSQHS Standards have been met
- contains resources to assist dental practices prepare for accreditation such as a list of terms and definitions often referred to throughout accreditation processes, and a decision support tool.

It is aimed at those responsible for coordinating accreditation processes. This may be a practice manager, principal dental practitioner or quality manager who is responsible for supporting improvement activity in a dental practice and collating the outcomes of these processes for accreditation.

Additional resources

This Guide should be read in conjunction with a range of other material that has been developed by the Commission. It is intended that these materials assist dental practices engage in continuous quality improvement activities and include:

- Reports, guidelines, evidence based resource documents and tools developed by the Commission that address the areas of patient care covered by the NSQHS Standards
- A list of accrediting agencies that have been approved by the Commission to assess health service organisations using the NSQHS Standards.
These resources can be accessed at the Commission’s website www.safetyandquality.gov.au.

The ADA and relevant state and territory health departments (the public sector Regulators) can also provide ongoing support for the implementation of the NSQHS Standards.

**How to use this Guide**

This Guide can be used by dental practices to review their preparedness for accreditation to NSQHS Standards and determine if there is sufficient evidence available to demonstrate systems and processes meet these requirements.

The Workbook is divided into two sections: Part A and Part B. Part A contains information about the accreditation process and detail on the following:

- Core and developmental actions
- Steps involved in the accreditation process
- Terms and definitions
- Decision support tool
- Resources to assist dental practices prepare for accreditation.

Part B contains information specific to each Standard including the criteria, items and actions. It also includes reflective questions to highlight the intent of each action and possible examples of evidence.

**Structure of the Standards**

Figure 1 illustrates how a Standard is presented in this Guide. It is set out so that each NSQHS Standard includes:

- A description of the **Standard**
- A statement of **intent** or the desired outcome for the Standard
- The **context** in which the Standard must be applied
- **Key criteria** of the Standard
- A series of **actions** relevant to each criterion
- **Reflective questions** to clarify the intent of each criterion
- Examples of **evidence**
- A column to assist dental practices identify if **further action** is required.
Standard 1: Governance for Safety and Quality in Health Service Organisations

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

The intention of this Standard is to:

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

Context

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

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

Governance and quality improvement systems

Clinical practice

Performance and skills management

Incident and complaints management

Patient rights and engagement
**Governance and quality improvement systems**

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

<table>
<thead>
<tr>
<th>Actions required</th>
<th>Reflective questions</th>
<th>Examples of Evidence - select only examples currently in use</th>
<th>Evidence available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Implementing a governance system that sets out the policies, procedures and/or protocols for:</td>
<td>How do we describe our decision-making and management processes to an outsider?</td>
<td>Policies, procedures and protocols that describe the management of patient safety and quality risks specified in Standard 1.1</td>
<td>No ⇒ further action is required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A brief statement of business structure or an organisational diagram that includes any committee structures</td>
<td>Yes ⇒ list source of evidence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relevant documentation from meetings that review policies, procedure and protocols</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>1.1.1 An organisation-wide management system is in place for the development, implementation and regular review of policies, procedures and/or protocols</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Policies, procedures and protocols that describe the management of patient safety and quality risks specified in Standard 1.1</td>
<td>Yes ⇒ list source of evidence</td>
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<td>A brief statement of business structure or an organisational diagram that includes any committee structures</td>
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<td>Relevant documentation from meetings that review policies, procedure and protocols</td>
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<td></td>
<td></td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

**Actions describe what must be done**

- unshaded are **core** and therefore must be met
- shaded are **developmental** and services need to demonstrate they are working towards implementation
- printed in faint grey text are ‘**not applicable**’

**Evidence for an action can be linked to similar actions elsewhere in this or other Standards**

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

**A health service organisation assesses the quality of the evidence in demonstrating the action is met. If there is insufficient evidence, the “No” box is there to prompt further action**
Core and developmental actions

The NSQHS Standards were written to apply to a wide variety of health service organisations. Due to variations in size, structure and complexity of health service delivery models, a degree of flexibility is required in the application of the NSQHS Standards.

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

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

100 percent of all core actions in Standards 1-6 of the NSQHS Standards need to be met by dental practices in order to achieve accreditation.

Forty eight actions have been classified as developmental for dental practices and these are listed at Appendix 1. A review of all core and developmental items will be undertaken by the Commission in 2015.

**Not applicable criterion or action**

In some circumstances a Standard, criterion or action may be rated as ‘not applicable’. Not applicable actions are those which are inappropriate in a specific service context or for which assessment would be meaningless.

There are two ways in which a criterion or action can be classified as not applicable:

1. The Commission has designated ‘not applicable’ actions for a health service by category. There are 14 actions designated ‘not applicable’ for dental practices. These are summarised at Appendix 2. For example, dental practices do not manage patients receiving blood, therefore this Standard is ‘not applicable’ and does not have to meet in order to achieve accreditation. ‘Not applicable’ actions are printed in faint grey text throughout the tables in this Guide.

2. During the accreditation process, there may be instances where an individual dental practice decides that a criterion or action is ‘not applicable’. A dental practice can apply to their accrediting agency to have either core or developmental actions considered ‘not applicable’. The process for applying for ‘not applicable’ actions is outlined in Appendix 3.
Designation of actions for dental practices

In Standards 1-6 there are 166 actions, of these:

- 104 are core
- 48 are developmental
- 14 are not applicable.

