

Clinical Governance Maturity Matrix (CGMM)

Glossary and Master Reference List

OFFICIAL

Glossary

Term	Definition
Adverse patient safety event	An incident that results, or could have resulted, in harm to a patient or consumer. A near miss is a type of adverse event. (SAPSE and sentinel event are a subset of APSE).
Attestation	A formal declaration or confirmation that information, processes, or outcomes are accurate, complete, and compliant with relevant or standards. It involves senior leaders signing off on reports, assessments, or documents to verify accountability and transparency.
Capability	The collective skills, knowledge, systems, and resources that enable an organisation or workforce to effectively deliver safe, high-quality care. Capability encompasses individual competencies as well as organisational structures and processes that support performance and continuous improvement ¹ .
Clinical governance	Clinical governance refers to the integrated systems, processes, leadership, and culture that are at the core of providing safe, timely, effective, efficient, equitable and person-centred care underpinned by continuous improvement. This applies to all care settings ¹ .
Clinical triage	The process of assessing and prioritising patients based on the urgency of their clinical condition to ensure timely and appropriate care.
Clinician credentialling	The formal process used by health services to verify that clinicians have the necessary qualifications, training registration, and experience to deliver safe, high-quality care. It ensures clinicians work within their defined scope of practice and is regularly reviewed as part of clinical governance ¹² .
Co-design	Co-design brings consumers and stakeholders together to design new products, systems, services, and policies.
Consumer	The term 'consumers' is inclusive and refers to patients, residents, clients, families, supporters, those with lived and living experience, carers, advocates, representatives, volunteers, and communities who may be past, current, or potential users of the service ¹ .
Continuous improvement	Organisational process that engages all team members in planning and implementing ongoing improvement strategies and practices.
Control	The word 'control' is simply a term that means 'ways to manage an issue.' Controls are things you can put in place to eliminate and reduce risks ³ .

¹ Australian Commission on Safety and Quality in Health Care, *NSQHS Standards – 2nd Edition, Standard 1.24*.

² Department of Health, Victoria, *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian public health services – Policy*.

³ WorkSafe Victoria, *Controlling hazards and risks in the workplace*.

Cultural awareness	Being aware of, and developing sensitivity to, cultural difference and cultural diversity ⁴ .
Cultural capability	Encompasses cultural awareness, cultural safety, and cultural competence ⁵ .
Cultural safety	Cultural safety is an environment which is safe for Aboriginal and/or Torres Strait Islander people, where there is no assault, challenge or denial of their identity and experience ⁵ .
Data	Raw facts, figures, and information collected from various sources that can be analysed to inform decision-making, monitor performance, and support clinical governance. In healthcare, data includes clinical outcomes, patient feedback, incident reports, and workforce statistics that underpin quality improvement and risk management activities ¹ .
Diversity	Diversity is our individual differences, perspectives, knowledge, and skills. It can include gender, disability, age, sexual identity, intersex status, language, ethnicity, cultural background, religious beliefs, and family responsibilities, as well as differences between individuals in life and personality ⁵ .
Employee /staff	All people engaged or employed by the organisation to fulfil specific roles and functions. This includes senior medical officers and visiting medical officers.
Employee wellbeing	Relates to all aspects of work life. It includes your workers' physical and psychological safety, workload, how their work is designed and organised, support from leaders and peers, and more. When you get it right, you create an environment that fosters meaning, purpose and belonging where workers are safe, healthy, satisfied and engaged ⁶ .
Escalation	The process of promptly communicating and referring issues, concerns, or risks to a higher level of authority when they cannot be resolved at the current level, require urgent attention, or pose significant safety or quality risks. Escalation ensures that critical incidents, emerging risks, or deteriorating patient conditions are addressed by the appropriate leaders or clinical experts without delay ¹ .
Feedback	Structured mechanisms and processes designed to capture insights, opinions, and experiences of consumers, communities, and employees regarding aspects of care, health service and employment environment and experience.
Framework	A structured set of principles, standards, or guidelines designed to support consistent and effective practice within a specific area. In clinical governance, a framework outlines the essential elements, roles, and responsibilities needed to ensure safe, high-quality care and continuous improvement ⁷ .
Hazard	A hazard is something that can cause harm ⁴ .
Health literacy	Health literacy is about how people understand information about health and health care, how they apply that information to their lives, use it to make decisions and act on it ⁸ .
Health workforce	All people working in a health service organisation, including clinicians and any other employed or contracted locum, agency, student, volunteer, or peer workers. The workforce can be members of the health service organisation or medical company representatives

⁴ Victorian Public Sector Commission, *Improving cultural competency of National Safety and Quality Health Service Standards – Action 1.21*.

⁵ WorkSafe Victoria, *WorkWell Toolkit – Diversity and Inclusion*.

⁶ Safer Care Victoria, *Victorian Safety Culture Guide*.

⁷ Murray PHN, *Desktop Guide to Clinical Governance*.

⁸ Australian Commission on Safety and Quality in Health Care, *Health Literacy*.

	providing technical support who have assigned roles and responsibilities for care of, administration of, support of, or involvement with, patients in the health service organisation.
High quality care	The elements of high-quality care are safe, timely, effective, efficient, equitable and person-centred.
Human factors	Human factors (or ergonomics) are concerned with the understanding of interactions among humans and other elements of a system to optimise human well-being and overall system performance ⁹ .
Inclusion	Inclusion in the workplace happens when everyone is valued and respected, has equal access to opportunities and resources, and has a say in decision making. Inclusive workplaces are ones where people feel a sense of belonging and have a shared sense of purpose. They are places where people feel they can contribute their perspectives and talents, and experience reward and recognition for their efforts ⁴ .
Integrated care	Provision of well-connected, effective, and efficient care that takes account of and is organised around a person's health and social needs ¹⁰ .
Key Performance indicators	Quantifiable measures used to evaluate the effectiveness, efficiency, and quality of processes or outcomes within an organisation. In clinical governance, KPIs help monitor progress against strategic goals, identify areas for improvement, and support accountability for delivering safe, high-quality care.
Key risk indicators	Quantitative or qualitative metrics used to signal increasing risk exposure and monitor trends to trigger interventions.
Leadership and culture	The combined influence of organisational leaders' behaviours and the shared values, beliefs, and norms within a workplace that shape how care is delivered and how safety and quality are prioritised. Strong leadership and a positive culture are critical enablers of effective clinical governance and continuous improvement.
Local Health Service Networks	A group Victorian health services within a geographical region and are responsible for supporting collaborative care for their community, as close to home as possible ¹¹ .
Models of care	The way in which a health service is delivered, including the process of care as well as the health care professionals or skills required to deliver the care.
Multidisciplinary teams	Multidisciplinary teams bring together the expertise and skills of different workforces, roles, and professionals (including those with lived and living experience). For the purposes of this framework, a multidisciplinary team is one that involves diverse expertise, and in which all expertise is valued, to provide care, support, and treatment collaboratively and compassionately ¹² .
Occupation violence and aggression	Any incident, irrespective of the intent or harm, where an employee is verbally, physically, or psychologically abused, harassed, or threatened by a patient, resident, or client, another employee or member of the public.
Open disclosure	A formal, transparent process for communicating with patients, their families, and carers when an incident results in harm during healthcare. It involves acknowledging the incident, explaining what happened, describing the steps being taken to manage the situation, and

⁹ International Ergonomics Association, *what is ergonomics (HFE)?*

¹⁰ Victorian Department of Health, *Integrated Care*.

