



Heavy Menstrual Bleeding

Clinical Care Standard

June 2024

The Australian Commission on Safety and Quality in Health Care acknowledges the traditional owners of Country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to elders both past and present.

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The *Heavy Menstrual Bleeding Clinical Care Standard* has been endorsed by the following organisations:



Contents

Heavy Menstrual Bleeding Clinical Care Standard	1	Quality statement 6 – Specialist referral	28
Indicators for local monitoring	2	Quality statement 7 – Uterine-preserving alternatives to hysterectomy	30
Updates in 2024	4	Quality statement 8 – Hysterectomy	33
Clinical care standards	5	Overall indicator	35
About the Heavy Menstrual Bleeding Clinical Care Standard	6	Appendix A: General principles of care	36
How to use this clinical care standard	8	Appendix B: Indicators to support local monitoring	37
Background	10	Appendix C: Measuring and monitoring patient experiences	38
Quality statement 1 – Assessment and diagnosis	12	Appendix D: Integration with national safety and quality standards	39
Quality statement 2 – Informed choice and shared decision making	16	Glossary	40
Quality statement 3 – Initiating medical management	20	References	45
Quality statement 4 – Quality ultrasound	23	Acknowledgements	50
Quality statement 5 – Intrauterine hormonal devices	26		

Heavy Menstrual Bleeding Clinical Care Standard

Quality statements

- 1 Assessment and diagnosis**

The initial assessment of a woman presenting with heavy menstrual bleeding includes a thorough history, assessment of impact on quality of life, a physical examination (where clinically appropriate), and exclusion of pregnancy, iron deficiency and anaemia. Further investigations are based on the initial assessment.
- 2 Informed choice and shared decision making**

A woman with heavy menstrual bleeding is informed about her treatment options and their potential benefits and risks. She is supported to participate in shared decision making based on her preferences, priorities and clinical situation.
- 3 Initiating medical management**

A woman presenting with heavy menstrual bleeding is offered medical management, taking into account evidence-based guidelines, her individual needs and preferences and any associated symptoms. Oral treatment is offered at first presentation when clinically appropriate, including when a woman is undergoing further investigation or waiting for other treatment.
- 4 Quality ultrasound**

When a woman requires an ultrasound to investigate the cause of her heavy menstrual bleeding, she is offered a pelvic (preferably transvaginal) ultrasound, which assesses all pelvic structures, including the uterus and endometrium, and is ideally performed in days 5–10 of her menstrual cycle.
- 5 Intrauterine hormonal devices**

When medical management options are being considered, a woman is offered a 52 mg levonorgestrel-releasing intrauterine device if clinically appropriate, as it is currently the most effective medical option for managing heavy menstrual bleeding.
- 6 Specialist referral**

A woman with heavy menstrual bleeding is referred for early specialist review when there is a suspicion of malignancy or other significant pathology based on clinical assessment or ultrasound. Referral is also offered to a woman who has not responded to medical management.
- 7 Uterine-preserving alternatives to hysterectomy**

A woman who has heavy menstrual bleeding of benign causes and who is considering non-medical management is offered uterine-preserving procedures that may be suitable (such as endometrial ablation, uterine artery embolisation or surgical removal of local pathology). She is supported to make an informed decision and is referred appropriately.
- 8 Hysterectomy**

Hysterectomy for management of heavy menstrual bleeding is considered when other treatment options are ineffective or are unsuitable, or at the woman's request. A woman considering a hysterectomy is fully informed about the potential benefits and risks of the procedure before making a decision.

Indicators for local monitoring

The following indicators will support healthcare services to monitor how well they are implementing the care recommended in this clinical care standard and are intended to support local quality improvement activities.

1 Assessment and diagnosis

Indicator 1a: Proportion of patients with heavy menstrual bleeding who were tested for iron deficiency and anaemia.

3 Initiating medical management

Indicator 3a: Proportion of patients with heavy menstrual bleeding who were offered medical management at their first presentation.

4 Quality ultrasound

Indicator 4a: Evidence of local arrangements to support appropriate referral for investigative pelvic ultrasounds for heavy menstrual bleeding.

The local arrangements should specify the process to:

- Encourage patients to arrange for their ultrasound to be conducted in the first half of their menstrual cycle, ideally in days 5–10
- Support clinicians to specify the expected timing of the ultrasound in requests
- Support discussions with patients about transvaginal ultrasound as the preferred method when imaging is recommended and clinically appropriate
- Assess adherence to the local arrangements.

Indicator 4b: Evidence of local arrangements for conducting investigative pelvic ultrasounds for heavy menstrual bleeding. The local arrangements should specify the:

- Protocol or guideline to check the appointment timing with the patient and ideally book the appointment in days 5–10 of their menstrual cycle
- Consent policy that ensures patients are supported to make informed decisions about pelvic ultrasounds, including specific requirements for transvaginal ultrasounds
- Process to assess adherence to the local arrangements.