Therefore 104 actions must be fully met to meet the requirements for accreditation.

Examples of evidence

This Guide includes a list of typical examples of evidence a dental practice may generate as part of the usual business and improvement of the practice that can be used to demonstrate that the dental practice meets each of the actions required for the NSQHS Standards.

The purpose of the evidence list is to help a dental practice determine the way it can show safety and quality processes and systems are in place, that they are reviewed, evaluated and practices are changed when necessary.

The examples of evidence can be used as a checklist. However, it is important to note that this Guide does not cover all possible sources of evidence that could be used by a dental practice. Services may therefore use additional examples of evidence that are not included in the list and this can be indicated by ticking the “Other” box. Dental practices vary in size and have different structures and will have different ways of developing and presenting the evidence. For example, a large dental practice is more likely to have formal processes and committees in place and therefore have formal meeting agendas, minutes and reports, while a smaller organisation may use structured meetings rather than committees and so may use different types of records such as meeting notes, message books and issues logs.

Each dental practice should interpret the evidence listed with respect to its own model of service delivery and care.

If a dental practice finds there is insufficient evidence available to demonstrate an action has been met, the ‘No’ box in the last column of the tables in the Guide (see Figure 1) is there to prompt further action that may be required to address identified gaps.

Dental practices are not expected to have every form of evidence provided as examples. You are strongly encouraged to only use enough evidence to show actions are being addressed. The evidence used would typically come from the usual improvement and business processes of the practice rather than created specifically for accreditation.
Types of dental practices to be accredited

Private dental practices

Private dental practices will participate in accreditation largely on a voluntary basis. For these practices, the process will be established as a self-regulated scheme driven by the industry through the Australian Dental Association Inc (ADA).

Public dental practices

Accreditation to the NSQHS Standards commences after 1 January 2013. For public dental practices located within a public hospital this means that they will be assessed to all six NSQHS Standards at the scheduled time of their next recertification audit or organisational-wide accreditation visit.

At their next mid cycle review (also known as periodic review or surveillance audit) a dental practice will be assessed against:

2. their quality improvement plan, and
3. recommendations from previous accreditation assessments.

Public dental practices located in a community health service should confirm the requirement to participate in accreditation with their jurisdiction and are encouraged to enrol from 1 January 2013.
Accreditation

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

- actions are being taken
- system data and information is being used to inform activity, and
- safety and quality improvement is being achieved.

Figure 2 summarises the common processes involved in an accreditation assessment. During any accreditation cycle a dental practice may undergo periods of self assessment, comprehensive review to the NSQHS Standards, an mid cycle assessment to some NSQHS Standards as an ongoing monitoring mechanism and the awarding of an accreditation award (if all requirements of the NSQHS Standards have been met).

Enrolling in an accreditation program

By selecting an approved accrediting agency, a dental practice will be selecting the style and timing of assessment to the NSQHS Standards. Not all accrediting agencies will take the same approach. The accreditation cycle ranges from three to four years, and the frequency and style of the mid cycle assessment, periodic review or surveillance audit may vary between agencies.

Approved accrediting agencies

Only an ‘approved accrediting’ agency can assess dental practices to the NSQHS Standards. The Commission is responsible for this approval process. Accrediting agencies are required to be accredited by an internationally recognised certification body, work with the Commission to ensure the consistent application of the NSQHS Standards and to provide accreditation data to the system regulator and the Commission on accreditation outcomes.

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

Assessment and rating scale

Accrediting agencies may use their own rating scales when assessing dental practices, but will be required to use the following three point rating scale to report accreditation outcomes to the ADA, public sector regulators and the Commission:

- **Not Met** – the actions required have not been achieved.
- **Satisfactorily Met** – the actions required have been achieved
- **Met with Merit** – in addition to achieving the actions required, measures of good quality and a higher level of achievement are evident. This would mean a culture of safety, evaluation and improvement is evident throughout the dental practice in relation to the action or standard under review.
This rating system can be used to rate individual actions within a Standard and to rate the Standard overall.

**Response to non-compliance by public dental practices**

When an accrediting agency finds a public dental practice is unable to comply with the requirements of the NSQHS Standards, state and territory health departments (as Regulators) have agreed that the initial response should be for the accrediting agency to inform the dental practice and for the dental practice to take remedial action.

Dental practices will generally have 90 days from the receipt of their survey report to rectify any ‘not met’ actions before a final determination is made on an accreditation award. Where improvements are not implemented or patient risks not addressed, accrediting agencies will notify Regulators.

The exception to this may be where an accrediting agency identifies a significant or serious risk to patient safety. In these circumstances, Regulators will be informed by the accrediting agency promptly. The notification will include information about the action the dental practice and accreditation agency have agreed will occur. An initial regulatory response may begin with a process of verifying the scope, scale and implications of the reported non-compliance and gradually increases in urgency and scope if the dental practice does not rectify the patient safety risk. States and territories are in the process of describing the policy requirements for dental practices and issuing this information to dental practices.

**Response to non-compliance by private dental practices**

The ADA will provide oversight and act as a quasi–regulator of dental practice accreditation processes.

The ADA is currently working with its members to develop an appropriate system for supporting dental practices to meet the requirements of the NSQHS Standards, describe its role as regulator and the associated processes for implementing this.