¹¹ Victorian Department of Health, *Local Health Service Networks*

¹² Victorian Department of Health, *Our workforce, our future: A capability framework for the mental health and wellbeing workforce*.

	outlining how the organisation will prevent similar events in the future. Open disclosure supports trust, accountability, and continuous improvement in care quality ¹³ .
Organisational culture	The shared values, customs, and behaviours that shape how an organisation operates, treats its employees, serves its customers, evaluates its leaders, and measures performance. Culture is the expression of the organisation's values, norms, and behaviours. A common interpretation of culture is "the way things are done around here".
Partnering with consumers	The collaborative and inclusive relationship between health professionals, consumers, families, carers, and communities that enables better health outcomes and a more efficient and effective health system. It is based on how different people's knowledge and insights can come together through collaboration, inclusion, and engagement. It is not only an exchange of knowledge and information, but a process through which new knowledge and strategies are cocreated for better outcomes and impact.
Patient reported experience measures	Information collected from consumers about their experience of the care they received from service providers and the outcomes achieved.
Patient reported outcome measures	Information collected from patients which captures their perception of their own health through questionnaires. PROMs enable patients to report on their quality of life, daily functioning, symptoms, and other aspects of their health and well-being.
Peer	A peer is someone who shares the same status, skills or other attribute or position ¹¹ .
Psychological safety	A shared belief that it is safe to speak up, offer ideas, ask questions, or raise concerns without fear of humiliation or negative consequences. It supports staff wellbeing, learning, and continuous improvement, and is essential to a positive safety culture ¹⁴ .
Psychosocial hazards	Psychosocial hazards are factors in the design or management of work that increase the risk of work-related stress and can lead to psychological or physical harm.
Quality Improvement	A systematic method used to achieve higher levels of performance in an organisation.
Reporting culture	A work environment where staff feel supported and empowered to report errors, near misses, safety concerns, and risks without fear of blame or punitive action. A strong reporting culture encourages transparency, learning, and system improvement, recognising that incident reporting is essential for preventing harm and strengthening clinical governance.
Risk	Risk is the possibility that harm might occur when someone is exposed to a hazard. ⁴
Risk appetite	Risk appetite defines how much risk an organisation is willing to take in pursuit of its objectives. In healthcare, this includes patient safety, preventable harm, financial sustainability, innovation, and compliance.
Risk assessment	Risk assessment is the overall process of risk identification, risk analysis and risk evaluation.
Risk management	A systematic process for identifying, assessing, prioritising, and controlling risks that could impact the safety, quality, and effectiveness of care. In clinical governance, risk management ensures that potential threats to patients, staff, or organisational operations

¹³ Australian Commission on Safety and Quality in Health Care, *Open disclosure framework*.

¹⁴ Australian Commission on Safety and Quality in Health Care, *NSQHS User Guide for Measuring and Evaluating Safety Culture in Hospitals*.

	are recognised early and addressed through mitigation strategies, monitoring, and continuous improvement ¹⁵ .
Risk matrix	A visual tool used to assess and prioritise risks by determining the likelihood of a risk event occurring against its potential impact or severity.
Risk registry	A centralised tool for recording identified risks, their likelihood, impact, mitigation strategies, and responsible owners. It promotes visibility and accountability.
Safety culture	The product of individual and group values, attitudes, and behaviours that determine the commitment to and practice of organisational safety.
Safety I and Safety II approaches	Two ways of thinking about safety in healthcare. Safety I focuses on preventing things from going wrong, while Safety II looks at how things go right and how people adapt to deliver safe care.
Scenario planning	Controlled or simulated set ups that enable exploration of potential future events and assess the organisation's resilience under different risk conditions.
Scope of practice	The roles, responsibilities, and functions that an individual health practitioner is educated, competent, and authorised to perform within the boundaries of their professional registration, organisational context, and relevant legislation ¹⁶ .
Self-determination	The 'ongoing process of choice' to ensure that Aboriginal and/or Torres Strait Islander people can meet their social, cultural, and economic needs ⁵ .
Sentinel event	Is defined in the Health Services (Quality and Safety) Regulations 2020 as an unexpected and adverse event that occurs infrequently in a health service and results in the death of, or serious physical or psychological injury to, a patient as a result of system and process deficiencies at the health service entity ¹⁷ .
Serious adverse patient safety event	A serious adverse patient safety event is defined, in section 3(1) of the Health Services Act 1988, as an event of a prescribed class or category that results in harm to one or more individuals ¹⁸ .
Statutory duty of candour	A legal obligation for Victorian health service entities to apologise to and communicate openly and honestly with patients, their families, or carers when a SAPSE has occurred. It builds on the Australian Open Disclosure Framework currently used for all cases of harm and near miss. Statutory duty of candour is set out in section 128ZC of the <i>Health Services Act 1988</i> , section 22I of the <i>Ambulance Services Act 1986</i> and section 637 of the <i>Mental Health and Wellbeing Act 2022</i> ¹⁹ .
Succession planning	Succession planning is the strategic process of identifying and developing internal staff with the potential to fill key leadership and critical roles within the organisation. It ensures workforce continuity, supports leadership development, and maintains high quality care by preparing future leaders ²⁰ .
Sustainability	The capacity of a health system to maintain and improve service quality, safety, and outcomes over time by effectively using resources, adapting to changing needs, and ensuring long-term viability ¹⁴ .

¹⁵ International Organisation for Standardisation, *Risk management - Guidelines*

¹⁶ Australian Health Practitioner Regulation Agency, *National Safety and Quality Health Service Standards – Standard 1.20*

¹⁷ Safer Care Victoria, *Sentinel Events*

¹⁸ Safer Care Victoria, *Policy: Adverse Patient Safety Event*

¹⁹ Safer Care Victoria, *Victorian Duty of Candour Guidelines*

²⁰ Australian Commission on Safety and Quality in Health Care, *National Model Clinical Governance Framework*.

Systems thinking	An approach that understands healthcare as a complex, interconnected system where different components—such as people, processes, technology, and environment—influence one another. It involves looking beyond individual parts to see patterns, relationships, and root causes to improve safety, quality, and outcomes across the entire system ²¹ .
Triangulate/triangulation	The practice of collecting data from multiple sources or employing various methods to confirm findings or validate conclusions. It enhances reliability and provides a comprehensive understanding of the subject.
Vicarious trauma (secondary trauma)	Vicarious trauma, also known as secondary trauma, refers to the negative effects of indirect exposure to potentially traumatic events during the course of one's work ²² .
Walkarounds	Walkarounds are a commitment by the senior leadership (Boards and executive) of an organisation to meet and talk with staff working at the point of care, specifically focusing on issues affecting consumer and employee safety. They occur regularly, allow quick and effective follow up of safety issues, and enhance relationships and communication between senior leadership and point of care teams.
Workforce	All individuals engaged by a health service, including employees, contractors, agency staff, students, and volunteers, who contribute to the delivery of care and organisational functions. An effective workforce is appropriately skilled, resourced, and supported through education, training, and wellbeing initiatives to deliver safe, high-quality care.

²¹ Australian Commission on Safety and Quality in Health Care, *Australian Patient Safety Foundation: Systems Thinking and Patient Safety*.

²² WorkSafe Victoria, *Work related stress and traumatic events*.

Reference List

Foundational Literature Base

- Australian Commission on Safety and Quality in Health Care. (n.d.). *Clinical Governance Standard*. Retrieved July 30, 2025, from <https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance/clinical-governance-standard>
- Safer Care Victoria. (2023). *In-depth reviews of health services 2020–23*. Victorian Government. Available at: <https://www.safercare.vic.gov.au/reports-and-publications/in-depth-reviews-of-health-services-2020-23> [Accessed 5 Aug. 2025].
- Safer Care Victoria. (2018). *Organisational Strategy for Improvement Matrix (OSIM): Administration Guide (3rd ed.)*. Safer Care Victoria, State Government of Victoria, Melbourne. Retrieved from <https://www.safercare.vic.gov.au/improvement/getting-started/getting-your-service-ready/organisational-strategy-for-improvement-matrix-osim>
- Safer Care Victoria. (2019). *Partnering in healthcare: A framework for better care and outcomes*. State Government of Victoria. Retrieved from <https://www.safercare.vic.gov.au/publications/partnering-in-healthcare>
- Safer Care Victoria. (2024). *Victorian Clinical Governance Framework – Delivering High-Quality Care*. Retrieved July 30, 2025, from <https://www.safercare.vic.gov.au/best-practice-improvement/clinical-governance/framework>
- Safer Care Victoria. (2024). *Victorian Safety Culture Guide*. Retrieved July 30, 2025, from <https://www.safercare.vic.gov.au/publications/victorian-safety-culture-guide>
- Victorian Public Sector Commission. (2025). *2025 People Matter Survey questions*. Available at: <https://www.vpsc.vic.gov.au/data-collection/about-the-people-matter-survey/2025-survey-questions/> [Accessed 30 Jul. 2025].