5 Intrauterine hormonal devices

Indicator 5a: Proportion of patients with heavy menstrual bleeding deemed clinically suitable for a 52 mg levonorgestrel-releasing IUD, who had one inserted or were referred to another clinician for insertion.

Indicator 5b: Evidence of local arrangements to refer or recommend patients with heavy menstrual bleeding to a clinician trained to insert levonorgestrel-releasing intrauterine devices. (Only applicable to services without a clinician trained in intrauterine device insertion.)

6

Specialist referral

Indicator 6a: Evidence of protocols or pathways to ensure timely and appropriate referral of patients with heavy menstrual bleeding.

The protocols or pathways should specify the process to:

- Offer early referral to a non-GP specialist when there is suspicion of malignancy or other significant pathology
- Offer a referral to a non-GP specialist when the patient has not had a satisfactory response to medical management
- Assess adherence to the protocols or pathways.

7

Uterine-preserving alternatives to hysterectomy

Indicator 7a: Proportion of patients with heavy menstrual bleeding of benign cause(s) who received uterine-preserving procedural alternatives to hysterectomy.

Overall indicator

Indicator 9a: Hospital rate of hysterectomy per 100 episodes.

The definitions required to collect and calculate indicator data are specified online: meteor.aihw.gov.au/content/788514. More information about indicators and other quality improvement measures is provided in [Appendix B](#).

Updates in 2024

A review of the evidence sources used to develop the first *Heavy Menstrual Bleeding Clinical Care Standard* was undertaken for this update and identified minor changes in guidance, with little change in the underlying evidence.

Key updates in the current version include:

- Increased emphasis throughout on informed choice and shared decision making
- Additional explanatory information for patients and clinicians about relevant investigations and treatment options
- The addition of cultural safety and equity considerations
- Changes to Quality statement 3 including
 - Renaming the quality statement ‘Initiating medical management’ and replacing the term ‘pharmaceutical treatment’ with ‘medical management’ throughout
 - Clarifying that women should be offered oral treatment for symptom relief at first presentation if they are undergoing further investigations or waiting for other treatment
- Changes to other quality statements including
 - Supporting information for Quality statement 4 to address the issue of informed consent for transvaginal ultrasound
 - Quality statement 5 to specify the appropriate dose form of levonorgestrel-releasing intrauterine device
 - Quality statement 6 so that no specific interval is specified before specialist referral for a woman who is not responding to medical management (previously six months)
 - Quality statement 7 to include uterine artery embolisation as one of the uterine-preserving alternatives to hysterectomy
 - Supporting information for Quality statement 8 to include discussion of minimally invasive surgical approaches for women choosing hysterectomy
- Changes to indicators including
 - Indicator 3 (now 3a) to reflect the focus on first presentation
 - Indicator 4a (now 4b) to include informed consent in local arrangements for conducting investigative pelvic ultrasounds
 - Indicator 7 (now 7a) to measure proportion of patients who ‘received’ (previously ‘were offered’) uterine-preserving alternatives to hysterectomy
- Adding Indicator 4a ‘Evidence of local arrangements to support appropriate referral for investigative pelvic ultrasounds for heavy menstrual bleeding’
- Retiring indicators including
 - Indicator 2 ‘Local arrangements for the provision of consumer-focused information about heavy menstrual bleeding’
 - Indicator 4b ‘Proportion of patients with heavy menstrual bleeding who have appropriate reporting following an investigative pelvic ultrasound’
 - Indicator 9 ‘Local arrangements to measure and act upon patient-reported outcomes related to heavy menstrual bleeding’.

Clinical care standards

Clinical care standards help support the delivery of evidence-based clinical care and promote shared decision making between patients, carers and clinicians. They aim to ensure patients receive best-practice care for a specific clinical condition or procedure, regardless of where they are treated in Australia.

A clinical care standard contains a small number of quality statements that describe the level of clinical care expected for a specific clinical condition or procedure. Indicators are included for some quality statements to assist healthcare services monitor how well they are implementing the care recommended in the clinical care standard.

A clinical care standard differs from a clinical practice guideline. Rather than describing all the components of care for a specific clinical condition or procedure, a clinical care standard focuses on key areas of care where the need for quality improvement is greatest.

Clinical care standards aim to improve healthcare outcomes by describing key components of appropriate care, enabling:

- Patients and the community to understand the care that is recommended and their healthcare choices
- Clinicians to provide best-practice care
- Healthcare services to monitor their performance and make improvements in the care they provide.

Clinical care standards are developed by the Australian Commission on Safety and Quality in Health Care (the Commission), an Australian Government agency that leads and coordinates national improvements in the safety and quality of health care, based on the best available evidence. By working in partnership with the Australian Government, states and territories, the private sector, clinical experts, and patients and carers, the Commission aims to ensure that the health system is better informed, supported and organised to deliver safe and high-quality care.

