

SA Health Chronic Heart Failure Management Program - Model of Care

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The chronic heart failure management program model of care outlines the core components and best-practice approach for delivering chronic heart failure services across SA Health.



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Introduction

Heart failure (HF) remains a leading cause of mortality in Australia and continues to place a substantial financial burden on the healthcare system. Despite significant advances in the treatment and management of chronic heart failure, it remains one of the most common causes of hospital admissions nationwide.

In Australia, heart failure is responsible for almost one in 50 deaths – the equivalent of one life lost every 3 hours, or 8 each day ¹. Heart failure is the leading cause of hospitalisations in patients aged >65 years and is responsible for >150000 hospital admissions per year ². In 2017 in South Australia there were 12600 admissions per year with heart failure, equating to 87000 days of hospital stay ². The risk of hospital readmissions in this patient population is high, with the greatest risk occurring in the immediate post-discharge period. Almost 25% of people who are hospitalised with heart failure in Australia are readmitted to hospital within the first 30 days of discharge ³.

An important part of heart failure care is the development of multidisciplinary heart failure services comprising of medical clinicians, nurses, pharmacists and allied health practitioners. These services are aimed at supporting those with a diagnosis of heart failure by providing education and management of heart failure care in a high quality, compassionate and timely setting. Specifically, these services have been shown to be beneficial to those recently hospitalised with heart failure, those at high risk of readmission (including patients with active comorbidities and symptomatic heart failure), the elderly, and patients with inadequate social and economic support ⁴, leading to improved symptoms and quality of life, significant reduction in heart failure hospitalisations and mortality.

As such, multidisciplinary Heart Failure Management Programs (HFMP's) have already been established in South Australia based on the evidence above. However, with the increasing burden of chronic heart failure and the increasing strain on the healthcare system and workforce, the Heart Failure Sub-Committee of the Commission of Excellence and Innovation in Health undertook a review of current Chronic Heart Failure Services across all Local Health Networks and Country Health in late 2023.

The aim of the project was to:

- Identify all outpatient heart failure services available in LHNs and Country Health
- Define type of currently available services including number of physician clinics, nurse-led clinics and allied health services

This information then allowed us to identify gaps in clinical care:

- between metropolitan LHNs, between metropolitan and country Networks and against interstate HF Services
- and to develop the first South Australian Chronic Heart Failure Management Program Model of Care.

Model of Care for Chronic Heart Failure Management Program in SA

Definition

The Chronic HF Management Program Model of Care (MoC) proposed will define the way health services for HF are delivered. It outlines best practice care and services for HF patients from initial diagnosis to advanced stages of HF.

The Chronic HFMP MoC aims to ensure:

- Care is person centred
- Delivered in metropolitan and regional areas to ensure equal access
- By the right multidisciplinary team with the right skill set
- Delivery of services in a timely manner
- Aiming to reduce patient symptoms and improve quality of life
- Aiming to reduce heart failure hospitalizations
- Aiming to reduce heart failure related mortality

Discovery – The case for change

Multidisciplinary Heart Failure Management Programs (HFMPs) have already been established in South Australia based on evidence that there are benefits of multi-disciplinary care to patients, and impact on patient outcomes including self-reported and risk of need for urgent care/hospitalisation and death⁵.

The Heart Failure Sub-Committee comprises of medical specialists, nurses and nurse practitioners, allied health professionals, general practitioner and researchers. In our goal to improve Heart Failure Care for South Australians, we identified marked differences between Heart Failure Services set-up, workforce, patient access and delivery of care. Therefore, a formal review of the state's Heart Failure Services was undertaken.

There are recognised challenges in accessing digital and telehealth infrastructure in remote and regional areas, where connectivity limitations and difficulty accessing GPs contribute to considerable variation in service availability and consistency, particularly for Aboriginal and/or Torres Strait Islander peoples.

Our current analysis revealed significant gaps in the delivery of the services in SA which include:

- A lack of outlined uniform standards in service requirement and delivery in the state, leading to different accessibility and delivery of services amongst local health networks (LHN's).
- Significant inequity of care to rural patients and Aboriginal peoples.
- Variable and limited access to allied health professionals including pharmacists (not currently available in the outpatient setting)
- Limited availability of heart failure exercise programs

A Model of Care for Chronic Heart Failure Management Programs was developed by the SA Heart Failure Sub-committee, to ensure that all patients with symptomatic heart failure have equal and timely access to appropriate specialist medical review and management, as well as coordinated nursing and allied health care across South Australia. This has been endorsed by the CEIH.

