National Safety and Quality Health Service Standards (third edition) – Public Consultation

19th September 2025

The Cancer Nurses Society of Australia (CNSA) represents the more than 8,000 cancer nurses working across Australia. As the peak national body for cancer nursing, the CNSA strives to promote excellence in cancer care through the professional contribution of cancer nurses. To achieve this mission, CNSA acts as a resource to cancer nurses and all nurses who provide care to individuals diagnosed with cancer around Australia, regardless of geographical location or area of practice. We are the critical link between cancer nurses in Australia, the consumers of cancer nursing services, and other health services and providers involved in cancer control.

Our Vision: Best possible outcomes and experiences for all people affected by cancer.

Our Mission: Promoting excellence in cancer care and control through the professional contribution of cancer nurses.

The CNSA would like to lend our support to the Australian Commission on Safety and Quality in Health Care in updating the National Safety and Quality Health Service (NSQHS) Standards and welcome the opportunity to contribute to this consultation process. We look forward to being actively involved in the ongoing consultation and collaboration process, contributing to the development and design of Standards that shape and impact the role of cancer nurses in delivering high-quality, safe care. This consultation was developed in collaboration with the CNSA Vascular Access Device and Infusion Therapy Specialist Practice Network (VAD&IT SPN), who have a specific interest in improving the clinical management of vascular access devices through integration of current evidence, local and system-level data, and multidisciplinary and collaborative clinical expertise to positively impact patient vascular access device experiences and outcomes in cancer care.

CNSA would welcome the opportunity to discuss the details of this submission further and explore how we can support the development and implementation of the next edition of the Standards.

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Submission Questions

1. **What existing and emerging safety and quality risks should the Commission be considering in the third edition?**

   We would welcome consideration by the Commission of incorporating Standards on the safety and quality of vascular access devices. Insertion of these invasive devices is the most common invasive procedure performed in healthcare in all patient populations.[1] This is a specific high-risk area of patient care with significant safety risks associated with complications due to the healthcare variation—gap between clinical management and current evidence—in clinical practice. Currently, the 2nd Edition of the Standards does not include any specific recommendations regarding the use of vascular access devices. These invasive devices, including peripheral intravenous cannulas (PIVCs) and central venous access devices (CVADs), are pivotal for the efficient and effective delivery of systemic anticancer therapies, supportive therapies, and repeated or frequent blood sampling for cancer patients. However, Australian studies have shown that in clinical practice, up to 42% of CVADs[2] and 35% of PIVCs[3] are removed prematurely. The risk of complications and premature failure is increased for cancer patients due to the pathophysiology of the disease and the diverse, potentially prolonged and considerable side effects of therapies. This inherently increases the challenge for cancer clinicians to safely, effectively, and efficiently manage vascular access devices.

   We would recommend that the Australian Commission on Safety and Quality in Health Care (ACSQHC) establish a CVAD Clinical Care Standard and add it to version 3 of the Standards alongside the Management of Peripheral Intravenous Catheters Clinical Care Standard as a priority.

   References:

1. Australian Commission on Safety and Quality in Health Care. (2021). Management of Peripheral Intravenous Catheters Clinical Care Standard. Sydney. Retrieved from https://www.safetyandquality.gov.au/sites/default/files/2021-05/management_of_peripheral_intravenous_catheters_clinical_care_standard_-_accessible_pdf.pdf

2. Curtis, K., Keogh, S., Krishnasamy, M., & Gough, K. Central Venous Access Device Complications and Premature Removal in Patients with Haematological Malignancies: A Multi-Site Cohort Study. *eJHaem* 2025;6(2): e1090. doi:10.1002/jha2.1090.

3. Larsen, E. N., Marsh, N., O'Brien, C., Monteagle, E., Friese, C., & Rickard, C. M. Inherent and modifiable risk factors for peripheral venous catheter failure during cancer treatment: a prospective cohort study. *Support Care Cancer* 2021;29(3):1487-96. doi:10.1007/s00520-020-05643-2.

2. **How can the third edition have a greater impact on driving high performance?**

   Our recommended suggestions on how the Standards from the 2nd Edition could be improved in the 3rd Edition, with the addition of specific considerations.

   - **Clinical Governance Standard 1.10 – Risk Management**

     This section should include a reference to the importance of standardised data collection and surveillance, and reporting of comprehensive key performance indicators that indicate clinical governance standards are being met. In the example of vascular access device-related adverse outcomes—the most common invasive procedure in healthcare— we would suggest the need for a minimum standardised data set to be collected across all cancer centres, including details of the patient, device, insertion, management, complication and removal data[1]. The local collection of standardised data can then be used to contribute to system-level data analysis to inform future clinical practice and Standards.