About the Heavy Menstrual Bleeding Clinical Care Standard

Context

This clinical care standard was first released in 2017 in response to the Atlas of Healthcare Variation series, which found substantial variation in the rates of hysterectomy and endometrial ablation across Australia^{1,2}, with Australian women undergoing hysterectomy at a higher rate than women in comparable Organisation for Economic Co-operation and Development (OECD) countries.³ Based on a recommendation in the first *Atlas of Healthcare Variation*¹, the clinical care standard was developed with the aim of ensuring that women with heavy menstrual bleeding can make informed decisions about treatment options, including less invasive treatments and procedures where appropriate.

The revised clinical care standard maintains a similar scope and goal to the 2017 standard. It has been developed to align the quality statements and indicators to the current evidence base and current best practice.

Goal

To ensure that women with heavy menstrual bleeding are offered the least invasive and most effective treatment appropriate to their clinical needs and preferences, and are able to make an informed choice from the range of treatments suitable to their individual situation.

Scope

This clinical care standard relates to the care of women of reproductive age with heavy menstrual bleeding. It covers management from first recognition of clinically significant heavy menstrual bleeding until its resolution in women before or at menopause.

What is not covered

The specific management of underlying uterine pathology (including malignancy) and coagulopathy is out of scope of the clinical care standard. The management of acute heavy menstrual bleeding in an emergency context is not covered; nor are other presentations of abnormal uterine bleeding including post-coital, intermenstrual and postmenopausal bleeding. Detailed consideration of indications, contraindications and potential complications of treatments for heavy menstrual bleeding is also out of scope.

While the standard is broadly applicable to adolescents with heavy menstrual bleeding, these patients have some specific needs that are not covered in the standard. They may need earlier specialist review.

Healthcare settings

This standard relates to care provided in:

- Primary and community healthcare settings, including general practice, women's health, family planning and sexual health services and clinics
- Public and private specialist gynaecology clinics and practices, radiology clinics and hospitals.

Terminology used in the standard

The usage of key terms in this clinical care standard is described below (also see [Background](#) and [Glossary](#)).

Term	How it is used in this document
patient, woman	<p>The term 'patient' in this clinical care standard refers to a person receiving health services.</p> <p>The care described in this standard is intended for all people who menstruate and experience heavy menstrual bleeding, recognising that individuals have diverse gender identities and not everyone who menstruates identifies as a woman.</p>
clinician	<p>A trained health professional, including registered and non-registered practitioners, who provides direct clinical care to patients.</p> <p>In the context of heavy menstrual bleeding, this includes:</p> <ul style="list-style-type: none">■ Aboriginal and Torres Strait Islander health workers and practitioners■ Medical practitioners such as general practitioners (GPs), GP obstetricians, rural generalists, obstetrician/gynaecologists, sexual health physicians, sonologists, and radiologists and interventional radiologists■ Nurses, including rural and remote registered nurses⁴, and nurse practitioners■ Midwives and endorsed midwives■ Allied health practitioners such as sonographers and pharmacists.
healthcare services	<p>Where information is provided 'for healthcare services' in this standard, it is intended for those responsible for leading and governing the service. Healthcare services deliver health care in a wide range of settings, and vary in size and organisational structure from single healthcare providers to complex organisations.</p>

Evidence that underpins this clinical care standard

Key sources that underpin the *Heavy Menstrual Bleeding Clinical Care Standard* are current clinical guidelines from the United Kingdom's National Institute for Health and Care Excellence (NICE) and the Society of Obstetricians and Gynaecologists of Canada, and Australian guidance including Therapeutic Guidelines.⁵⁻⁷

While the first version of this standard was based on these guidelines, the NICE guideline on the assessment and management of heavy menstrual bleeding was updated in 2018 and Therapeutic Guidelines were updated in 2020.

A list of the evidence sources for this clinical care standard is available on the Commission's [website](#).

Supporting resources

Clinical care standard resources

Supporting documents for this clinical care standard are available on the Commission's [website](#).

These include the:

- [Consumer guide](#)
- [Clinician fact sheet](#)
- [Healthcare services information sheet](#).

How to use this clinical care standard

The quality statements in this clinical care standard describe the expected standard for key components of patient care. The standard explains what each statement means:

- **For patients**, so they know what care may be offered by their healthcare system and can make informed treatment decisions in partnership with their clinician
- **For clinicians**, to support recommendations about appropriate care
- **For healthcare services**, to inform them of the policies, procedures and organisational factors that can enable the delivery of high-quality care.

General principles of care

This clinical care standard should be implemented as part of an overall approach to safety and quality, incorporating the following principles that are the foundation for achieving safe and high-quality care:

- Person-centred care and shared decision making
- Informed consent
- Cultural safety
- Equity of care.

When applying the information contained in a clinical care standard, clinicians are advised to use their clinical judgement and to consider the individual patient's circumstances, in consultation with the patient or their support people.

For more information and additional Commission resources, see [Appendix A](#).

Cultural safety and equity



The Commission is committed to supporting healthcare services to deliver safe and high-quality care to the Australian community and recognises that culturally safe and responsive health care is critical to improving equitable access and outcomes.