Objective

This MOC aims to establish and provide guidance on optimal standards of care for HF in South Australia. SA currently does not have a working framework for delivery of chronic heart failure care. The standards and recommendations made are based on evidence for best clinical practice care and recommendations from interstate networks.

We identified 10 standards that impact on delivery of Heart Failure Services in SA, and constructed recommendations accordingly. These standards are focused on patient's care from time of diagnosis of heart failure through to management in the outpatient setting, either referred from community or transitioned on discharge from hospital.

Essential standards of Heart Failure service

Table 1. Essential standards of Heart Failure Management Programs

Standards	Recommendations
Specialist Medical Review and Management	For initial management of complex HF patients
Heart Failure Multidisciplinary Services Structure	For comprehensive care to improve symptoms, quality of life, and mortality
Timing of Support: From Hospital to Home	Early follow-up within 7-10 days of hospital discharge where available
Referrals and Inclusion Criteria	Criteria used to identify patients for referral to HFMP
Patient Assessment and Management	Minimum initial and review patient assessments based on clinical needs
Managing Risk of Decompensation	Identification of factors determining risk and management of risk
Discharge Criteria	Minimum criteria prior to discharge from HFMP
Benchmarking and Outcomes	Use of statewide data collection and reporting
Workforce Levels, Skill Mix, and roles	Recommendations for key stakeholders to develop comprehensive HFMP's

Standards	Recommendations
Clinical Roles	Recommendations for key stakeholders to deliver best clinical practice

Target Audience

The document may be used by hospital administrators, general practitioners, nurses, doctors, allied health staff and Aboriginal health service providers, who need to understand, to engage with or to develop/improve HF service delivery.

This document is solely focussed on establishing/defining the minimum standards of care for Heart Failure management and is not a clinical pathway for diagnosis or management of heart failure.

Recommendations for implementation and ongoing review will be undertaken every five years, or as required in response to updates in evidence-based guidelines for heart failure management.

Standards

Standard 1: Specialist Medical Review and Management

Patients admitted to hospital with chronic heart failure should be referred to cardiology specialist care, general physician and other subspecialty services, if clinically indicated, for review and advice on management to improve patient outcomes. Patients with heart failure in the community should also be considered for cardiology and specialist referral to support delivery of evidence-based management.

Standard 2: Chronic Heart Failure Management Program (HFMP) Structure

Multidisciplinary structured programs target high risk heart failure patients to provide and deliver individually tailored programs that include:

- Chronic disease management
- Case management
- Self-management
- Rehabilitation

HFMP's are cost effective and have demonstrated improvements in survival, quality of life and a reduction in heart failure hospitalisations⁵.

A HFMP is usually coordinated by a nurse with expertise in heart failure management. Components are outlined in **Table 2**. Clinical follow up by the multidisciplinary team can be either by telehealth, home visit, nurse-led clinic, group rehabilitation and education, or a combination of strategies.

Whilst the preference is for face-to-face care delivery, in circumstances where this is not possible, remote management via structured telephone support, remote titration and telemonitoring is advisable (Strong recommendation, CSANZ Chronic Heart Failure Guidelines, 2018).

Table 2: Recommended Essential Components of a Heart Failure Management Program

Description
Comprehensive education and counselling individualised to patients needs
Promotion of self-care, including self-adjustment of diuretic therapy in appropriate patients (or with family member/caregiver assistance)
Exercise training, including referral to an Exercise Physiologist where available
Emphasis on behavioural strategies to increase adherence – referral to psychology services, where appropriate
Follow-up within 7-10 days of hospital discharge or after period of instability (either face to face or telehealth)
Optimisation of medical therapy, including referral to Titration Clinics (usually nurse led)
Increased access to providers
Recognition of and attention to signs and symptoms of fluid overload
Assistance with social and financial concerns – referral to social worker, welfare worker as required
Advanced care planning, including referral to Palliative Care using the statewide referral document: Palliative care referral form (sahealth.sa.gov.au)

Adapted from: The HFSA’s 2010 Comprehensive Heart Failure Practice Guideline: Section 8 Disease management, advance directives, and end-of-life care in heart failure⁶

CSANZ Guidelines for the prevention, detection, and management of chronic heart failure in Australia. Updated July 2011.⁷

Standard 3: Specialist Medical Review and Management

The Heart Failure Management Program (HFMP) aims to extend the time that patients remain clinically well and stable in the community, prolong life, improve quality of life and reduce avoidable readmissions.