- **Clinical Governance Standard 1.23 – Credentialing and Scope of Clinical Practice**
  This section should include consideration of workforce factors on the delivery of care and how to identify and address workforce shortages that could impact safety and quality. For instance, the health service organisation should have a process to identify workforce shortages and prioritise enhancing clinical service capacity by expanding or extending the scope of practice to address workforce shortages as appropriate to meet patient needs.
  In the example of vascular access device use in cancer care – limited medical staff time to insert PIVCs means the need to train vascular access specialist nursing teams. In health services where there is limited access to fluoroscopy-inserted PICC out of hours, there is a need to institute a nurse-led PICC insertion service.[2]
- **Preventing and Controlling Infections Standard 3.12 – Invasive Medical Devices**
  We would recommend that further information be provided here about specific standards that could be referenced for the use of invasive medical devices. This should include details of the Australian Commission on Safety and Quality in Health Care – Management of Peripheral Intravenous Catheters Clinical Care Standard (https://www.safetyandquality.gov.au/sites/default/files/2021-05/management_of_peripheral_intravenous_catheters_clinical_care_standard_-_accessible_pdf.pdf) and the CNSA Vascular Access Devices: Evidence-Based Clinical Practice Guideline recommendations (https://www.cnsa.org.au/implement/vascular-access-devices/vascular-access-guidelines.html). At present, a Clinical Care Standard for central venous access devices does not exist, despite a clear need. Recent Australian data demonstrate that 42% of CVADs were removed prematurely due to healthcare variation, highlighting the importance of addressing this gap, which should also be included here.[3]
- **Comprehensive Care Standard – Minimising Patient Harm**
  In this section, it highlights 'patients at risk of specific harm', but we would suggest that it should be the goal of care to minimise harm for 'all patients' by implementing proactive and preventative care, evidence-based practice instead of reactionary care.
  This section does not address the need to 'identify and address healthcare variation'. This can occur when there is a gap between the evidence and clinical practice, and there is a need to support and resource health services to identify and address these gaps.[3]

References:

1. Schults J, Kleidon T, Chopra V, et al. International recommendations for a vascular access minimum dataset: a Delphi consensus-building study. *BMJ Qual Saf* 2021;30(9):722-30. doi:10.1136/bmjqs-2020-011274.
2. Fernandez-Fernandez I, Parra-García G, Blanco-Mavillard I, et al. Vascular access specialist teams versus standard practice for catheter insertion and prevention of failure: a systematic review. *BMJ open* 2024;14:e082631. doi:10.1136/bmjopen-2023-082631.
3. Curtis K, Keogh S, Krishnasamy M, & Gough K. Central Venous Access Device Complications and Premature Removal in Patients With Haematological Malignancies: A Multi-Site Cohort Study. *EJHaem* 2025;6(2):e1090. doi:10.1002/jha2.1090.

3. How can the third edition support integration of services, within and across health services?

Our recommended suggestions on how the Standards from the 2nd Edition could be improved in the 3rd Edition, with the addition of specific considerations related to the integration of services.

- **Partnering with Consumers Standard 2.06 and 2.07 – Sharing Decisions and Planning Care**
  This standard does not address continuity of care across health institutions regarding patient-focused healthcare decision making. For example, patients might not recall previous treatments, especially when they are in stressful or vulnerable situations, but need to make decisions about their future care without knowledge of previous treatments. It is important to provide information to patients about their previous care to help inform decisions about their future care. This is especially important for patients with chronic conditions, such as

cancer, when previous treatment could have occurred a long time ago or at another health institution.

- **Partnering with Consumers Standard 2.10 – Communication that Supports Effective Partnerships**
  We would recommend including more guidance on the timing, frequency, format and provider of information to consumers. This would help to reinforce that information provision to consumers should be an ongoing process with regular opportunities provided to share information throughout the patient's care. It is also important that the preferences of patients, carers, families and consumers regarding the provision of information are recorded so that during future interactions with other health professionals, these preferences for information provision are considered when delivering information.

4. **How can the third edition support a continuous learning approach and minimise a compliance mindset?**
   We would recommend the following resource could help support the implementation of better compliance with vascular access device best practices with the Standards: Quality statement 3 in ACSQHC Management of Peripheral Intravenous Catheters Clinical Care Standard - A patient's PIVC is inserted and maintained by clinicians who are trained and assessed as competent in current evidence-based practices for vessel health preservation and preventing device-related complications, relevant to their scope of practice. Insertion by a clinician working towards achieving competency is supervised by a clinician who is trained and assessed as competent.[1]

References:

1. Australian Commission on Safety and Quality in Health Care. (2021). Management of Peripheral Intravenous Catheters Clinical Care Standard. https://www.safetyandquality.gov.au/sites/default/files/2021-05/management_of_peripheral_intravenous_catheters_clinical_care_standard_-_accessible_pdf.pdf

5. **What needs to change in the current format and structure of the standards for the third edition to be easier to understand and act on?**
   The current version of the Standards includes broad descriptions, which introduces the risk that they can be interpreted differently in clinical settings. There should be sufficient detail in each Standard so that measurable outcomes can be applied, enabling services to demonstrate compliance in clinical practice. We would recommend either the introduction of specific case study examples or more detailed descriptions of how the standards should be applied in practice in the updated 3rd edition of the Standards.

6. **Are there areas of duplication or redundancies that could be removed from the current standards?**
   No comment

7. **Please provide any additional comments you think will assist the Commission with the development of the third edition of the NSQHS Standards.**
   We would also like to highlight the importance of equity of access to equipment, resources, education, and technology, as this impacts the ability of the health service to deliver optimal care. Equity of access to optimal cancer care for all Australians is a key pillar of the Australian Cancer Plan. These standards should reflect the importance of equity across all health care.