Person-centred care includes care that recognises and respects individual needs, beliefs and culture and encompasses cultural safety. Cultural safety is about overcoming the cultural power imbalances of places, people and policies to contribute to improvements in health, especially for Aboriginal and Torres Strait Islander people.⁸ Health consumers are safer when clinicians have considered power relations, cultural differences and patients' rights, and are providing patient-centred care. Part of this process requires clinicians to review their own beliefs and attitudes.⁹

In Australia, Aboriginal and Torres Strait Islander people generally experience poorer health outcomes than the rest of the population, with systemic racism being a root cause. The considerations for improving cultural safety and equity throughout this clinical care standard focus primarily on overcoming cultural power imbalances and addressing the many barriers Aboriginal and Torres Strait Islander people face in accessing and receiving health care.^{8,10}

Although it is usually applied in the context of Aboriginal and Torres Strait Islander people, the concept of cultural safety can be applied more broadly.

Cultural safety in health care is underpinned by the:

- National Registration and Accreditation Scheme, which aims to ensure consistency for cultural safety in the health professions' codes of conduct nationally¹¹
- ***National Agreement on Closing the Gap***, which is built around four priority reforms for transforming the way governments work with, and for, Aboriginal and Torres Strait Islander people to improve outcomes

- [Cultural Respect Framework 2016–2026](#), which commits the Australian Government and all states and territories to embed cultural respect principles into their health systems¹⁰
- National Safety and Quality Health Service (NSQHS) Standards
 - Clinical governance – [Actions 1.15](#) and [1.28](#)
 - Partnering with consumers – [Actions 2.11](#) and [2.13](#)
- National Safety and Quality Primary and Community Healthcare Standards
 - [Clinical Governance Standard](#) – Actions 1.09, 1.10, 1.16, 1.24, 1.25
 - [Clinical Safety Standard](#) – Actions 3.22 and 3.23.

Embedding cultural safety in health care

Addressing inequity requires recognition that people with different levels of advantage may require different approaches and resources to achieve the same healthcare outcomes.

When implementing this clinical care standard, cultural safety can be improved through:

- Embedding an organisational approach to cultural safety
- Specific considerations for women with heavy menstrual bleeding described within the relevant quality statements.

Organisational approaches include:

- Ensuring the use of interpreter services and cultural translators when this will assist the patient and is in line with their wishes
- Considering the role of Aboriginal and Torres Strait Islander Health Workers and Practitioners and how their involvement could improve patient care
- Identifying variation in healthcare provision or outcomes for specific patient populations – for example, based on ethnicity¹²
- Disaggregating data by Aboriginal and Torres Strait Islander status when using the indicators included in this standard. This will support identification of access and outcome issues so that improvements can be made
- Implementing and monitoring the six specific actions for Aboriginal and Torres Strait Islander care outlined for acute care services in the NSQHS Standards, and equivalent actions in the Primary and Community Healthcare Standards.

Related resources

Resources that can help healthcare services and clinicians improve cultural safety and equity include:

- The NSQHS Standards [User Guide for Aboriginal and Torres Strait Islander Health](#)⁹
- The NSQHS Standards [User Guide for Health Service Organisations Providing Care for Patients from Migrant and Refugee Backgrounds](#)¹³
- NSW Health's [Communicating Positively: A guide to appropriate Aboriginal terminology](#).¹⁴

Measurement for quality improvement

Measurement is a key component of quality improvement processes. The Commission has developed a set of indicators to support clinicians and healthcare services to monitor how well they are implementing the care recommended in this clinical care standard. The indicators are intended to support local quality improvement activities. No benchmarks are set for these indicators.

The indicators are listed with the relevant quality statements. The definitions required to collect and calculate indicator data are available online. More information about indicators and other quality improvement measures is provided in [Appendix B](#).

Information on other quality measures, including patient-reported outcome measures and patient experience measures, is provided in [Appendix C](#).

Meeting the requirements of national standards and accreditation

Implementing this clinical care standard as part of a quality improvement activity can help healthcare services meet actions in the NSQHS Standards¹⁵, and the National Safety and Quality Primary and Community Healthcare Standards.¹⁶

For more information, see [Appendix D](#).

Background

Heavy menstrual bleeding is a common problem, affecting 25% of women of reproductive age.¹⁷ It is commonly defined as ‘excessive menstrual blood loss which interferes with the woman’s physical, emotional, social and material quality of life, and which can occur alone or in combination with other symptoms’.⁶

Many women with heavy menstrual bleeding consider their experience normal, and it is estimated that around 50% do not seek medical care despite the substantial and sometimes debilitating impact on their daily life.^{18,19} Some of the factors preventing women from seeking care include:

- Taboos and stigma that can be associated with menstrual issues
- Normalisation of heavy menstrual bleeding by society and healthcare providers
- The absence of a trusted clinical relationship, such as with a general practitioner, where sensitive issues can be discussed.²⁰

Symptoms such as flooding through clothing, being unable to leave the house on the heaviest days, and having to change pads and tampons every one or two hours, including at night, are all indicative of heavy menstrual bleeding. Many women also experience lethargy, fatigue, anxiety and menstrual pain.¹⁸ Women with heavy menstrual bleeding are a high-risk group for iron deficiency which, left untreated, can progress to iron deficiency anaemia.^{21,22}