Leadership and Culture

- Aged Care Quality and Safety Commission. (n.d.). *Developing and implementing a clinical governance framework*. Retrieved July 30, 2025, from https://www.agedcarequality.gov.au/sites/default/files/media/Developing_and_implementing_a_clinical_governance_framework.pdf
- Australian Commission on Safety and Quality in Health Care. (n.d.). *Action 1.02: Governance, leadership and culture*. Retrieved July 30, 2025, from <https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/governance-leadership-and-culture/action-102>
- Australian Commission on Safety and Quality in Health Care. (n.d.). *Action 1.08: Measurement and quality improvement. National Safety and Quality Health Service (NSQHS) Standards*. Retrieved June 19, 2025, from <https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/patient-safety-and-quality-systems/action-108>
- Australian Commission on Safety and Quality in Health Care. (n.d.). *Action 1.21: Improving cultural competency*. Retrieved July 30, 2025, from <https://www.safetyandquality.gov.au/standards/national-safety-and-quality-health-service-nsqhs-standards/resources-nsqhs-standards/user-guide-aboriginal-and-torres-strait-islander-health/action-121-improving-cultural-competency>
- Australian Commission on Safety and Quality in Health Care (n.d.) *Action 2.13: Working in partnership*. Retrieved August 13, 2025, from <https://www.safetyandquality.gov.au/standards/national-safety-and-quality-health-service-nsqhs-standards/resources-nsqhs-standards/user-guide-aboriginal-and-torres-strait-islander-health/action-213-working-partnership>.
- Australian Commission on Safety and Quality in Health Care. (n.d.). *Communicating for Safety Standard*. Retrieved July 30, 2025, from <https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard>
- Australian Commission on Safety and Quality in Health Care. (2020). *Communicating for Safety: Improving clinical communication, collaboration and teamwork in Australian health services*. Retrieved July 30, 2025, from https://www.safetyandquality.gov.au/sites/default/files/2020-12/final_scoping_paper_-_improving_communication_collaboration_and_teamwork_in_australian_health_services_-_june_2020.pdf
- Australian Commission on Safety and Quality in Health Care. (n.d.). *Measures of Patient Safety Culture*. Retrieved July 30, 2025, from <https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/patient-safety-culture/measures-patient-safety-culture>
- Australian Commission on Safety and Quality in Health Care. (2021). *National Safety and Quality Primary and Community Healthcare Standards*. Retrieved July 30, 2025, from <https://www.safetyandquality.gov.au/standards/primary-and-community-healthcare>
- Australian Commission on Safety and Quality in Health Care. (2017). *NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health*. Retrieved July 30, 2025, from <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/nsqhs-standards-user-guide-aboriginal-and-torres-strait-islander-health>
- Australian Commission on Safety and Quality in Health Care. (n.d.). *Patient safety and quality systems. National Safety and Quality Health Service (NSQHS) Standards*. Retrieved June 17, 2025, from <https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/patient-safety-and-quality-systems>
- Australian Commission on Safety and Quality in Health Care. (n.d.). *Policies and procedures – NSQPCH Standards Guide*. Retrieved July 30, 2025, from <https://www.safetyandquality.gov.au/publications-and->

resources/resource-library/nsqpcch-standards-guide-healthcare-services/clinical-governance-standard/patient-safety-and-quality-systems/policies-and-procedures

- Balanced Scorecard Institute. (2025). *Balanced Scorecard Basics*. Retrieved July 30, 2025, from <https://balancedscorecard.org/>
- Balding, C. (2005). Strengthening clinical governance through cultivating the line management role. *Australian Health Review*, 29(3), 353–359. Retrieved July 30, 2025, from <https://www.publish.csiro.au/ah/pdf/AH050353>
- Bell, S., Garud, N., Pati, R., Sojo, V., Healy, J., & Adamovic, M. (2022). *Happier workers, healthier patients: An analysis of healthcare worker engagement and health service outcomes in Victoria*. Safer Care Victoria & Victorian Managed Insurance Authority. <https://doi.org/10.6084/m9.figshare.18830621>
- Carayon, P., Schoofs Hundt, A., Karsh, B.T., Gurses, A.P., Alvarado, C.J., Smith, M., & Flatley Brennan, P. (2006). Work system design for patient safety: the SEIPS model. *Quality & Safety in Health Care*, 15(Suppl 1), i50–i58. <https://doi.org/10.1136/qshc.2005.015842>
- Carayon, P., Wetterneck, T.B., Rivera-Rodriguez, A.J., Hundt, A.S., Hoonakker, P., Holden, R., & Gurses, A.P. (2014). Human factors systems approach to healthcare quality and patient safety. *Applied Ergonomics*, 45(1), 14–25. <https://doi.org/10.1016/j.apergo.2013.04.023>
- Carthey, J., & Downham, N. (2017). *Safety Measurement and Monitoring Maturity Matrix (SaMMMM)*. Retrieved July 30, 2025, from https://internationalforum.bmj.com/wp-content/uploads/2023/05/W2-Handout-2-maturity-matrix-_integratedFINAL-Canadianized-Final.pdf
- Clinical Excellence Commission. (n.d.). *Leadership Walk-Arounds: Executives Guide*. NSW Health. Retrieved July 30, 2025, from https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0003/409818/Leadership-Walk-Arounds-Executives-Guide.pdf
- Daley Ullem, E., Gandhi, T.K., Mate, K., Whittington, J., Renton, M., & Huebner, J. (2018). *Framework for Effective Board Governance of Health System Quality*. IHI White Paper. Boston, Massachusetts: Institute for Healthcare Improvement. Retrieved July 30, 2025, from <https://www.ihl.org/resources/white-papers/framework-effective-board-governance-health-system-quality>
- De Savigny, D., Adam, T., & World Health Organization. (2009). *Systems thinking for health systems strengthening (1st ed.)*. Geneva: World Health Organization. Retrieved from <https://apps.who.int/iris/handle/10665/44204>
- Department of Health and Human Services, Victoria. (n.d.). *Director's toolkit: Chapter 2 – Corporate governance. Victorian Government*. Retrieved June 18, 2025, from <https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/d/dhhs-directors-toolkit-chapter-2>
- Department of Health and Human Services, Victoria. (2020). *The Director's Toolkit: A resource for Victorian health service boards – Chapter 2: Clinical Governance*. Retrieved July 30, 2025, from <https://www2.health.vic.gov.au/hospitals-and-health-services>
- Fukami, T. (2024). Enhancing Healthcare Accountability for Administrators: Fostering Transparency for Patient Safety and Quality Enhancement. *Cureus*, 16(8), e66007. <https://doi.org/10.7759/cureus.66007>
- Good Governance Institute. (2023). *Clinical Quality Governance Maturity Matrix*. Version 1.0, October 2023. Available at: https://www.good-governance.org.uk/GGI_ClinicalQualityGovernance_MaturityMatrix [Accessed 30 Jul. 2025].
- Hodgen, A., Ellis, L., Churruca, K., & Bierbaum, M. (2017). *Safety Culture Assessment in Health Care: A review of the literature on safety culture assessment modes*. Australian Commission on Safety and Quality in Health Care.