**Appeals process**

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

**Accreditation awards**

Dental practices that meet the requirements in the NSQHS Standards will be issued an award by their accrediting agency specifying that it is:

‘Accredited to the National Safety and Quality Health Service Standards 1-6’.

In addition, awards will include:

- The period of accreditation (date awarded and expiry date)
- The name of the dental practice
- A description of the services covered by the award.
Where an application for ‘not applicable’ actions in addition to those already declared by the Commission has been supported by the accrediting agency, the award will indicate that there are exclusions. These exclusions will be detailed on the accrediting agency’s web site, along with details of the accreditation status of the practice.

**Data and reporting**

The accreditation model allows the ADA, public sector Regulators and the Commission to receive information from accrediting agencies on dental practice accreditation outcomes.

The Commission uses this information to review and maintain the NSQHS Standards and report to Health Ministers on the safety and quality of health care services across Australia.

The following data will be submitted to the ADA, public sector Regulators and the Commission:

- Name and description of the dental practice
- Any ‘not applicable’ or NSQHS Standards excluded from the assessment process
- Outcome of all core and development actions met, not met and met with merit, and
- May include high priority recommendations.

While the Commission has developed the AHSSQA Scheme, it will continue to collaborate with the Australian Dental Association to further develop details about implementation of the Scheme as it relates to private dental practices.
Figure 2: The accreditation process

**Enrol in Accreditation:** Enrolled dental practices can access information on processes, timing and resources available from an approved accrediting agency.

**Self Assessment:** A self-assessment may be conducted over a number of months, initially to determine the gap between the requirements of the Standards and the care provided by the dental practice, and later to assess the available evidence to demonstrate compliance with the NSQHS Standards.

**Timing:** Specified by accrediting agency.

**External Assessment:** The external assessment may be undertaken as a desk top exercise or may involve a site visit by a surveyor. The collated evidence is reviewed to determine if the actions required in the NSQHS Standard have been met.

**Timing:** Specified by accrediting agency.

**Report on Assessment:** Following assessment, the accrediting agency will provide a written report of their assessment. It specifies met and not met actions, and may provide recommendations for improvement.

**Timing:** Specified by accrediting agency, generally one week from external assessment.

**Actions met:** Accreditation awarded.

**Timing:** Period of accreditation specified by accrediting agency, generally 3 to 4 years.

**Actions NOT met:** Practices implement quality improvement strategies to address not met actions and provides accrediting agency with evidence on actions met.

**Timing:** 90 days from written notification (120 days during 2015)

**Mid cycle assessment:** Confirmation of continuing improvement via assessment of Standards 1-3, progress against quality improvement plan and recommendations from previous assessment.

**Timing:** Specified by accrediting agency.

**Re-assessment:** Evidence of improvement provided by practice to accrediting agency.

**Actions met:** Accreditation awarded.

**Timing:** Generally 3-4 years.

**Actions NOT met:** Quality improvement and self-assessment processes recommended. If issues are unresolved, ADA or public sector regulators are informed.

**Timing:** On notification.
Resources in the Guide

A major focus of the Commission’s work is to support health service organisations implement the NSQHS Standards. This Guide contains a number of tools to assist dental practices prepare for accreditation. These include:

- **Terms and definitions** – contains an explanation of key terms often referred to throughout the accreditation process.

- **Decision support tool** – this can be used as a guide in making an assessment of evidence against each Action. It is at Appendix 4.

- **Summary of actions for policies, protocols and procedures** – many of the NSQHS Standards include a requirement to establish a process for developing, reviewing and updating policies, procedures and protocols. These are summarised at Appendix 5.

- **Summary of actions for training** – Appendix 6 will assist health services identify which NSQHS Standards require the workforce to participate in education and training activity.

- **Summary of actions related to the patient clinical record** – This is at Appendix 7.

- **Summary of actions that require data collection for audit or review** – auditing and review are key elements in many of the NSQHS Standards. They are listed in Appendix 8.

Many of these resources can be downloaded in an electronic format from the Commission’s website at [www.safetyandquality.gov.au](http://www.safetyandquality.gov.au).
Terms and Definitions

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

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

**Antibiotic**: A substance that kills or inhibits the growth of bacteria. 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.
Audit: A systematic review of clinical care against a pre-determined set of criteria.73

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. 8

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. 9 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).10

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.11

Clinical handover: Is 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 basis83. See Transfer of Care.

Clinical handover will vary depending on the size of the health service organisation, setting and circumstances, including:

- The situation of the handover, such as:
  - during a shift change
  - when patients are transferred inter and intra hospital or dental service
  - on presentation of care, at referral or discharge
  - transfer of a patient for a medical emergency (a deteriorating patient)

- The method of the handover, such as:
  - face-to-face
  - via telephone
  - in writing
  - when aided by electronic handover tools or systems

- The venue where handover takes place, such as:
  - at the patient’s chair-side or bedside
  - in a common staff area
  - at the practice’s reception
Clinical handover solutions must be standardised and fit for local purpose and appropriate to the clinical context in which handover occurs.

- **Structured handover:** That the minimum data set (information content) and conduct of handover be delivered in a structured format.

- **Minimum data set:** The minimum set of information content that must be contained and transferred in a particular type of clinical handover. There are many possible minimum data sets which will vary depending on the context and reason for handover.

**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. In a dental practice this may include dental practitioners and others such as dental assistants who expose radiographs or undertake other extended duties at the direction of a dental practitioner.