There are diverse causes of heavy menstrual bleeding in women of reproductive age. Heavy menstrual bleeding is the most common type of abnormal uterine bleeding, which is described by its presentation (flow, frequency, duration and regularity), and categorised into structural and non-structural causes or contributors according to the PALM-COEIN classification (Table 1).^{23,24}

Table 1: International Federation of Gynecology and Obstetrics (FIGO) classification system for causes of abnormal uterine bleeding (PALM-COEIN)^{23,25}

Abnormal uterine bleeding (including heavy menstrual bleeding)*			
Structural causes (PALM)		Non-structural causes (COEIN)	
P	Polyps	C	Coagulopathy
A	Adenomyosis	O	Ovulatory dysfunction
L	Leiomyoma (fibroids)	E	Endometrial
M	Malignancy or hyperplasia	I	Iatrogenic
		N	Not otherwise classified

* Abnormal uterine bleeding includes any departure from normal menstruation or from a normal menstrual cycle pattern. Heavy menstrual bleeding is the most common. Other types of abnormal uterine bleeding include intermenstrual bleeding and post-coital bleeding.

Appropriate treatment for heavy menstrual bleeding is determined by women's preferences, the cause(s) of bleeding, comorbid conditions and related symptoms such as pressure and pain.⁶ Treatment options may include medical management including hormonal and non-hormonal options, procedural interventions that preserve the uterus and/or hysterectomy.

Hysterectomy is the most definitive treatment for heavy menstrual bleeding, but is not generally recommended for first-line management unless less invasive options are unsatisfactory or inappropriate.⁶ Hysterectomy is associated with increased risks including infection, bleeding, bowel or urinary tract injury and general surgical complications, leading to unexpected readmissions.²⁶ Longer-term complications depend partly on the approach to surgery, but may include urinary incontinence, pelvic organ prolapse, early menopause if the ovaries are removed, and increased risk of coronary artery disease even without removal of ovaries.^{6,27-32}

Variations in care

Hysterectomy rates in Australia are higher than in comparable OECD countries. In 2019, there were 215 hysterectomies per 100,000 women in Australia, compared with 126 in New Zealand and 132 in the United Kingdom (for cancer and non-cancer diagnoses).³

Within Australia for non-cancer diagnoses, the Commission's [*Women's Health Focus Report*](#)³³ has identified:

- A 20% reduction in the age-standardised rate of hysterectomy between 2014–15 and 2021–22
- A five-fold difference in hysterectomy rates between the local area with the highest rate and the local area with the lowest rate in 2021–22, down from a seven-fold difference in 2014–15.
- A 10% increase in the age-standardised rate of endometrial ablation between 2013–16 and 2019–22
- Higher rates of both hysterectomy and endometrial ablation in inner and outer regional areas compared with major cities and remote areas. The hysterectomy rate for Aboriginal and Torres Strait Islander women was 9% higher than for other Australian women in 2021–22.

These findings are encouraging and demonstrate that there has been improvement since the *Heavy Menstrual Bleeding Clinical Care Standard* was first released in 2017. However, they also reveal that therapeutic alternatives to hysterectomy are still not being consistently used across Australia for women with heavy menstrual bleeding.

While the reasons for this variation are not fully understood, it is evident that access to, and uptake of, appropriate care is influenced by several factors. These include low patient awareness of available options and choices; treatment costs to patients; limited availability of services; and limited numbers of clinicians with the knowledge, skills and equipment, or willingness to deliver services such as intrauterine device (IUD) insertion^{34,35}, endometrial ablation or uterine artery embolisation. Women living in rural and remote Australia face additional challenges when it comes to accessing investigations and services such as ultrasound, IUD insertion and appropriate specialist medical care.

Implementation of this clinical care standard will help clinicians and healthcare services to address unwarranted variations in care and to ensure women with heavy menstrual bleeding are supported to make informed choices about the care that is right for them.

1

Quality statement 1 – Assessment and diagnosis

The initial assessment of a woman presenting with heavy menstrual bleeding includes a thorough history, assessment of impact on quality of life, a physical examination (where clinically appropriate), and exclusion of pregnancy, iron deficiency and anaemia. Further investigations are based on the initial assessment.

Purpose

To ensure a comprehensive history and assessment of the bleeding, its probable causes and impact on the woman's life, in order to guide appropriate investigation, referral, diagnosis and management.

What the quality statement means

■ For patients

If you have heavy menstrual bleeding, your clinician will carry out a thorough assessment to help find the cause. They will ask questions to understand more about your bleeding and how it affects your life, including your physical and emotional wellbeing, your mental health, and your ability to work, exercise and take part in social events. They will also ask about your past general health and any family medical problems. They may ask about your sexual health, previous pregnancies and births, current sexual activity, and whether you wish to become pregnant in the future.