Retrieved July 30, 2025, from <https://www.safetyandquality.gov.au/sites/default/files/migrated/Safety-Culture-Assessment-in-Health-Care-A-review-of-the-literature-on-safety-culture-assessment-modes.pdf>

- National Aboriginal Community Controlled Health Organisation (NACCHO). (n.d.). *Aboriginal Community Controlled Health Organisations*. Retrieved July 30, 2025, from <https://www.naccho.org.au/aboriginal-community-controlled-health/>
- Patterson, M., & Deutsch, E.S. (2015). Safety-I, Safety-II and Resilience Engineering. *Current Problems in Pediatric and Adolescent Health Care*, 45(12), 382–389. <https://pubmed.ncbi.nlm.nih.gov/26549146/>
- Safer Care Victoria. (2024). *Victorian Safety Culture Guide*. Retrieved July 30, 2025, from <https://www.safercare.vic.gov.au/publications/victorian-safety-culture-guide>
- Sampath, B., Rakover, J., Baldoza, K., Mate, K., Lenoci-Edwards, J., & Barker, P. (2021). *Whole system quality: A unified approach to building responsive, resilient health care systems (IHI White Paper)*. Institute for Healthcare Improvement. Retrieved July 30, 2025, from <https://www.ihl.org>
- Spanos, S., Leask, E., Patel, R., Datyner, M., Loh, E., & Braithwaite, J. (2024). Healthcare leaders navigating complexity: a scoping review of key trends in future roles and competencies. *BMC Medical Education*, 24, Article 720. <https://doi.org/10.1186/s12909-024-05689-4>
- van Elten, H.J., & van der Kolk, B. (2024). Performance management, metric quality, and trust: Survey evidence from healthcare organizations. *British Accounting Review*. <https://doi.org/10.1016/j.bar.2024.101511>
- Victorian Department of Health. (2024). *Health Services Plan – Final Report of the Expert Advisory Committee*. Retrieved July 30, 2025, from <https://www.health.vic.gov.au/sites/default/files/2024-08/health-services-plan-final-report-expert-advisory-committee.pdf>
- Victorian Managed Insurance Authority (VMIA). (n.d.). *Risk management roles and responsibilities*. Retrieved July 30, 2025, from <https://www.vmia.vic.gov.au/-/media/Internet/Content-Documents/Tools/VGRMF-tools/Risk-management-roles-and-responsibilities>
- Victorian Public Sector Commission. (n.d.). *Aboriginal and/or Torres Strait Islander Cultural Capability Toolkit*. Retrieved July 30, 2025, from <https://www.vpsc.vic.gov.au/workforce-programs/aboriginal-cultural-capability-toolkit/>
- Vincent, C., Burnett, S., & Carthey, J. (2014). Safety measurement and monitoring in healthcare: a framework to guide clinical teams and healthcare organisations in maintaining safety. *BMJ Quality & Safety*, 23(8), 670–677. <https://qualitysafety.bmj.com/content/23/8/670>
- WorkSafe Queensland. (2020). *Establishing policies and procedures*. Retrieved July 30, 2025, from <https://www.worksafe.qld.gov.au/safety-and-prevention/creating-safe-work/establishing-policies-and-procedures>
- WorkSafe Queensland. (n.d.). *Safety climate and safety culture*. Retrieved July 30, 2025, from <https://www.worksafe.qld.gov.au/safety-and-prevention/creating-safe-work/safety-capability-leadership-and-culture/culture-leadership-and-teamwork/safety-climate-and-safety-culture>
- WorkSafe Victoria. (2023). *Create and review your occupational health and safety policy*. Retrieved July 30, 2025, from <https://www.worksafe.vic.gov.au/workwell-toolkit-occupational-health-and-safety-ohs-policy>

Consumer Partnership

- Al Shamsi, H., Almutairi, A. G., Al Mashrafi, S., & Al Kalbani, T. (2020). Implications of language barriers for healthcare: A systematic review. *Oman Medical Journal*, 35(2), e122. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9932446/>
- Australian Commission on Safety and Quality in Health Care. (2014). National statement on health literacy: Taking action to improve safety and quality. <https://www.safetyandquality.gov.au/sites/default/files/migrated/Health-Literacy-National-Statement.pdf>
- Australian Commission on Safety and Quality in Health Care. (n.d.). Action 2.08: Communication that supports effective partnerships. Retrieved June 6, 2025, from <https://www.safetyandquality.gov.au/standards/nsqhs-standards/partnering-consumers-standard/health-literacy/action-208>
- Australian Commission on Safety and Quality in Health Care. (n.d.). Partnering with consumers in organisational design and governance. Retrieved June 3, 2025, from <https://www.safetyandquality.gov.au/standards/nsqhs-standards/partnering-consumers-standard/partnering-consumers-organisational-design-and-governance>
- Australian Commission on Safety and Quality in Health Care. (n.d.). Communicating with patients and colleagues. Retrieved June 6, 2025, from <https://www.safetyandquality.gov.au/our-work/communicating-safety/communicating-patients-and-colleagues>
- Australian Commission on Safety and Quality in Health Care. (n.d.). Feedback and complaints management. Retrieved June 6, 2025, from <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/nsqch-standards-guide-healthcare-services/clinical-governance-standard/patient-safety-and-quality-systems/feedback-and-complaints-management>
- Australian Commission on Safety and Quality in Health Care. (n.d.). Health literacy. Retrieved August 5, 2025, from <https://www.safetyandquality.gov.au/standards/nsqhs-standards/partnering-consumers-standard/health-literacy>
- Australian Commission on Safety and Quality in Health Care. (n.d.). Standard 2 Tip Sheet 6: How to get feedback from consumers on patient information publications. Retrieved June 6, 2025, from <https://www.safetyandquality.gov.au>
- Australian Commission on Safety and Quality in Health Care. (n.d.). Standard 2: Partnering with Consumers – Tip Sheet 3: Training for partnerships with consumers.
- Australian Commission on Safety and Quality in Health Care. (n.d.). Implementing Patient Experience. Retrieved from <https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/patient-experience/implementing-patient-experience>
- Australian Health Practitioner Regulation Agency. (n.d.). Checklist for practitioners handling feedback and complaints. Retrieved June 6, 2025, from <https://www.ahpra.gov.au/Resources/Checklist-for-practitioners-handling-feedback-and-complaints.aspx>
- Blomkamp, E. (2018). Sharing the principles of co-design. Medium. Retrieved from <https://emmablomkamp.medium.com/sharing-the-principles-of-co-design-4a976bb55c48>
- Clinical Excellence Commission. (n.d.). Health literacy. NSW Government. Retrieved August 5, 2025, from <https://www.cec.health.nsw.gov.au/improve-quality/system-safety-culture/person-centred-care/health-literacy>
- Health Complaints Commissioner. (2024). Complaint handling standards – 30 April 2024. Victorian Government. Retrieved June 6, 2025, from <https://hcc.vic.gov.au/providers/complaint-handling-standards>
- Health Issues Centre. (2023). Six steps to successfully onboarding consumer advisors. Institute for Health Transformation, Deakin University. Retrieved from <https://iht.deakin.edu.au/wp-content/uploads/sites/153/2025/03/6-steps-to-successfully-onboarding-consumer-advisors-July-2023.pdf>

- NHS England. (2015). Using patient stories to improve patient, carer and staff experiences and outcomes. <https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/08/using-patient-stories.pdf>
- Merner, B., Schonfeld, L., Virgona, A., Lowe, D., Walsh, L., Wardrope, C., Graham-Wisener, L., Xafis, V., Colombo, C., Refahi, N., Bryden, P., Chmielewski, R., Martin, F., Messino, N. M., Mussared, A., Smith, L., Biggar, S., Gill, M., Menzies, D., Gaulden, C. M., Earnshaw, L., Arnott, L., Poole, N., Ryan, R. E., & Hill, S. (2023). Consumers' and health providers' views and perceptions of partnering to improve health services design, delivery and evaluation: A co-produced qualitative evidence synthesis. *Cochrane Database of Systematic Reviews*, 3(3), CD013274. <https://doi.org/10.1002/14651858.CD013274.pub2>
- Safer Care Victoria. (2018). Organisational Strategy for Improvement Matrix (OSIM): Administration Guide (3rd ed.). Safer Care Victoria, State Government of Victoria, Melbourne. Retrieved from <https://www.safercare.vic.gov.au/improvement/getting-started/getting-your-service-ready/organisational-strategy-for-improvement-matrix-osim>
- Safer Care Victoria. (2019). Partnering in healthcare: A framework for better care and outcomes. State Government of Victoria. Retrieved from <https://www.safercare.vic.gov.au/publications/partnering-in-healthcare>
- Safer Care Victoria. (2022). Consumer involvement following a serious adverse patient safety event: A 9-step guide for health services. https://www.safercare.vic.gov.au/sites/default/files/2022-12/Consumer%20involvement%20following%20a%20SAPSE_9-step%20guide.docx
- Safer Care Victoria. (2022). Victorian Duty of Candour Guidelines. Retrieved June 12, 2025, from <https://www.safercare.vic.gov.au/report-manage-issues/adverse-events/duty-of-candour>
- Shariya, S. H. (2023). Quality communication can improve patient-centred health outcomes among older patients: A rapid review. *BMC Health Services Research*, 23, 886. <https://doi.org/10.1186/s12913-023-09869-8>
- Victorian Department of Health. (2015). Language services – when to use them. Retrieved June 6, 2025, from <https://www.health.vic.gov.au/mental-health-services/language-services-when-to-use-them>.