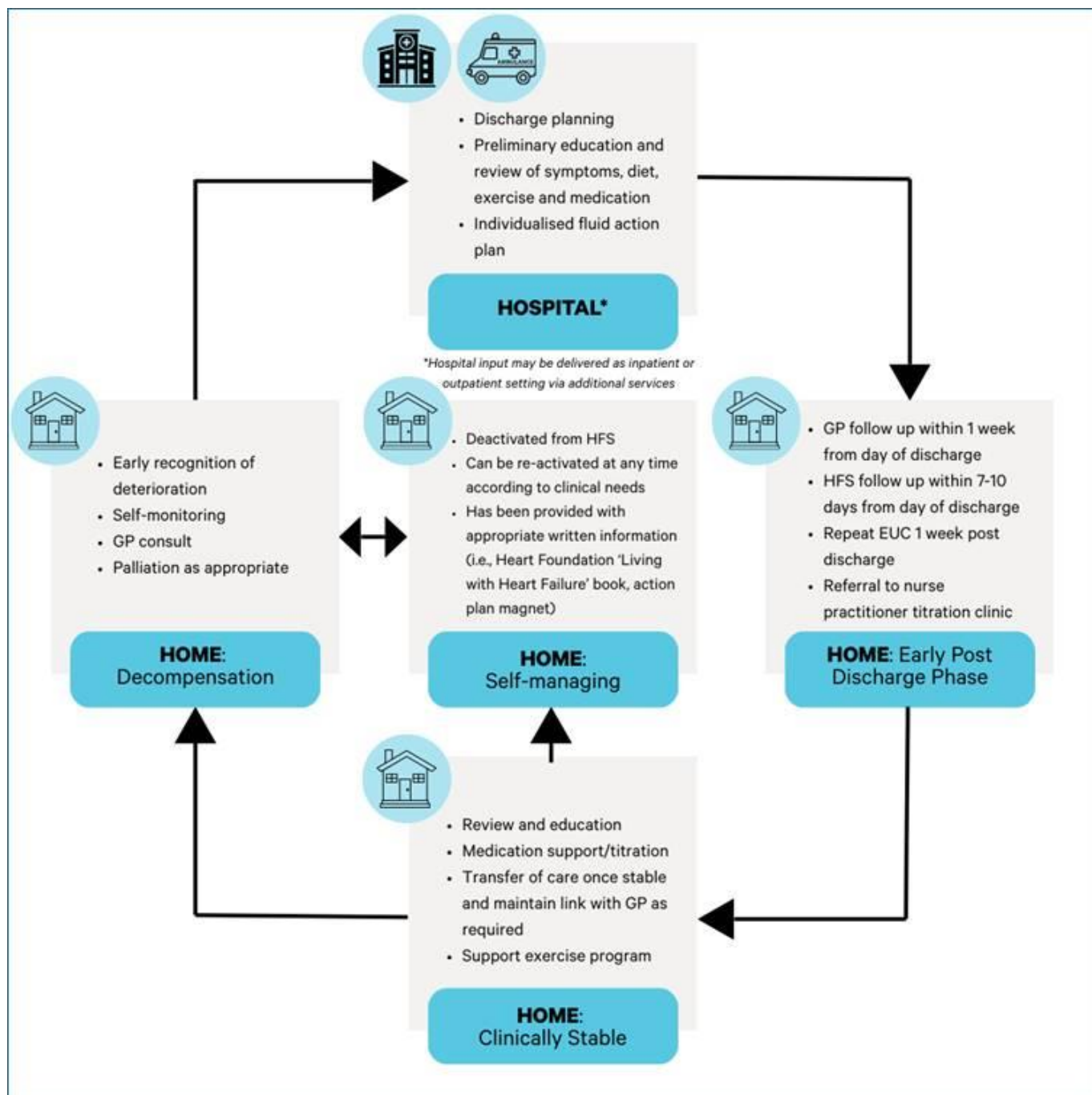
The inpatient management team delivers preliminary education and support to the patient and/or their carer with a focus on discharge planning and future hospital avoidance strategies. Although the 30-day readmission rate is historically reported to be as high as 30%, if services are provided in a timely manner, ideally within 7-10 days post discharge, the readmission rate can be reduced significantly.^{8,9,10}