With your consent, your clinician will carry out a physical examination. This may involve an internal examination where your clinician will use a tool called a speculum to help look at your vagina and cervix. They may also place one or two gloved fingers inside your vagina while pressing gently on the outside of your abdomen to be able to feel your pelvic organs, including your uterus. If you do not feel comfortable about having an internal examination, let your clinician know.

Your clinician will recommend a pregnancy test if there is any chance you are pregnant, and blood tests for iron deficiency (a lack of iron) and anaemia (a lack of red blood cells). Whether you need any other tests will depend on your individual assessment, but these may include other blood tests, a cervical screening test, internal swab tests for infection or an ultrasound.

■ For clinicians

When assessing a patient with heavy menstrual bleeding, consider the diverse possible causes as per the PALM-COIEN classification system^{23,24} (refer to [Table 1](#)), and other possible diagnoses such as endometriosis or miscarriage.

Take a detailed history that includes:⁵⁻⁷

- The nature of bleeding, including duration, frequency, heaviness and pattern (regular or irregular) (note: post-coital, intermenstrual and postmenopausal bleeding require specific investigation)
- The impact on quality of life, including impact on mental health and limitations on work, exercise and social functioning
- Related symptoms such as pelvic pain or pressure
- Symptoms suggestive of iron deficiency, with or without anaemia
- Sexual and reproductive health, including parity, desire for future fertility, contraception use, likelihood of pregnancy or miscarriage, risk of sexually transmitted infection and cervical screening status
- History or symptoms suggestive of systemic causes of bleeding, such as a bleeding disorder, polycystic ovary syndrome (PCOS) or thyroid disease
- Relevant family history, such as history of bleeding disorders, endometriosis or endometrial or colorectal cancer
- Current medications and use of over-the-counter supplements that may be associated with ovulation or bleeding
- Other factors that may affect treatment options, such as comorbidities or previous treatments for heavy menstrual bleeding.

Conduct a physical examination if appropriate and with consent. This will usually include a speculum examination, and a bimanual pelvic examination to identify any palpable mass or abnormal uterine size. Situations in which pelvic examination may be inappropriate include for women and adolescents who are not sexually active, women who have been sexually assaulted in the past, women who have experienced birth trauma, or women who decline for cultural reasons.

Exclude pregnancy with a urinary beta HCG if indicated. Routinely evaluate iron deficiency and anaemia with serum ferritin and a full blood count.^{5,36}

Arrange other investigations based on a careful history and presentation. These might include testing for bleeding disorders or thyroid dysfunction, a cervical screening test³⁷ (if clinically indicated), genital swab tests (if clinically indicated) or ultrasound for assessment of uterine abnormalities. Refer to current guidelines^{5,7} such as Therapeutic Guidelines.⁵

Consider using a validated health-related quality-of-life questionnaire to help inform clinical decision-making and monitor treatment effectiveness, and to inform quality improvement.

Discuss and arrange referral for any other support the patient may require, such as counselling, acknowledging the effect that heavy menstrual bleeding can have on emotional wellbeing and mental health.

■ For healthcare services

In healthcare services involved in the assessment of patients with heavy menstrual bleeding, ensure that guidelines and protocols are in place to support:

- A thorough history, assessment of the nature of the bleeding and its impact on quality of life, a physical examination where appropriate, and exclusion of pregnancy, iron deficiency and anaemia
- Systematic assessment of the structural and non-structural causes of heavy menstrual bleeding based on history and presentation, with relevant investigations recommended according to this assessment
- Appropriate testing for bleeding disorders or thyroid dysfunction, cervical screening and pelvic ultrasound; these are not routinely required
- Patients to see a particular type of clinician if that is their preference – for example, someone of the same gender
- Referral and access to additional services that the patient may require, including counselling or other services to support their emotional wellbeing and mental health as appropriate.



Cultural safety and equity

Clinicians can

- Recognise the social and cultural factors influencing a woman's access to, and experience of, health care related to their heavy menstrual bleeding. These can include attitudes and norms that prevent the open discussion of menstruation, generate feelings of shame and embarrassment, and limit access to health information about menstruation.^{19,38,39}
- Be aware of Women's Business and the wishes of many Aboriginal women to keep women's health issues private and separate from other health issues.³⁹
- If appropriate, offer Aboriginal and Torres Strait Islander women access to culturally safe models of care, such as those offered through, or in partnership with, Aboriginal Community Controlled Health Organisations or Aboriginal and Torres Strait Islander health and medical services.
- Recognise that a history of trauma may affect a person's experience of care.
- Consider the needs of trans and non-binary people who menstruate, who may find it difficult discussing menstrual issues or undergoing clinical examination.
- Recognise the diverse needs of women with disabilities and ensure they are assessed similarly to women without disabilities, including a comprehensive history, and appropriate examinations and investigations. Where required, make reasonable adjustments to support women with disabilities to access appropriate care.

Healthcare services can

- Ensure that systems support the assessment of women in a way that is free from racism, bias and assumptions.
- Consider developing pathways and models of care that involve working collaboratively with Aboriginal Community Controlled Health Organisations and Aboriginal health workers or practitioners to improve access to care and continuity of care for women experiencing heavy menstrual bleeding.