Workforce

- Abihiro, G.A., De Allegri, M., & Mbau, R. (2023). Institutionalizing health workforce planning in low- and middle-income countries: A scoping review. *Health Policy*, 137, 105–114. Available at: <https://www.sciencedirect.com/science/article/pii/S0168851023001124> [Accessed 30 Jul. 2025].
- Asnicar, S. (2025). *Diversity, equity & inclusion in the workplace: A strategic approach for business success*. Diversity Australia. Available at: <https://www.diversityaustralia.com.au/diversity-equity-inclusion-in-the-workplace-a-strategic-approach-for-business-success/> [Accessed 26 Jun. 2025].
- Australian Commission on Safety and Quality in Health Care. (2017). *National Model Clinical Governance Framework*. Sydney: ACSQHC. Available at: <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-model-clinical-governance-framework> [Accessed 30 Jul. 2025].
- Australian Commission on Safety and Quality in Health Care. (2018). *Review of key attributes of high-performing person-centred healthcare organisations*. Sydney: ACSQHC. Available at: <https://www.safetyandquality.gov.au/sites/default/files/migrated/FINAL-REPORT-Attributes-of-person-centred-healthcare-organisations-2018.pdf> [Accessed 30 Jul. 2025].
- Australian Commission on Safety and Quality in Health Care. (2021). *Clinical Governance Standard – Action 1.20*. In: *National Safety and Quality Health Service Standards* (2nd ed.). Sydney: ACSQHC. Available at: <https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance/clinical-governance-standard> [Accessed 30 Jul. 2025].
- Australian Commission on Safety and Quality in Health Care. (2021). *National Safety and Quality Health Service Standards* (2nd ed.). Sydney: ACSQHC. Available at: <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-safety-and-quality-health-service-standards-second-edition> [Accessed 30 Jul. 2025].
- Australian Commission on Safety and Quality in Health Care. (2021). *National Safety and Quality Primary and Community Healthcare Standards: Guide for Healthcare Services*. Sydney: ACSQHC. Available at: <https://www.safetyandquality.gov.au/standards/primary-and-community-healthcare> [Accessed 30 Jul. 2025].
- Australian Commission on Safety and Quality in Health Care. (2021). *NSQHS Standards – Actions 1.11, 1.12, and 1.13*. In: *National Safety and Quality Health Service Standards* (2nd ed.). Sydney: ACSQHC. Available at: <https://www.safetyandquality.gov.au/standards/nsqhs-standards> [Accessed 30 Jul. 2025].
- Australian Commission on Safety and Quality in Health Care. (n.d.). *Clinical Governance Standard – Action 1.22: Clinical performance and effectiveness*. Available at: <https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/clinical-performance-and-effectiveness/action-122> [Accessed 12 Jun. 2025].
- Australian Commission on Safety and Quality in Health Care. (n.d.). *Governance, leadership and culture – Action 1.05*. Available at: <https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/governance-leadership-and-culture/action-105> [Accessed 30 Jul. 2025].
- Australian Government Department of Health. (2021). *National Medical Workforce Strategy 2021–2031*. Available at: <https://www.health.gov.au/resources/publications/national-medical-workforce-strategy-2021-2031> [Accessed 30 Jul. 2025].
- Australian Nursing and Midwifery Federation. (2023). *Preventing workplace violence and aggression: Position statement*. Available at: <https://www.anmf.org.au/media/k3td4rii/anmf-position-statement-preventing-wva.pdf> [Accessed 30 Jul. 2025].
- Australian Nursing and Midwifery Federation (Victorian Branch). (2020). *Prevention of occupational violence and aggression: Policy statement*. Available at: <https://www.anmfvic.asn.au/~/-/media/files/anmf/guidancenotes-policies->

positionstatements/prevention%20of%20occupational%20violence%20and%20aggression.pdf [Accessed 30 Jul. 2025]

- Australian Nursing and Midwifery Federation (Victorian Branch). (2022). *10-point plan to end violence and aggression: A guide for health services*. Available at: <https://www.anmfvic.asn.au/~media/files/anmf/ohs/ovaguide-10pp.pdf> [Accessed 30 Jul. 2025].
- Bednall, T.C. & Orr, P. (2024). *Managing a neurodiverse workforce*. Australian Psychological Society. Available at: <https://psychology.org.au/insights/managing-a-neurodiverse-workforce> [Accessed 30 Jul. 2025].
- Chubb, C., Reilly, P., & Brown, D. (2011). *Performance Management: Literature Review*. HR Network Paper MP90. Brighton: Institute for Employment Studies. Available at: <https://www.employment-studies.co.uk/resource/performance-management-literature-review> [Accessed 30 Jul. 2025].
- Daley Ullem, E., Gandhi, T.K., Mate, K., Whittington, J., Renton, M., & Huebner, J. (2018). *Framework for Effective Board Governance of Health System Quality*. IHI White Paper. Boston, MA: Institute for Healthcare Improvement. Available at: <https://www.ihl.org/sites/FrameworkEffectiveBoardGovernanceHealthSystemQuality> [Accessed 30 Jul. 2025].
- Department of Health and Human Services, Victoria. (2017). *Framework for preventing and managing occupational violence and aggression: Guide to implementation*. Available at: <https://www.vgls.vic.gov.au/client/> [Accessed 30 Jul. 2025].
- Department of Health, Victoria. (2024). *Victoria's healthcare workforce*. Available at: <https://www.health.vic.gov.au/victorian-health-workforce-strategy> [Accessed 30 Jul. 2025].
- DeSarno, J., Davis, K., McNett, M., & McLaughlin, M. (2021). Succession planning within the health care organization. *Nurse Leader*, 19(4), pp. 411–415. doi:10.1016/j.mnl.2020.08.010.
- Good Governance Institute. (2023). *Clinical Quality Governance Maturity Matrix*. Version 1.0, October 2023. Available at: https://www.good-governance.org.uk/GGI_ClinicalQualityGovernance_MaturityMatrix [Accessed 30 Jul. 2025].
- International Organization for Standardization (ISO). (2016). *ISO 30409:2016 Human resource management — Workforce planning*. Geneva: ISO. Available at: <https://www.iso.org/standard/64150.html> [Accessed 30 Jul. 2025].
- National Institutes of Health (NIH). (2021). *Succession Planning: A Step-by-Step Guide*. Office of Human Resources. Available at: https://hr.nih.gov/sites/default/files/public/documents/2021-03/Succession_Planning_Step_by_Step_Guide.pdf [Accessed 30 Jul. 2025].
- NHS England. (n.d.). *The five components of NHS IMPACT*. Available at: <https://www.england.nhs.uk/nhsimpact/about-nhs-impact/> [Accessed 30 Jul. 2025].
- Queensland Government Public Service Commission. (2019). *Strategic workforce planning maturity model*. Available at: https://www.forgov.qld.gov.au/__data/assets/pdf_file/0031/183856/strategic-workforce-planning-maturity-model-2019.pdf [Accessed 30 Jul. 2025].
- Safe Work Australia. (2019). *Work-related psychological health and safety: A systematic approach to meeting your duties*. Available at: https://www.safeworkaustralia.gov.au/system/files/documents/1911/work-related_psychological_health_and_safety_a_systematic_approach_to_meeting_your_duties.pdf [Accessed 30 Jul. 2025].
- Safe Work Australia. (2021). *Guide for preventing workplace violence and aggression*. Available at: <https://www.safeworkaustralia.gov.au/sites/default/files/2021-06/Guide%20for%20preventing%20workplace%20violence%20and%20aggression.pdf> [Accessed 30 Jul. 2025].
- Safer Care Victoria. (2025). *Quality and Safety Capability Framework*. Available at <https://www.safercare.vic.gov.au/best-practice-improvement/quality->

improvement/framework?auHash=uzMKZQfvWYSPVbKB6MoHLVFykkVWCF54_FgM1WV88IA [Accessed 18 Aug. 2025].