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

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

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

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

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

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

**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.4

**Continuous improvement:** A systematic, ongoing effort to raise an organisation’s performance as measured against a set of standards or indicators. 16

**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.76

**Dental Practitioner:** This include dentists, dental hygienists, dental prosthetists, dental therapists and oral health therapists.77

**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.6

**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. 3

**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

**Evaluation:** A systematic analysis of the merit, worth or significance of an object, system or program.73

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

**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.²⁹

**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 and dental practices.

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

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

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.

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 devises are medical devises that are labeled by the original manufacture as ‘single use’ and are only intended to be used once.

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

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

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

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

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.

Medication incident: See Adverse medicines event.

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

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

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

**Medicine:** A chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental welfare of people. Prescription, non-prescription and complementary medicines, irrespective of their administration route, are included.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). Organisations may elect to include
other forms of patient care mismatching (e.g. provision of an incorrect meal resulting
in an adverse event) in their reporting however these should be recorded separately.\textsuperscript{81}

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

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

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

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

- optimisation of blood volume and red cell mass
- minimisation of blood loss
- optimisation of the patient’s tolerance of anaemia.\textsuperscript{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.\textsuperscript{30}

**Patient/procedure matching protocols:** Protocols that provide guidance regarding
the steps that should be taken to correctly match patients to their intended care.\textsuperscript{81}

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

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

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

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

**Prescription medicine:** A prescription medicine is any medicine that requires a
prescription before it can be supplied. A prescription must be authorised by an
appropriately registered practitioner.\textsuperscript{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.

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

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

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

**Scope of clinical practice**: The extent of an individual practitioner’s approved clinical practice within a particular health service organisation based on the individual’s credentials, competence, performance and professional suitability and the needs and capability of the health service organization.⁷⁶

**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.

**Single use**: Single use means the medical device is intended to be used on an individual patient during a single procedure and then discarded. It is not intended to be reprocessed and used on another patient. Some single-use devices are marketed as non-sterile which require processing to make them sterile and ready for use. The manufacture of the device will include appropriate processing instructions to make it ready for use.⁸⁰

**Spaulding classification**: Strategy for reprocessing contaminated medical devices. The system classifies a medical device as critical, semicritical, or noncritical on the basis of risk to patient safety from contamination on a device. The system also established three levels of germicidal activity (sterilisation, high-level disinfection, and
low-level disinfection) for strategies with the three classes of medical devices (critical, semicritical, and noncritical).82

**Standardisation of the handover process:** Organisations have standardised processes, policies and procedures for the organisation of handover. This includes that the conduct and information content of handover be delivered in a structured format to improve patient safety. Standardised processes of handover can help clarify the purpose and content of handovers and reduce confusion. This approach needs to be easy to use so it can be easily taught and recalled. The Standardisation of the handover process does not mean that all handovers will be the same in all settings. Rather, they should be designed to fit the local context and clinical setting of the health service organisation and the situation of the handover.83

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

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

**Tall Man Lettering:** Tall Man lettering uses a combination of lower and upper case letters to highlight the differences between “look-alike” “sounds alike” drug names, like fluOXETine and fluVOXAMine, helping to make them more easily distinguishable. Tall Man lettering reduces error by warning health care professionals about the risk of confusing a particular medicine name and by helping health professionals to select the right product in electronic systems or from shelves.82

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

**Transfer of care:** Any instance where the responsibility for care of a patient passes from one individual or team to another. This includes nursing and medical change of shift, transfer of to another medical officer or primary care practitioner and transfer of a patient to another health facility.81

**Transmission-based precautions:** Extra work practices in situations where standard precautions alone may be insufficient to prevent infection (e.g. for patients known or suspected to infected or colonised with infectious agents that may not be contained with standard precautions along).80

**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’.3

**Workforce:** All those people employed by a health service organisation. In a dental practice this may include team members.
## Appendix 1: Developmental actions for Dental Practices

<table>
<thead>
<tr>
<th>Standard</th>
<th>Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance for Safety and Quality in Health Service Organisations</td>
<td>1.2.2</td>
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<tr>
<td></td>
<td>1.4.1</td>
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<tr>
<td></td>
<td>1.4.2</td>
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<td>1.4.3</td>
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<td>1.4.4</td>
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<tr>
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<td>1.13.1</td>
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<td>1.13.2</td>
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<td>1.16.2</td>
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<tr>
<td></td>
<td>1.17.3</td>
</tr>
<tr>
<td>Partnering with Consumers</td>
<td>2.1.1</td>
</tr>
<tr>
<td></td>
<td>2.1.2</td>
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<td>2.8.1</td>
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<td>2.9.1</td>
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<tr>
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<td>2.9.2</td>
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<tr>
<td>Preventing and Controlling Healthcare Associated Infections</td>
<td>3.1.4</td>
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<tr>
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<td>3.4.1</td>
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<td></td>
<td>3.19.2</td>
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<tr>
<td>Medication Safety</td>
<td>4.5.1</td>
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<tr>
<td></td>
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<td></td>
<td>4.8.1</td>
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<td></td>
<td>4.13.1</td>
</tr>
<tr>
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<td>4.13.2</td>
</tr>
<tr>
<td>Patient Identification and Procedure Matching</td>
<td>Nil</td>
</tr>
<tr>
<td>Clinical Handover</td>
<td>6.2.1</td>
</tr>
<tr>
<td></td>
<td>6.3.1</td>
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<tr>
<td></td>
<td>6.3.3</td>
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<td>6.4.2</td>
</tr>
<tr>
<td></td>
<td>6.5.1</td>
</tr>
<tr>
<td>Blood and Blood Products</td>
<td>N/A</td>
</tr>
<tr>
<td>Preventing and Managing Pressure Injuries</td>
<td>N/A</td>
</tr>
<tr>
<td>Recognizing and Responding to Clinical Deterioration in Acute Health Care</td>
<td>N/A</td>
</tr>
<tr>
<td>Preventing fall and Harm from Falls</td>
<td>N/A</td>
</tr>
<tr>
<td>Total number of developmental actions</td>
<td>48*</td>
</tr>
</tbody>
</table>