The outpatient HFMP provides further education and support to consumers, facilitating early engagement with the heart failure nursing team and review with community General Practitioners. Formal outpatient review to further guide initiation and up titration of guideline directed therapies needs to be arranged in a

timely fashion and triaged such that the patients at greatest risk of readmission are reviewed as a priority. Contact should be established by the community team to schedule a home visit or telehealth review within 7-10 days of discharge.

The chronic heart failure patient’s journey, as outlined in Figure 1, highlights that the majority of services are community-based. Given the frequency with which heart failure patients seek medical review (12x/year at GP clinics and 1-2x/year with specialists), up-skilling of community-based teams is paramount to improve outcomes, by facilitating early recognition of decompensation and intervention to minimise hospital readmissions.

Figure 1. Chronic Heart Failure Management Program Model of Care



Standard 4: Referrals and Inclusion Criteria for HFMP

Patients may be referred to a HFMP from outpatient or inpatient settings and GPs (depending on service capacity). Services should accept referrals from other Chronic Disease services in South Australia.

All persons over the age of 18 years with symptoms of heart failure and a confirmed diagnosis, regardless of aetiology, should be considered for enrolment into a HFMP. This includes patients with:

- reduced ejection fraction (HFrEF) including patients post infarct
- heart failure with preserved ejection fraction (HFpEF)
- heart failure with associated valvular disease
- isolated right heart failure (e.g. cor pulmonale).

Standard 5: Patient Assessment and Management

Comprehensive assessment of the patient will include:

- Symptom control and recognition of deterioration/decompensation
- Medication management and education
- Self-management and lifestyle
- Cardiovascular risk factor modification
- NYHA functional status
- Psychosocial concerns
- Exercise capacity
- Nutritional status
- Social supports
- Comorbidities management
- Goals of care and advanced care planning discussion
- Resuscitation status and 7 step pathway discussion

Standard 6: Managing Risk of Decompensation

The individualised risk of decompensated heart failure and readmission to hospital will determine the timing of follow-up as well as the intensity and type of intervention. Whilst local needs and resources may differ, services should be provided in a manner that best suits the needs of the patient.

By utilising telehealth strategies, regional titration services, and engaging in the up skilling of community service providers (General Practitioners and Clinical Nurses), services offered to rural patients should mirror those provided to metropolitan patients⁵.

A Regional Heart Failure Optimisation Service was established in 2025 as an extension of the Rural Support Service to assist in the support and management of heart failure patients from regional South Australia and support the rapid up-titration of guideline-directed medical therapy to improve quality of life, reduce heart failure hospitalisations, decrease mortality and halt disease progression¹¹.

The identification of risk and suggested management is outlined in **Table 3**.