- WorkSafe Victoria. (2023). *Prevention and management of violence and aggression in health services*. Available at: <https://content-v2.api.worksafe.vic.gov.au/sites/default/files/2023-11/Prevention-and-management-of-violence-and-aggression-health-services-2023-11.pdf> [Accessed 30 Jul. 2025].
- WorkSafe Victoria. (2023). *Work-related stress – violent or traumatic events*. Available at: <https://www.worksafe.vic.gov.au/work-related-stress-violent-or-traumatic-events> [Accessed 30 Jul. 2025].
- WorkSafe Victoria. (2025). *Work Well Toolkit: Diversity and inclusion*. Available at: <https://www.worksafe.vic.gov.au/workwell-toolkit-diversity-and-inclusion> [Accessed 26 Jun. 2025].

Risk Management

- American Society of Health-System Pharmacists (n.d.) *Just Culture Toolkit*. [Online] Available at: https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/patient-safety/Just-Culture-Toolkit_Final.pdf [Accessed 5 Aug. 2025].
- Ansvr Insurance (n.d.) *Risk Maturity Assessment*. [Online] Available at: <https://www.ansvar.com.au/rma-online> [Accessed 5 Aug. 2025].
- Australian Commission on Safety and Quality in Health Care (2013) *Australian Open Disclosure Framework*. Sydney: ACSQHC. [Online] Available at: <https://www.safetyandquality.gov.au/sites/default/files/migrated/Australian-Open-Disclosure-Framework-Feb-2014.pdf> [Accessed 5 Aug. 2025].
- Australian Commission on Safety and Quality in Health Care (2017) *National Safety and Quality Health Service Standards: Action 1.10 – Risk management*. [Online] Available at: <https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/patient-safety-and-quality-systems/action-110> [Accessed 9 Jul. 2025].
- Australian Commission on Safety and Quality in Health Care (2021) *Incident Management Guide*. Sydney: ACSQHC. [Online] Available at: https://www.safetyandquality.gov.au/sites/default/files/2021-12/incident_management_guide_november_2021.pdf [Accessed 5 Aug. 2025].
- Australian Commission on Safety and Quality in Health Care (2025) *Australian sentinel events list (Version 2): Specifications*. [Online] Available at: <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/australian-sentinel-events-list-version-2-specifications> [Accessed 5 Aug. 2025].
- Australian Commission on Safety and Quality in Health Care (n.d.) *Clinical Governance Framework: Governance, leadership and culture*. [Online] Available at: <https://www.safetyandquality.gov.au/our-work/clinical-governance/national-model-clinical-governance-framework/clinical-governance-framework-governance-leadership-and-culture> [Accessed 23 Jun. 2025].
- Australian Commission on Safety and Quality in Health Care (n.d.) *Governance, leadership and culture*. [Online] Available at: <https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/governance-leadership-and-culture> [Accessed 23 Jun. 2025].
- Australian Commission on Safety and Quality in Health Care (n.d.) *Hospital-acquired complications (HACs)*. [Online] Available at: <https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/hospital-acquired-complications-hacs> [Accessed 5 Aug. 2025].
- Australian Commission on Safety and Quality in Health Care (n.d.) *Incident management and sentinel events*. [Online] Available at: <https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/incident-management-and-sentinel-events> [Accessed 5 Aug. 2025].
- Australian Commission on Safety and Quality in Health Care (n.d.) *National Model Clinical Governance Framework*. [Online] Available at: <https://www.safetyandquality.gov.au/our-work/clinical-governance/national-model-clinical-governance-framework> [Accessed 23 Jun. 2025].
- Australian Commission on Safety and Quality in Health Care (n.d.) *National Safety and Quality Health Service (NSQHS) standards (2nd ed.)*. [Online] Available at: <https://www.safetyandquality.gov.au/standards/nsqhs-standards> [Accessed 5 Aug. 2025].
- Australian Commission on Safety and Quality in Health Care (n.d.) *Patient safety and quality systems*. [Online] Available at: <https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/patient-safety-and-quality-systems> [Accessed 23 Jun. 2025].

- Australian Commission on Safety and Quality in Health Care (n.d.) *Risk management approach*. [Online] Available at: <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/nsqhs-standards-risk-management-approach> [Accessed 23 Jun. 2025].
- Australian Commission on Safety and Quality in Health Care (n.d.) *Safety and quality roles and responsibilities*. [Online] Available at: <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/nsqpch-standards-guide-healthcare-services/clinical-governance-standard/clinical-performance-and-effectiveness/safety-and-quality-roles-and-responsibilities> [Accessed 23 Jun. 2025].
- Daley Ullem, E., Gandhi, T.K., Mate, K., Whittington, J., Renton, M. & Huebner, J. (2018) *Framework for Effective Board Governance of Health System Quality*. IHI White Paper. Boston, MA: Institute for Healthcare Improvement. [Online] Available at: <https://www.ihl.org/resources/white-papers/framework-effective-board-governance-health-system-quality> [Accessed 5 Aug. 2025].
- Victorian Department of Health (n.d.) *Risk Management: Director's Toolkit Chapter 7*. [Online] Available at: <https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/d/dhhs-directors-toolkit-chapter-7---risk-1.pdf> [Accessed 5 Aug. 2025].
- Fukami, T. (2024) Enhancing Healthcare Accountability for Administrators: Fostering Transparency for Patient Safety and Quality Enhancement. *Cureus*, 16(8), e66007. doi: 10.7759/cureus.66007 [Online] Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC11366401> [Accessed 5 Aug. 2025].
- Health and Safety Executive (n.d.) *Safety critical communications: Overview*. [Online] Available at: <https://www.hse.gov.uk/humanfactors/topics/communications.htm> [Accessed 5 Aug. 2025].
- International Organization for Standardization. (2018) *ISO 31000:2018 Risk Management – Guidelines*. Geneva: ISO. [Online] Available at: <https://www.iso.org/standard/65694.htm> [Accessed 5 Aug. 2025].
- Kaplan, G.S. (2018) *Building a culture of transparency in health care*. *Harvard Business Review*. [Online] Available at: <https://hbr.org/2018/11/building-a-culture-of-transparency-in-health-care> [Accessed 5 Aug. 2025].
- National Patient Safety Foundation's Lucian Leape Institute (2015) *Shining a light: Safer health care through transparency*. Institute for Healthcare Improvement. [Online] Available at: <https://www.ihl.org/resources/publications/shining-light-safer-health-care-through-transparency> [Accessed 5 Aug. 2025].
- Pascarella, G., Rossi, M., Montella, E., Capasso, A., De Feo, G., Botti, G., Nardone, A., Montuori, P., Triassi, M., D'Auria, S. & Morabito, A. (2021) Risk analysis in healthcare organizations: Methodological framework and critical variables. *Risk Management and Healthcare Policy*, 14, pp. 2897–2911. [Online] Available at: <https://doi.org/10.2147/RMHP.S309098> [Accessed 5 Aug. 2025].
- Safe Work Australia (2023) *Model Code of Practice – Work Health and Safety Consultation, Cooperation and Coordination*. [Online] Available at: <https://www.safeworkaustralia.gov.au> [Accessed 5 Aug. 2025].
- Safer Care Victoria (2019) *Adverse Patient Safety Event Policy*. Victorian Government. [Online] Available at: <https://www.safercare.vic.gov.au> [Accessed 5 Aug. 2025].
- Safer Care Victoria (2022) *Statutory Duty of Candour and protections for SAPSE reviews*. [Online] Available at: <https://www.safercare.vic.gov.au/report-manage-issues/adverse-events/duty-of-candour> [Accessed 5 Aug. 2025].
- Safer Care Victoria (2023) *Adverse Patient Safety Event Guideline*. Victorian Government. [Online] Available at: <https://www.safercare.vic.gov.au> [Accessed 5 Aug. 2025].
- Safer Care Victoria (2024) *Victorian sentinel event guide (Version 2)*. State Government of Victoria. [Online] Available at: <https://www.safercare.vic.gov.au> [Accessed 5 Aug. 2025].
- Safer Care Victoria (n.d.) *Incident management and sentinel events*. [Online] Available at: <https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events> [Accessed 5 Aug. 2025].