*Note: Dental practices are only required to meet all core actions in Standards 1-6 for accreditation.
Appendix 2: Non-applicable actions for Dental Practices

<table>
<thead>
<tr>
<th>Health Service Type</th>
<th>Definition</th>
<th>Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental practices participating in mandatory accreditation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Public Dental Practice</strong></td>
<td>Practice providing dental care including minor surgery under local anaesthetic or sedation</td>
<td>The following items are not applicable: 1.18.3 1.18.4</td>
</tr>
<tr>
<td>Dental practices participating in voluntary accreditation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Private Dental Practice</strong></td>
<td>Practice providing dental care including minor surgery under local anaesthetic or sedation</td>
<td>The following items are not applicable: 1.18.3 1.18.4</td>
</tr>
</tbody>
</table>

*Note: Dental practices are only required to meet all core actions in Standards 1-6 for accreditation.*
Appendix 3: Steps in applying for ‘not applicable’ actions

If a dental practice feels that a Standard or action is ‘not applicable’ to their service, it can apply to their accrediting agency to have either core or developmental actions considered as not applicable according to the following process.

<table>
<thead>
<tr>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>A health service organisation assesses an action as 'not applicable' and applies to the accrediting agency by providing evidence or arguments for the action to be rated as not applicable.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment</th>
</tr>
</thead>
</table>
| Assessment of submissions for ‘not applicable’ actions by the accrediting agency will be against the following criteria:

- 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 or wrist bands.
- The health service organisation demonstrates an action, criteria or standard has limited applicability to the services it provides. For example, Standard 9 ‘Recognising and responding to clinical deterioration’ is not applicable in a 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. |

<table>
<thead>
<tr>
<th>Confirmation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The accrediting agency confirms with the health service organisation, surveyor and regulator that an action is ‘not applicable’ for the purpose of accreditation of that facility based on the evidence, context and precedence.</td>
</tr>
<tr>
<td>A health service can appeal any decision with their accrediting agency, which will have their own appeals process.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Notification</th>
</tr>
</thead>
</table>
| All actions that are confirmed as ‘not applicable’ and the basis for the decision is provided to the Commission, as the national coordinator, to determine national trends with a view to:

- clarifying the requirements of the action
- providing additional tools and resources for health services to met a Standard
- making amendment to the Guides
- considering amendments to the NSQHS Standards. |
| This information will only apply within the context of a national review on the applicability of the criteria in health service organisation. |
Appendix 4: Decision Support Tool for determining the level of performance to meet the NSQHS Standards

This decision support tool has been developed as general guidance for health services undertaking self assessment. It is designed to be read in conjunction with the ten, standards specific Safety and Quality Improvement Guides developed by the Commission.

<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 knows the documents exist, can access them, and know and use the contents  
 • Include the tools, forms and processes refaced 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 | • 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
<table>
<thead>
<tr>
<th>Issue</th>
<th>Satisfactory Performance</th>
<th>Unsatisfactory Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>service</td>
<td>organisational priority or risk</td>
</tr>
<tr>
<td></td>
<td>• Action outcomes will inform future improvement plans across the health service or target specific risks</td>
<td>• Significant delays exist between the identification of an issue and 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>
</tr>
<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 workforce 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>
</tr>
<tr>
<td></td>
<td>• The risks are reviewed on a regular basis, and/or</td>
<td></td>
</tr>
<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>
<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>• Reviewed data is not representative of all areas where the issue occurs</td>
</tr>
<tr>
<td></td>
<td>• May be peer reviewed, and/or</td>
<td>• The review inappropriately excludes consumers</td>
</tr>
<tr>
<td></td>
<td>• Where possible or appropriate, are consistent with national specifications or standards.</td>
<td></td>
</tr>
<tr>
<td>Issue</td>
<td>Satisfactory Performance</td>
<td>Unsatisfactory Performance</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</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 processes and procedures for each Standard | • Workforce are not aware of the processes/systems, and/or  
  • Processes/systems are cumbersome and/or not adhered to |
| Communication         | • Format of communication (for example email, posters or website updates) is appropriate to the purpose  
  • Language is clear and concise  
  • Workforce is 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 is 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 |

**Met with Merit:**

For an action to be assessed as ‘met with merit’ it is expected that the health service would be able to demonstrate that:

- all of the requirements of satisfactory performance were met and  
- this performances was reflected across all relevant area of the organisation and  
- this level of performance was sustainable and  
- the programs, strategies or changes are built into day to day operations of the organisation and  
- performance reflects the safety and quality culture in the organisation and  
- mechanisms were in place to evaluate the effectiveness of programs, strategies or changes implemented.
Appendix 5: Summary of actions for policies, protocols and procedures

An overarching requirement of the NSQHS Standards is to establish a process for reviewing and updating policies, protocols and procedures. The table below will assist health service organisations to identify criteria and actions relating to policies, protocols and procedures.