Table 3. Managing the Risk of Decompensated Heart Failure

Risk Level	Factors Determining Risk	Management of Risk
Low	<ul style="list-style-type: none"> • Class I-II NYHA symptoms of heart failure • Demonstrates understanding of condition • Ability to follow medication and dietary guidelines • No admissions for decompensated heart failure within the last 6 months • Adequate social support • Regular, timely contact between GP and the HFMP 	<ul style="list-style-type: none"> • Inpatient review pre-discharge if possible • Follow up within 7-10 days post discharge or referral • Specialist medical outpatient clinic 4-6 weeks (if warranted) and ongoing as needed • Physical, social and emotional assessment • Provision of simplified medication list and drug information, including an explanation of the prognostic benefits and techniques to aid adherence. To consider the need for a home medicines review via community pharmacy • Referral to Nurse Practitioner Titration Clinics if available • Link with regional service including Country Access to Cardiac Health (CATCH) and Virtual Clinical Care (VCC) through Integrated Cardiovascular Clinical network (iCCnet) • Education regarding self-management strategies • Exercise prescription for home or group program
High	<ul style="list-style-type: none"> • Class II-IV NYHA symptoms of heart failure • New diagnosis of heart failure/poor understanding of condition • Renal impairment (eGFR < 30mL/min) • Ongoing symptoms on discharge • Communication difficulty • Culturally and linguistically diverse background • Poor cognitive function • Multiple heart failure admissions (3 in the prior 12 months) • Aboriginal and/or Torres Strait Islander patients • Socially isolated • Multiple comorbidities and risk factors • Polypharmacy • Poor adherence with medication or diet • Frailty 	<ul style="list-style-type: none"> • Inpatient review prior to discharge • Follow up within the first 7-10 days following hospital discharge or outpatient referral • Enrol in the Heart Failure Management Program • Provide or refer to a structured exercise and education program or home-based exercise program • Ongoing education on symptom control, particularly fluid management • Medication management support and up titration as appropriate and support for flexible diuretic regimes • Utilise the EMR Clinical Document 'Heart Failure medication titration plan' • Ongoing assessment and referral • Regular, timely contact between the GP, HFMP and other referrers • Referral to palliative care team if appropriate • Subsequent follow up to be arranged to meet the patient's needs

1 Patient risk level status may rapidly change

2 New York Heart Association (NYHA) Classification of heart failure. It places patients in one of four categories based on how much they are limited during physical activity. <https://www.heart.org/en/health-topics/heart-failure/what-is-heart-failure/classes-of-heart-failure>

3 Heart Failure Medication Plan available from: https://www.health.qld.gov.au/heart_failure/asp/med_titration

Standard 7: Discharge Criteria

HFMP should manage patient flow to ensure that there is capacity to care for new patients. Discharge from HFMP, once optimized and clinically stable, will depend on availability of local health providers such as GPs and domiciliary care. Patients who have frequent episodes of destabilisation after discharge from a program should be referred again for support. Clinicians can follow a discharge criteria and deactivate where appropriate back to GP care and re-enrol the patient again as necessary.

Prior to HFMP discharge, all patients (or their family or care givers) should, at a minimum:

- Be able to self-manage, recognise worsening symptoms, have an action plan and know how to use it (or have a carer and/or support services organised if required)
- Know how to exercise safely according to his or her condition and participate in life-long activity
- Be in the care of a GP (and specialist outpatient or palliative care if required)
- Have reached optimal tolerated doses of heart failure medications and have a medication plan provided to GP. (Titration by GP may still require involvement by HFMP until target is achieved.)

Some patients may also need to be considered for:

- Electrophysiology review to assess need and suitability for ICD/CRT where the ejection fraction is <35%, the patient is on maximum medication therapy for several months, and it is deemed medically appropriate
- Cardiac genetic review for patients with hypertrophic or familial cardiomyopathy
- Early specialist heart failure review to a quaternary referral heart failure centre (for advanced therapies and transplantation suitability) for patients who deteriorate or do not tolerate medication up titration despite best efforts.¹

Standard 8: Benchmarking and Outcomes

Statewide coordination of data collection and reporting

HFMP multidisciplinary teams should be assisted to collect relevant data relating to referrals received. Data should be used by clinicians as part of state-wide and local quality assurance initiatives to identify gaps in service delivery, improve patient care and facilitate benchmarking between services.

Acknowledging that improved alignment between databases, registries, and KPI reporting systems is required to enhance visibility of outcome-related data and support more accurate, meaningful measurement of patient outcomes.

¹ iCARDIO Alliance Global Implementation Guidelines on Heart Failure 2025. Chopra, Vijay et al. Heart, Lung and Circulation, Volume 34, Issue 7, e55 - e82 - [iCARDIO Alliance Global Implementation Guidelines on Heart Failure 2025](#)

Clinical indicators may change to focus on areas requiring improvement. Current indicators are listed in the **Table 4**. Readmission rates, average length of stay, and mortality rates should also be reported.