- Toren, O. Dokhi, M. & Dekeyser Ganz, F. (2021) Hospital nurses' intention to report near misses, patient safety culture and professional seniority. *International Journal for Quality in Health Care*, 33(1), mzab031. [Online] Available at: <https://doi.org/10.1093/intqhc/mzab031> [Accessed 5 Aug. 2025].
- Victorian Agency for Health Information (VAHI) (2025) *Clinical incident severity rating (ISR): Guidance for health services reporting the VHIMS MDS (version 2)*. [Online] Available at: <https://vahi.vic.gov.au> [Accessed 5 Aug. 2025].
- Victorian Department of Health (2021) *Health services' responsibilities in emergencies*. [Online] Available at: <https://www.health.vic.gov.au/health-services-responsibilities-in-emergencies> [Accessed 9 Jul. 2025].
- Victorian Department of Health (2021, October 31) *Health services emergency management policy*. [Online] Available at: <https://www.health.vic.gov.au/health-services-emergency-management-policy> [Accessed 9 Jul. 2025].
- Victorian Department of Health (2024) *Directors' toolkit*. [Online] Available at: <https://www.health.vic.gov.au/boards-and-governance/directors-toolkit> [Accessed 5 Aug. 2025].
- Victorian Department of Health (n.d.) *Clinical incident investigations and responsibilities*. [Online] Available at: <https://www.health.vic.gov.au/quality-safety-service/clinical-incident-investigations-and-responsibilities> [Accessed Jul. 2025].
- Victorian Department of Health (n.d.) *Victorian Health Incident Management Policy*. [Online] Available at: <https://www.health.vic.gov.au/quality-safety-service/clinical-risk-management> [Accessed 5 Aug. 2025].
- Victorian Department of Treasury and Finance (2020) *Victorian Government Risk Management Framework: August 2020 (to take effect from 1 July 2021)*. Melbourne, VIC: State of Victoria. [Online] Available at: <https://www.dtf.vic.gov.au> [Accessed 5 Aug. 2025].
- Victorian Government (2020) *Health Services (Quality and Safety) Regulations 2020 (Vic)*. [Online] Available at: <https://www.legislation.vic.gov.au> [Accessed 5 Aug. 2025].
- Victorian Managed Insurance Authority (VMIA) (2022) *Defining your organisation's risk appetite*. Melbourne, VIC: VMIA. [Online] Available at: <https://www.vmia.vic.gov.au> [Accessed 5 Aug. 2025].
- Victorian Managed Insurance Authority (VMIA) (n.d.) *Building your risk management framework*. [Online] Available at: <https://www.vmia.vic.gov.au/tools-and-insights/practical-guidance-for-managing-risk/building-risk-management-framework> [Accessed 5 Aug. 2025].
- Victorian Managed Insurance Authority (VMIA) (n.d.) *Clinical Governance Standards*. [Online] Available at: <https://www.vmia.vic.gov.au/risk-resilience-hub/clinical-governance> [Accessed 5 Aug. 2025].
- Victorian Managed Insurance Authority (VMIA) (n.d.) *Risk management roles and responsibilities*. [Online] Available at: <https://www.vmia.vic.gov.au> [Accessed 5 Aug. 2025].
- Victorian Managed Insurance Authority (VMIA) (n.d.) *Victorian Government Risk Management Framework*. [Online] Available at: <https://www.vmia.vic.gov.au/tools-and-insights/victorian-government-risk-management-framework> [Accessed 5 Aug. 2025].
- WorkSafe Victoria (n.d.) *Checklist for health and safety consultation*. [Online] Available at: <https://content-v2.api.worksafe.vic.gov.au/Checklist-for-health-and-safety-consultation-2012-10.pdf> [Accessed 5 Aug. 2025].
- WorkSafe Victoria (n.d.) *Consultation: Safety basics*. [Online] Available at: <https://www.worksafe.vic.gov.au/consultation-safety-basics> [Accessed 5 Aug. 2025].
- WorkSafe Victoria (n.d.) *Healthcare and hospitals: Safety basics*. [Online] Available at: <https://www.worksafe.vic.gov.au/healthcare-and-hospitals-safety-basics> [Accessed 5 Aug. 2025].

- WorkSafe Victoria (n.d.) *The hierarchy of control*. [Online] Available at: <https://www.worksafe.vic.gov.au/hierarchy-control> [Accessed 5 Aug. 2025].

Clinical Practice

- Agency for Healthcare Research and Quality. (n.d.). *Human factors engineering*. PSNet Patient Safety Network. Retrieved June 27, 2025, from <https://psnet.ahrq.gov/primer/human-factors-engineering>
- Ahern, S. (2019). *Clinical service planning*. In E. Loh, P. N. Kenny, & L. J. McDonald (Eds.), *Textbook of medical administration and leadership* (pp. 47–61). Springer. https://doi.org/10.1007/978-981-10-5454-9_4
- Ahern, S., Feiler, R., & Sdrinis, S. (2020). Maximising the value of clinical registry information through integration with an organisation clinical governance framework: a case study. *Australian Health Review*, 44(4), 421–426. <https://doi.org/10.1071/AH19004>
- Australasian College for Emergency Medicine. (2023). *Guidelines on the Implementation of the Australasian Triage Scale in Emergency Departments*. Retrieved from <https://acem.org.au/>
- Australian Commission on Safety and Quality in Health Care. (2015). *Credentialing health practitioners and defining their scope of clinical practice: A guide for managers and practitioners*. <https://www.safetyandquality.gov.au/publications-and-resources>
- Australian Commission on Safety and Quality in Health Care. (2018). *Implementing the Comprehensive Care Standard: Approaches to person-centred risk screening*. Sydney: ACSQHC. Retrieved June 12, 2025, from <https://www.safetyandquality.gov.au>
- Australian Commission on Safety and Quality in Health Care. (2021). *NSQHS Standards – Communicating for Safety Standard*. Retrieved July 18, 2025, from <https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard>
- Australian Commission on Safety and Quality in Health Care. (2022). *The National Clinical Trials Governance Framework and user guide for health service organisations conducting clinical trials*. <https://www.safetyandquality.gov.au>
- Australian Commission on Safety and Quality in Health Care. (2023). *Public Interest Disclosure Policy and Procedures (v1.7)*. Retrieved from <https://www.safetyandquality.gov.au>
- Australian Commission on Safety and Quality in Health Care. (2024). *Australian Framework for National Clinical Quality Registries 2024*. Sydney: ACSQHC. Available at: <https://www.safetyandquality.gov.au>
- Australian Commission on Safety and Quality in Health Care. (n.d.). *Action 1.06: Clinical leadership*. <https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/governance-leadership-and-culture/action-106>
- Australian Commission on Safety and Quality in Health Care. (n.d.). *Action 1.08: Measurement and quality improvement*. <https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/patient-safety-and-quality-systems/action-108>
- Australian Commission on Safety and Quality in Health Care. (n.d.). *Action 6.11 – Documentation of information*. Retrieved July 18, 2025, from <https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard/documentation-information/action-611>
- Australian Commission on Safety and Quality in Health Care. (n.d.). *Communication at clinical handover*. Retrieved July 18, 2025, from <https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard/communication-clinical-handover>
- Australian Commission on Safety and Quality in Health Care. (n.d.). *Critical information. Communicating for Safety Resource Portal*. Retrieved July 18, 2025, from <https://c4sportal.safetyandquality.gov.au/critical-information>
- Australian Commission on Safety and Quality in Health Care. (n.d.). *Detecting and recognising acute deterioration and escalating care*. Retrieved June 17, 2025, from <https://www.safetyandquality.gov.au/standards/nsqhs->

standards/recognising-and-responding-acute-deterioration-standard/detecting-and-recognising-acute-deterioration-and-escalating-care