**KEY: C= Core action  D= Developmental action**

<table>
<thead>
<tr>
<th>This criterion will be achieved by:</th>
<th>Actions required:</th>
<th>C/D</th>
</tr>
</thead>
</table>
| 1.1 Implementing a governance system that sets out the policies, procedures and/or protocols for:  
- establishing and maintaining a clinical governance framework  
- identifying safety and quality risks  
- collecting and reviewing performance data  
- implementing prevention strategies based on data analysis  
- analysing reported incidents  
- implementing performance management procedures  
- ensuring compliance with legislative requirements and relevant industry standards  
- communicating with and informing the clinical and non-clinical workforce  
- undertaking regular clinical audits | 1.1.1 An organisation-wide management system is in place for the development, implementation and regular review of policies, procedures and/or protocols | 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 | C |
| 2.2 Implementing policies, procedures and/or protocols for partnering with patients, carers and consumers in:  
- strategic and operational/services planning  
- decision making about safety and quality initiatives  
- quality improvement activities | 2.2.1 The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation | D |
| 3.1 Developing and implementing governance systems for effective infection prevention and control to minimise the risk to patients of healthcare associated infections | 3.1.1 A risk management approach is taken when implementing policies, procedures and/or protocols for:  
- standard infection control precautions  
- transmission-based precautions  
- aseptic 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 communicable infection | |
<table>
<thead>
<tr>
<th>This criterion will be achieved by:</th>
<th>Actions required:</th>
<th>C/D</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>● processing of reusable medical devices</td>
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<td></td>
<td>● single-use devices</td>
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<td></td>
<td>● surveillance and reporting of data where relevant</td>
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<tr>
<td></td>
<td>● reporting of communicable and notifiable diseases</td>
<td></td>
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<tr>
<td></td>
<td>● provision of risk assessment guidelines to workforce</td>
<td></td>
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<tr>
<td></td>
<td>● exposure-prone procedures</td>
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<tr>
<td>3.1.2 The use of policies, procedures and/or protocols is regularly monitored</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>3.1.4 Action is taken to improve the effectiveness of infection prevention and control policies, procedures and/or protocols</td>
<td></td>
<td>D</td>
</tr>
<tr>
<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 being implemented to address:</td>
<td>C</td>
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<tr>
<td></td>
<td>● communicable disease status</td>
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<td></td>
<td>● occupational management and prophylaxis</td>
<td></td>
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<td></td>
<td>● work restrictions</td>
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<td></td>
<td>● personal protective equipment</td>
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<tr>
<td></td>
<td>● assessment of risk to healthcare workers for occupational allergy</td>
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<tr>
<td></td>
<td>● evaluation of new products and procedures</td>
<td></td>
</tr>
<tr>
<td>3.13 Developing and implementing protocols relating to the admission, receipt and transfer of patients with an infection</td>
<td>3.13.1 Mechanisms are in use to check for pre-existing healthcare associated infection or communicable disease on presentation for care</td>
<td>C</td>
</tr>
<tr>
<td>3.15 Using risk management principles to implement systems that maintain a clean and hygienic environment for patients and healthcare workers</td>
<td>3.15.1 Policies, procedures and/or protocols for environmental cleaning that address the principles of infection prevention and control are implemented, including:</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>● maintenance of building facilities</td>
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<tr>
<td></td>
<td>● cleaning resources and services</td>
<td></td>
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<tr>
<td></td>
<td>● risk assessment for cleaning and disinfection based on transmission-based precautions and the infectious agent involved</td>
<td></td>
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<tr>
<td></td>
<td>● waste management within the clinical environment</td>
<td></td>
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<tr>
<td></td>
<td>● laundry and linen transportation, cleaning and storage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● appropriate use of personal protective equipment</td>
<td></td>
</tr>
<tr>
<td>3.15.2 Policies, procedures and/or protocols for environmental cleaning are regularly reviewed</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>This criterion will be achieved by:</td>
<td>Actions required:</td>
<td>C/D</td>
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<tr>
<td>---------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<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>4.1.2 Policies, procedures and/or protocols are in place that are consistent with legislative requirements, national, jurisdictional and professional guidelines</td>
<td>C</td>
</tr>
<tr>
<td>5.1 Developing, implementing and regularly reviewing the effectiveness of a patient identification system including the associated policies, procedures and/or protocols that:</td>
<td>5.1.1 Use of an organisation-wide patient identification system is regularly monitored</td>
<td>C</td>
</tr>
<tr>
<td>• define approved patient identifiers</td>
<td></td>
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<tr>
<td>• require at least three approved patient identifiers on registration or admission</td>
<td></td>
<td></td>
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<tr>
<td>• require at least three approved patient identifiers when care, therapy or other services are provided</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• require at least three approved patient identifiers whenever clinical handover, patient transfer or discharge documentation is generated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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</td>
<td>5.5.1 A documented process to match patients and their intended treatment is in use</td>
<td>C</td>
</tr>
<tr>
<td>6.1 Developing and implementing an organisational system for structured clinical handover that is relevant to the healthcare setting and specialities, including:</td>
<td>6.1.1 Clinical handover policies, procedures and/or protocols are used by the workforce and regularly monitored</td>
<td>C</td>
</tr>
<tr>
<td>• documented policy, procedures and/or protocols</td>
<td>6.1.2 Action is taken to maximise the effectiveness of clinical handover policies, procedures and/or protocols</td>
<td></td>
</tr>
<tr>
<td>• agreed tools and guides</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.2 Establishing and maintaining structured and documented processes for clinical handover</td>
<td>6.2.1 The workforce has access to documented structured processes for clinical handover that include:</td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>• preparing for handover, including setting the location and time whilst maintaining continuity of patient care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• organising relevant workforce members to participate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• being aware of the clinical context and patient needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• participating in effective handover resulting in transfer of responsibility and accountability for care</td>
<td></td>
</tr>
</tbody>
</table>
# Appendix 6: Summary of training actions