Table 4. Clinical Performance Indicators

Clinical Performance Indicators
1. Timely follow-up by a HF Management Program for inpatient and outpatient referrals (all patients)
2. Assessment of ventricular function within the last two years (all patients)
3. Average length of stay for a heart failure admission
4. Cardiac and all-cause readmission rates at 30 days, 3 months and 6 months post diagnosis
Medication Management of Patients with a Diagnosis
<ul style="list-style-type: none"> • Angiotensin-converting-enzyme inhibitor (ACEI) or angiotensin II receptor blockers (ARB) or Angiotensin Receptor-Nepriylsin Inhibitors (ARNI) (HFrEF only)
<ul style="list-style-type: none"> • Guideline recommended beta blockers (Bisoprolol, Carvedilol, Metoprolol sustained release, or Nebivolol) (HFrEF only)
<ul style="list-style-type: none"> • Mineralocorticoid receptor antagonist (MRA)
<ul style="list-style-type: none"> • Sodium-glucose co-transporter-2 inhibitors (SGLT2i)
<ul style="list-style-type: none"> • Beta blocker/RAAS system medication review and titration status at 6 months post referral to a HF Management Program (HFrEF only)
<ul style="list-style-type: none"> • Review of iron studies and replacement as indicated
<ul style="list-style-type: none"> • Clinical pharmacist review upon hospital discharge for provision of medication counselling including prognostic benefits and adherence techniques, and medication list/dose administration aid when indicated.

Standard 9: Workforce Levels, Skill Mix and Roles

Patients require access to a multidisciplinary team of trained, experienced health professionals who routinely see a critical mass of patients with heart failure. The heart failure nurse is central to this model, as they provide case-management in close liaison with medical specialists and GP specialists. In rural and small centres, the nurse may be the sole case manager accessing allied health staff by referral only. A HFMP may incorporate face to face reviews and/or telehealth/telephone services. In regional areas, access to programs designed to increase accessibility for regional and remote patients such as the Virtual Cardiovascular Care Services or telehealth services to tertiary hospitals are critical.

Staffing of Heart Failure Support Services

Workload recommendations are based on the following assumptions:

Manageable workloads and an appropriate skill mix of the clinical team leads to better health outcomes for patients such as avoiding hospital readmission and improving quality of life.

Patients and their carers receive support including enrolment in a heart failure management program if available, inpatient education and discharge coordination, post discharge care and medication titration, and support over time during different phases of disease progression.

Continuity of care is best achieved using designated heart failure nurse practitioners and specialist allied health staff (physiotherapists, accredited exercise physiologists, pharmacists, dietitians, occupational therapists, psychologists and social workers). Rotational posts should be used cautiously as they cannot contribute to continuity of care and have a large training burden.

Support services are provided Monday to Friday inclusive with external health care providers and agencies providing after hour and weekend care as arranged by the core HF team. After hours support will be provided in collaboration with hospital on-call services and various community services as required.

The duration of care is flexible. Whilst patients are routinely enrolled in a 6-month Heart Failure Management Program, clinicians can elect to discharge patients from the service or extend their involvement as determined by clinical need.

It is important that adequate backfill is available for all types of leave for all members of the heart failure team, including professional development, to prevent interruption of services.

Staff to patient ratios and caseload hours recommendations

While staff to patient ratios are commonly used for inpatient settings, ratios are difficult to calculate in a chronic disease management model of care where most of the support occurs when the patient is living in the community. The time spent in direct patient care is more commonly used to estimate case-load management in non-acute care.¹² However, some estimate of staff to patient ratios is useful to ensure that teams are appropriately resourced to meet patient needs. A heart failure statewide coordination role is important to reduce hospitalisations, ensure efficiency of services, enable benchmarking, training, and maintain high standards of care.

Standard 10: Clinical Roles

Medical Specialist

Each HFMP requires a medical sponsor (a cardiologist or general physician) with an interest and expertise in heart failure. The role not only provides patient care but also mentors the team regarding up-skilling in medical management. Where medical mentorship is not available locally (as in some rural and remote areas) such support should be provided by formalising links with another centre that can provide remote support via telehealth or periodic remote visits.

Nursing

An ideal standard for nurses in a HFMP is to ensure that patients receive all components of care (as outlined in Table 1) from relevant health professionals with consideration of comorbidities.

The heart failure service coordinator is usually a registered nurse. Due to the level of expertise and accountability in reporting outcomes at least one nurse on the team should be a Nurse Practitioner (NP) or Nurse Consultant (NC) with expertise in heart failure management and chronic disease, or the capacity to rapidly acquire these skills.