Related resources

Clinician resources

- The *[Minymaku Kutju Tjukurpa Women's Business Manual](#)* is a Remote Primary Health Care Manual containing evidence-based protocols to help manage the health of Aboriginal and Torres Strait Islander women in remote Australia.³⁹

Indicator for local monitoring

Indicator 1a: Proportion of patients with heavy menstrual bleeding who were tested for iron deficiency and anaemia.

METEOR link: meteor.aihw.gov.au/content/788520

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

2

Quality statement 2 – Informed choice and shared decision making

A woman with heavy menstrual bleeding is informed about her treatment options and their potential benefits and risks. She is supported to participate in shared decision making based on her preferences, priorities and clinical situation.

Purpose

To ensure that a woman with heavy menstrual bleeding participates in shared decision making that is informed by an understanding of each treatment option and its benefits, risks and probable outcomes. The principles of informed choice and shared decision making apply throughout this clinical care standard whenever choices about care are being considered.

What the quality statement means

■ For patients

There are several ways to treat heavy menstrual bleeding and each woman has different needs and preferences.

Your clinician will discuss your condition with you and will ask questions to understand what is important to you. For example, they will ask questions about your goals for treatment, and whether you want to become pregnant in the future. They will explain the treatment options that are available to you and discuss the expected benefits and potential risks of each option. Together, you and your clinician should decide about the care that is best for you.

If you are not sure about understanding the information in English, you can ask for an interpreter.

You may also be given printed information or directed to useful electronic resources. Information should be provided in a format that suits you and that you can understand.

■ For clinicians

Shared decision making enables individuals' preferences and priorities to be considered alongside the best available evidence. It can lead to improved satisfaction and better-quality decisions.⁴⁰ To support informed choice and shared decision making:

- Discuss the patient's condition, their treatment options and the benefits, risks and probable outcomes of possible treatments, including side effects and complications, and the possibility of treatment failure
- Discuss the patient's treatment goals and their preferences and priorities, including desire for pregnancy and/or future fertility
- Provide high-quality patient information in the most appropriate format based on their needs and preferences – for example, a fact sheet or link to a website
- Consider the use of decision aids to systematically address options and support informed choice
- Accept and acknowledge that the patient's informed view on the balance of benefits, risks and probable outcomes of treatments may differ from yours as a healthcare professional.⁴¹

■ For healthcare services

Ensure that policies, protocols and procedures support informed choice and shared decision making. Specifically:

- Ensure that high-quality patient information resources are available in a range of formats and are clinically accurate, evidence based and easy to understand
- Ensure that resources provide information about both benefits and risks of relevant treatment options offered through referral or by the service; consider making a decision aid available to support shared decision making.
- Provide ready access to information for clinicians on the benefits, risks and probable outcomes of the various treatment options for heavy menstrual bleeding
- Provide clinicians with training and professional development to ensure they have the skills, knowledge and confidence to participate in, and support patients to participate in, shared decision making
- Put in place policies to facilitate referral and access to services that a woman may prefer, but that are not offered in the health service
- In rural and remote areas, adapt service delivery models to support patients to access appropriate care – for example, through the use of telehealth and other models of care.



Cultural safety and equity

Clinicians can

- Recognise the woman's personal and cultural beliefs that may influence decisions about investigations and treatments for heavy menstrual bleeding.
- Ensure that the information and education you provide is culturally appropriate and culturally safe.
- Use an interpreter if needed and provide written information in the patient's preferred language. Consider whether any aids are needed (for example, visual resources such as videos or flip charts).
- Offer women access to culturally appropriate services such as those offered through, or in partnership with, Aboriginal Community Controlled Health Organisations or Aboriginal and Torres Strait Islander health and medical services.
- Attend cultural safety training provided by your healthcare service or professional organisation.
- Recognise that women with disability have the same healthcare rights as women without disability, including the right to be offered the same options and to be involved in decisions about their care.⁴² As for any patient, consider any specific communication needs, and their decision-making capability. If needed, make reasonable adjustments to support their understanding and facilitate their involvement in decision-making, even for women with a nominated substitute decision-maker. Assess whether a multidisciplinary approach is required.⁴²

Healthcare services can

- Provide patient information about heavy menstrual bleeding in a variety of languages and formats appropriate to your service's patient population.
- Consider developing or adapting pathways and models of care that support women to access culturally safe and appropriate services and community supports in a timely way.
- Ensure that policies and procedures support the rights of women with disabilities. Make reasonable adjustments for women with disabilities to ensure their access to appropriate care and active participation in shared decision making about management of heavy menstrual bleeding.