The table below will assist health service organisations identify which NSQHS Standards require the team to participate in education and training.

**KEY: C= Core action  D= Developmental action**

<table>
<thead>
<tr>
<th>This criterion will be achieved by:</th>
<th>Actions required:</th>
<th>C/D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4 Implementing training in the assigned safety and quality roles and responsibilities</td>
<td>1.4.1 Orientation and ongoing training programs provide the workforce with the skill and information needed to fulfil their safety and quality roles and responsibilities</td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>1.4.2 Annual mandatory training programs to meet the requirements of these Standards</td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>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</td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>1.4.4 Competency-based training is provided to the clinical workforce to improve safety and quality</td>
<td>D</td>
</tr>
<tr>
<td>1.12 Ensuring that systems are in place for ongoing safety and quality education and training</td>
<td>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</td>
<td>C</td>
</tr>
<tr>
<td>1.16 Implementing an open disclosure process based on the national open disclosure standard</td>
<td>1.16.2 The clinical workforce are trained in open disclosure processes</td>
<td>D</td>
</tr>
<tr>
<td>2.3 Facilitating access to relevant orientation and training for consumers and/or carers partnering with the organisation</td>
<td>2.3.1 Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role</td>
<td>D</td>
</tr>
<tr>
<td>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</td>
<td>2.6.1 Clinical leaders, senior managers and the workforce access training on patient-centred care and the engagement of individuals in their care</td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>2.6.2 Consumers and/or carers are involved in training the clinical workforce</td>
<td>D</td>
</tr>
<tr>
<td>3.9 Implementing protocols for invasive device procedures regularly performed within the organisation</td>
<td>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</td>
<td>D</td>
</tr>
<tr>
<td>3.10 Developing and implementing protocols for aseptic non-touch technique</td>
<td>3.10.1 The clinical workforce is trained in aseptic non-touch technique</td>
<td>D</td>
</tr>
<tr>
<td>3.18 Ensuring workforce who decontaminate reusable medical devices undertake competency-based training in these practices</td>
<td>3.18.1 Action is taken to maximise coverage of the relevant workforce trained in a competency-based program to decontaminate reusable medical devices</td>
<td>D</td>
</tr>
</tbody>
</table>
Appendix 7: Summary of actions related to the patient clinical record

The table below will assist health service organisations to identify criteria and actions relating to patient clinical records.

**KEY:** C = Core action  D = Developmental action  N/A Not applicable

<table>
<thead>
<tr>
<th>This criterion will be achieved by:</th>
<th>Actions required:</th>
<th>C/D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.9 Using an integrated patient clinical record that identifies all aspects of the patient's care</td>
<td>1.9.1 Accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point of care</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>1.9.2 The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards</td>
<td>C</td>
</tr>
<tr>
<td>1.18 Implementing processes to enable partnership with patients in decision about their care, including informed consent to treatment</td>
<td>1.18.2 Mechanisms are in place to monitor and improve documentation of informed consent</td>
<td>C</td>
</tr>
<tr>
<td>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</td>
<td>4.6.1 A best possible medication history is documented for each patient</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>4.7.1 Known medication allergies and adverse drug reactions are documented in the patient clinical record</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>4.8.1 Current medicines are documented and reconciled at admission and transfer of care between healthcare settings</td>
<td>D</td>
</tr>
<tr>
<td>4.14 Developing a medication management plan in partnership with patients and carers</td>
<td>4.14.1 An agreed medication management plan is documented and available in the patient’s clinical record</td>
<td>N/A</td>
</tr>
</tbody>
</table>
**Appendix 8: Summary of actions that require data collection for audit or review**

The table below identifies which of the NSQHS Standards require clinical audits to be undertaken by health service organisations.