- Australian Commission on Safety and Quality in Health Care. (n.d.). *Documenting information – Communicating for Safety Resource Portal*. Retrieved July 18, 2025, from <https://c4sportal.safetyandquality.gov.au/documenting-information>
- Australian Commission on Safety and Quality in Health Care. (n.d.). *Partnering with Consumers Standard*. Retrieved June 16, 2025, from <https://www.safetyandquality.gov.au/standards/nsqhs-standards/partnering-consumers-standard>
- Australian Commission on Safety and Quality in Health Care. (n.d.). *Patient safety and quality systems*. National Safety and Quality Health Service (NSQHS) Standards. Retrieved June 17, 2025, from <https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/patient-safety-and-quality-systems>
- Australian Commission on Safety and Quality in Health Care. (n.d.). *Transferred: Communicating at transitions of care*. Communicating for Safety Resource Portal. Retrieved July 18, 2025, from <https://c4sportal.safetyandquality.gov.au/transferred>
- Australian Government Department of Health and Aged Care. (2023). *Nurse practitioner workforce plan*. <https://www.health.gov.au/our-work/nurse-practitioner-workforce-plan>
- Australian Institute of Digital Health. (2025). *Virtual care in urgent healthcare: Challenges, opportunities, and the critical role of nurses*. <https://digitalhealth.org.au/blog/virtual-care-in-urgent-healthcare-challenges-opportunities-and-the-critical-role-of-nurses/>
- Australian Institute of Health and Welfare. (2009). *Towards national indicators of safety and quality in health care (Cat. no. HSE 75)*. AIHW. <https://www.aihw.gov.au/reports/health-care-quality-performance/towards-national-indicators-of-safety-and-quality/summary>
- Carini, E., Villani, L., Pezzullo, A. M., Gentili, A., Barbara, A., Ricciardi, W., & Boccia, S. (2021). The impact of digital patient portals on health outcomes, system efficiency, and patient attitudes: Updated systematic literature review. *Journal of Medical Internet Research*, 23(9), e26189. <https://doi.org/10.2196/26189>
- Clinical Excellence Commission. (2017). *Safety Huddle Implementation Guide*. NSW Health. <https://www.cec.health.nsw.gov.au/>
- Clinical Excellence Commission. (2017). *Safety Huddles – Information for Clinicians and Health Professionals*. NSW Health. <https://www.cec.health.nsw.gov.au/>
- Core Prescribing Solutions. (2025). *What is a clinical audit? NHS practice, cycle, and best practice explained*. Retrieved June 19, 2025, from <https://coreprescribingsolutions.co.uk/what-is-clinical-audit/>
- Daley Ullem, E., Gandhi, T. K., Mate, K., Whittington, J., Renton, M., & Huebner, J. (2018). *Framework for effective board governance of health system quality*. IHI White Paper. Institute for Healthcare Improvement. <https://www.ihl.org/resources/white-papers/framework-effective-board-governance-health-system-quality>
- Lamming, L., Montague, J., Crosswaite, K., Faisal, M., McDonach, E., Mohammed, M. A., Cracknell, A., Lovatt, A., & Slater, B. (2021). Fidelity and the impact of patient safety huddles on teamwork and safety culture: An evaluation of the Huddle Up for Safer Healthcare (HUSH) project. *BMC Health Services Research*, 21(1038). <https://doi.org/10.1186/s12913-021-07080-1>
- Le Lagadec, M. D., Massey, D., Byrne, A.-L., Connor, J., & Flenady, T. (2024). Nurse by numbers: The impact of early warning systems on nurses' higher-order thinking, a quantitative study. *Journal of Advanced Nursing*. Advance online publication. <https://doi.org/10.1111/jan.16235>

- Monash University. (2025). *Good Clinical Quality Registry Practice Guide: A guide for hospital Principal Investigators and staff who participate in Australian Clinical Quality Registries (Version 1)*. Monash University. <https://doi.org/10.26180/28440227>
- Safer Care Victoria. (2020). *Credentialing and scope of clinical practice for senior medical practitioners' policy*. <https://www.safercare.vic.gov.au/best-practice-improvement/publications/credentialing-and-scope-of-clinical-practice-for-senior-medical-practitioners-policy>
- Safer Care Victoria. (2025). *Opportunity to support the development of a Victorian Quality and Safety Capability Framework*. Retrieved June 19, 2025, from <https://www.safercare.vic.gov.au/news/opportunity-to-support-the-development-of-a-victorian-quality-and-safety-capability-framework>
- Sampath, B., Rakover, J., Baldoza, K., Mate, K., Lenoci-Edwards, J., & Barker, P. (2021). *Whole system quality: A unified approach to building responsive, resilient health care systems (IHI White Paper)*. Institute for Healthcare Improvement. <https://www.ihl.org>
- van Elten, H. J., & van der Kolk, B. (2024). Performance management, metric quality, and trust: Survey evidence from healthcare organizations. *British Accounting Review*. <https://doi.org/10.1016/j.bar.2024.101511>
- Victorian Agency for Health Information. (2019). *Clinical quality registry public report: Strengthening the quality and safety of healthcare*. State Government of Victoria. https://vahi.vic.gov.au/sites/default/files/2021-12/190723-1%20VAHI%20CQR%20public%20report_July%202019.pdf
- Victorian Department of Health. (2023). *Service capability frameworks in Victoria*. <https://www.health.vic.gov.au/media/23740>
- Victorian Department of Health (2021). *Victorian integrated care online resources*. Victorian Government. Retrieved June 20, 2025, from <https://www.health.vic.gov.au/integrated-care/victorian-integrated-care-online-resources>
- Victorian Department of Health (2025). *Community health data reporting*. Victorian Government. Retrieved June 20, 2025, from <https://www.health.vic.gov.au/community-health/community-health-data-reporting>
- Victorian Department of Health. (2025). *Managing demand for community health services*. Victorian Government. Retrieved June 20, 2025, from <https://www.health.vic.gov.au/community-health/managing-demand-for-community-health-services>
- Victorian Department of Health, (2025). *Standards for Safe and Timely Ambulance and Emergency Care for Victorians*. ISBN: 978-1-76131-746-0. Retrieved from <https://www.health.vic.gov.au/patient-care/standards-for-safe-and-timely-ambulance-and-emergency-care-for-victorians>
- Victorian Department of Health and Human Services. (2008). *Evaluation of community health demand management priority tools: Summary and departmental response*. Victorian Government. Retrieved June 20, 2025, from <https://www.health.vic.gov.au/publications/evaluation-of-community-health-demand-management-priority-tools-summary-and>
- Victorian Department of Health and Human Services. (2017). *Statewide design, service and infrastructure plan for Victoria's health system 2017–2037*. <https://www.health.vic.gov.au/publications/statewide-design-service-and-infrastructure-plan>
- Victorian Department of Health and Human Services. (2016). *Allied health: Credentialling, competency and capability framework (Rev. ed.)*. <https://www.health.vic.gov.au>
- Victorian Department of Health. (n.d.). *Credentialling, competency and capability framework*. <https://www.health.vic.gov.au/allied-health-workforce/credentialling-competency-and-capability-framework>
- Victorian Healthcare Association. (2025). *State of the health sector 2025 report*. <https://www.vha.org.au/news-item/20019/remarkable-resilience-and-adaptability-in-victorian-publicly-funded-healthcare>

- Victorian Managed Insurance Authority (VMIA). *Risk management roles and responsibilities*. Retrieved from <https://www.vmia.vic.gov.au/-/media/Internet/Content-Documents/Tools/VGRMF-tools/Risk-management-roles-and-responsibilities>
- Waring, J., Bishop, S., Black, G., Clarke, J., & Roe, B. (2023). What can clinical leaders contribute to the governance of integrated care systems? *BMJ Leader*, 7(4), 279–284. <https://doi.org/10.1136/leader-2022-000709>
- Wei, H., Corbett, R. W., Ray, J., & Wei, T. (2020). A culture of caring: The essence of healthcare interprofessional collaboration. *Journal of Interprofessional Care*, 34(3), 324–331.
- Whistleblower Security. (n.d.). *Psychological safety and whistleblowing hotlines: Creating a believable speak-up culture (Version 1.0 - External)*. Whistleblower Security. Retrieved from https://info.whistleblowersecurity.com/hubfs/Feature%20Sheets/WBS-FS-Psychological-Safety-and-Whistleblowing_EN-WEB.pdf