Nurse Practitioner (Level 4 NP/ Level 3 NP Candidate)

HF Nurse Practitioner is responsible for nursing clinical leadership and providing an advanced level of clinical care including assessment, ordering and review of diagnostic investigations, medication prescription and titration and referral to other health professionals for clients with heart failure. Where the position is the sole nursing position, the person will also be responsible for planning, data collection/auditing and evaluation of services.

Nurse Consultant (Level 3 NC)

A HF Nurse Consultant (NC) is responsible for the overall clinical coordination, planning, implementation and evaluation of the HFMP. The HF NC role includes a clinical specialist component, delivering HF patient education, and conducting post-discharge follow-up.

Clinical Nurse CN (Level 2 CN)

The CN role is primarily involved with patient related activities under the direction of the Nurse Practitioner or NC within the Metropolitan region. Within country LHN's there needs to be a clear reporting line with direct supervision by the treating medical officers.

Allied Health

Allied health staff may be part of a team or accessed by referral. While it is recognised that not all centres will be able to maintain allied health services specifically for a HFMP, the strongest evidence for achieving optimal outcomes is based on specialised HF multidisciplinary care⁵. Both metropolitan and country LHN's should aspire to building a multidisciplinary team.

Pharmacist

Pharmacists with expertise in heart failure management are responsible for the optimisation of medication management. This includes undertaking medication histories, medication reviews, assessment and resolution of medication related problems, supporting medication titration in accordance with evidence based guidelines, providing patient and carer education, including an explanation of the prognostic benefits supporting the medication regime, supporting medication adherence, screening for and managing drug-drug and drug-disease interactions, reviewing therapeutic drug monitoring where indicated, and liaison with community health providers to promote continuity of health care

Physiotherapist/Accredited Exercise Physiologist

Physiotherapists or accredited exercise physiologists are responsible for: comprehensive assessment, interpretation of relevant investigations, evaluation of exercise capacity, consideration of the patient's complex needs and comorbidities, and prescribing individual and group exercise programs in accordance with evidence-based guideline, and carer education regarding physical activity and exercise specific to the individual's needs.

Dietician

Assessment includes a diet history of client; calculation of estimated dietary intake; comparison of actual dietary intake to recommended dietary intake and screening for malnutrition; prescription of specific diets based on the identified needs of the individual and education. Patients with chronic heart failure and a malnutrition score of greater than 2 are a priority for dietetic intervention ¹³.

Occupational Therapist

Occupational therapists assist independence for patients with heart failure through personal goal setting; energy conservation and work simplification training; and home modifications for the purpose of maximising function, safety and falls prevention.

Social Worker

Social workers may provide advice and assistance with practical issues and concerns; information and assistance with financial and legal matters; end of life planning; and use intervention strategies such as stress management and relaxation, counselling and support.

Psychologist

Psychologists provide support for patients with heart failure with psychological distress such as depression and anxiety.

Clinical administration support

Administrative support may include telephone reception, scheduling of patients, data entry, clinical letters and minute taking.

Statewide Coordination of Heart Failure Management Programs

Statewide Coordination Manager

The Statewide HFMP Coordinator is responsible for coordinating multidisciplinary heart failure services across South Australia. Their role is to ensure high standards of practice and promote ongoing service development. This includes supporting high standards of care by developing and maintaining evaluation systems, leading service improvement initiatives, overseeing workforce training and education, and guiding service planning and development. The role could also encompass tracking referral patterns, including public vs. private referrals.

Statewide Administration Support Officer

The role of the statewide administration support officer is to: manage events and training courses, support and maintain local websites and collect and disseminate information to all multidisciplinary team members, including medical staff.

Appendix 1: Tools for Assessment and Management

Living Well with Heart Failure









<https://www.heartfoundation.org.au/bundles/for-professionals/heart-failure-resources-for-patients>

SA Health Palliative Care Referral Form

<https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/primary+and+specialised+services/palliative+care+services/palliative+care+services>

Safety, Quality and Risk Management

National Safety and Quality Health Service Standards

							
National Standard 1	National Standard 2	National Standard 3	National Standard 4	National Standard 5	National Standard 6	National Standard 7	National Standard 8
Clinical Governance	Partnering with Consumers	Preventing & Controlling Healthcare-Associated Infection	Medication Safety	Comprehensive Care	Communication for Safety	Blood Management	Recognising & Responding to Acute Deterioration
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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