*KEY: C= Core action  D= Developmental action  N/A Not applicable*

<table>
<thead>
<tr>
<th>This criterion will be achieved by</th>
<th>Actions required:</th>
<th>C/D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.7 Developing and/or applying clinical guidelines or pathways that are supported by the best available evidence</td>
<td>1.7.1 Agreed and documented clinical guidelines and/or pathways are available to the clinical workforce</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>1.7.2 The use of agreed clinical guidelines by the clinical workforce is monitored</td>
<td>C</td>
</tr>
<tr>
<td>1.10 Implementing a system that determines and regularly reviews the roles, responsibilities, accountabilities and scope of practice for the clinical workforce</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>C</td>
</tr>
<tr>
<td>1.18 Implementing processes to enable partnership with patients in decision about their care, including informed consent to treatment</td>
<td>1.18.2 Mechanisms are in place to monitor and improve documentation of informed consent</td>
<td>C</td>
</tr>
<tr>
<td>3.5 Developing, implementing and auditing a hand hygiene program consistent with the current national hand hygiene initiative</td>
<td>3.5.1 Workforce compliance with current national hand hygiene guidelines is regularly audited</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>3.10.2 Compliance with aseptic non-touch technique is regularly audited</td>
<td>D</td>
</tr>
<tr>
<td>3.11 Implementing systems for using standard precautions and transmission-based precautions</td>
<td>3.11.2 Compliance with standard precautions is monitored</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>3.11.4 Compliance with transmission-based precautions is monitored</td>
<td>C</td>
</tr>
<tr>
<td>3.14 Developing, implementing and regularly reviewing the effectiveness of the antimicrobial stewardship system</td>
<td>3.14.3 Monitoring of antimicrobial usage and resistance is undertaken</td>
<td>N/A</td>
</tr>
<tr>
<td>3.15 Using risk management principles to implement systems that maintain a clean and hygienic environment for patients and healthcare workers</td>
<td>3.15.3 An established environmental cleaning schedule is in place and environmental cleaning audits are undertaken regularly</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>3.17.1 A traceability system that identifies patients who have a procedure using sterile reusable medical instruments and devices is in place</td>
<td>D</td>
</tr>
<tr>
<td>4.2 Undertaking a regular, comprehensive assessment of medication use systems to identify risks to patient safety and implementing system changes to address the identified risks</td>
<td>4.2.1 The medication management system is regularly assessed</td>
<td>C</td>
</tr>
<tr>
<td>4.3 Authorising the relevant clinical workforce to prescribe, dispense and administer medications</td>
<td>4.3.2 The use of the medication authorisation system is regularly monitored</td>
<td>C</td>
</tr>
<tr>
<td>4.4 Using a robust organisation-wide system of reporting, investigating and managing change to respond to medication incidents</td>
<td>4.4.1 Medication incidents are regularly monitored, reported and investigated</td>
<td>C</td>
</tr>
<tr>
<td>This criterion will be achieved by:</td>
<td>Actions required:</td>
<td>C/D</td>
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<tr>
<td>----------------------------------</td>
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<td>-----</td>
</tr>
<tr>
<td>4.7 The clinical workforce documenting the patient’s previously known adverse drug reactions on initial presentation and updating this if an adverse reaction to a medicine occurs during the episode of care</td>
<td>4.7.3 Adverse drug reactions are reported within the organisation and to the Therapeutic Goods Administration</td>
<td>C</td>
</tr>
<tr>
<td>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</td>
<td>4.9.1 Information and decision support tools for medicines are available to the clinical workforce at the point of care</td>
<td>C</td>
</tr>
<tr>
<td>4.9.2 The use of the information and decision support tools are regularly reviewed</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>4.10.1 Risks associated with secure storage and safe distribution of medicines are regularly reviewed</td>
<td>C</td>
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<tr>
<td>4.10.3 The storage of temperature-sensitive medicines is monitored</td>
<td>N/A</td>
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<tr>
<td>4.10.5 The system for disposal of unused, unwanted or expired medications is routinely monitored</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>4.11.1 The risks for storing, prescribing, dispensing and administration of high-risk medicines are regularly reviewed</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>5.2 Implementing a robust organisation-wide system of reporting, investigation and change management to respond to any patient care mismatching events</td>
<td>5.2.1 The system for reporting, investigating and analysis of patient care mismatching events is regularly monitored</td>
<td>C</td>
</tr>
<tr>
<td>5.4 Developing, implementing and regularly reviewing the effectiveness of the patient identification and matching system at patient handover, transfer and discharge</td>
<td>5.4.1 A patient identification and matching system is implemented and regularly reviewed as part of structured clinical handover, transfer and discharge processes</td>
<td>C</td>
</tr>
<tr>
<td>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</td>
<td>5.5.2 The process to match patients to any intended procedure, treatment or investigation is regularly monitored</td>
<td>C</td>
</tr>
<tr>
<td>6.3 Monitoring and evaluating the agreed structured clinical handover processes, including:</td>
<td>6.3.1 Regular evaluation and monitoring processes for clinical handover are in place</td>
<td>D</td>
</tr>
<tr>
<td>• regularly reviewing local processes based on current best practice in collaboration with clinicians, patients and carers</td>
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<tr>
<td>• undertaking quality improvement activities and acting on issues identified from clinical handover reviews</td>
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<tr>
<td>• reporting the results of clinical handover reviews at executive level of governance</td>
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<td></td>
</tr>
<tr>
<td>6.4 Implementing a robust organisation-wide system of reporting, investigation and change management to respond to any clinical handover incidents</td>
<td>6.4.1 Regular reporting, investigating and monitoring of clinical handover incidents is in place</td>
<td>D</td>
</tr>
</tbody>
</table>
References


78. AS/NZS 4187: Cleaning, Disinfecting and Sterilizing Reusable Medical and Surgical Instruments and Equipment, and Maintenance of Associated Environments in Health Care Facilities.

79. AS/NZS 4815: Office-based healthcare facilities-Reprocessing of reusable medical and surgical instruments and equipment, and maintenance of the associated environment.