Related resources

Patient information resources

- Jean Hailes for Women's Health – various resources on [periods web page](#) including
 - [Heavy periods fact sheet](#)⁴³
 - [Periods and heavy bleeding – easy read](#) fact sheet for women with disabilities⁴⁴
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists – [Heavy Menstrual Bleeding fact sheet](#)⁴⁵
- Choosing Wisely Australia – [5 questions to ask your doctor or other healthcare provider](#) before you get any test, treatment or procedure – available in multiple languages⁴⁶
- Healthdirect – [Questions to ask your doctor](#)⁴⁷

Resources for clinicians

- Therapeutic Guidelines – [Menstrual Management and Contraception in Females with Developmental Disability](#) (subscriber content)⁴²
- Australian Commission on Safety and Quality in Health Care – [Shared decision making](#) resources and tools⁴⁹
- Australian Commission on Safety and Quality in Health Care – [Informed consent in health care](#)⁵⁰

3

Quality statement 3 – Initiating medical management

A woman presenting with heavy menstrual bleeding is offered medical management, taking into account evidence-based guidelines, her individual needs and preferences and any associated symptoms. Oral treatment is offered at first presentation when clinically appropriate, including when a woman is undergoing further investigation or waiting for other treatment.

Purpose

To ensure that women with heavy menstrual bleeding are offered appropriate medical management before procedural or surgical options are considered, and that those undergoing further investigations are offered preliminary treatment for symptom relief.

What the quality statement means

■ For patients

Your clinician will usually suggest medicine as the first treatment option to relieve your heavy menstrual bleeding. Which medicine is suitable for you will depend on several factors, including your preferences, the cause of your bleeding, whether you need contraception and any other health conditions you may have. Depending on your situation, options may include:

- **Tranexamic acid**, which comes as a tablet that you take during your period. It helps your blood to clot and can reduce menstrual blood loss. It does not provide contraception.
- **Anti-inflammatory medicines** including ibuprofen, mefenamic acid and naproxen, which come as tablets or capsules and are taken during your period. They can reduce inflammation, pain and blood loss. Some anti-inflammatories are available without a prescription. Anti-inflammatories do not provide contraception.
- **A combined oral contraceptive pill**, which contains synthetic hormones similar to the natural hormones oestrogen and progesterone. These thin the lining of the uterus and can reduce your period flow. The active hormones in the combined oral contraceptive pill may be taken for 21–24 days of a 28-day menstrual cycle but can also be taken continuously, which can avoid your period altogether. As its name suggests, this option also provides contraception.
- **Other hormonal treatments** that contain progestogen, which is similar to the natural hormone, progesterone. These may be in tablet form (oral progestogens) or given as an injection every three months (depot medroxyprogesterone). Some of these treatments also provide contraception.
- **A hormone-releasing intrauterine device (IUD)**, which is a small plastic device that is placed inside your uterus and continuously releases a small amount of progestogen. This thins the lining of the uterus and is very effective at reducing bleeding. This device also provides contraception. (See [Quality statement 5 – Intrauterine hormonal devices](#).)

Your clinician will explain your treatment options, their expected benefits and possible side effects, and ask about your preferences. If the first medicine you try is not satisfactory, you can return to your clinician to discuss other options.

If you need further tests to investigate your bleeding, such as a blood test or an ultrasound, or if you need to see a different clinician for your preferred treatment, your clinician will offer you medicine that you can start straight away to provide relief while you wait for other appointments. Later, you may decide on a different treatment.

■ For clinicians

Consider medical management of heavy menstrual bleeding before more invasive treatment options. In the absence of significant pathology, many patients with heavy menstrual bleeding may be effectively managed with medical therapy alone.

Discuss the medical options available, including hormonal and non-hormonal therapy, and explain what to expect from each, including benefits, risks and probable outcomes. The choice of therapy will be influenced by the woman's preferences and priorities, including her need for contraception, the cause(s) of bleeding, coexisting conditions, and associated symptoms requiring further investigation, including pressure and pain.⁶ Medical options include:^{5,6,51}

- Non-hormonal options, including tranexamic acid (an antifibrinolytic) and non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen, mefenamic acid or naproxen, which reduce blood flow and/or provide analgesia during menstruation
- Hormonal options, including combined oral contraceptives, oral progestogens or depot medroxyprogesterone; oral hormones may be taken intermittently (during a menstrual cycle) or continuously after discussion of issues, implications for contraception and side effects
- A 52 mg levonorgestrel-releasing intrauterine device (LNG-IUD), which is currently the most effective medical therapy for heavy menstrual bleeding in women without significant pathology, in addition to its contraceptive action (see [Quality statement 5 – Intrauterine hormonal devices](#)).

When clinically appropriate, offer initial oral treatment such as tranexamic acid and/or NSAIDs at first presentation to relieve symptoms and limit complications (for example, from iron deficiency) if the patient's preferred treatment option is not immediately apparent or available⁶, when further investigations are recommended, or the patient needs to wait for further appointments (for example, for insertion of the LNG-IUD).

Support patients to participate in shared decision making about their treatment options.

Advise patients they should return for review if their initial chosen treatment option is unsatisfactory.

Refer to Therapeutic Guidelines, the *Australian Medicines Handbook* or clinical guidelines for information regarding efficacy, contraindications, adverse effects and treatment regimens.^{5,6,51}

■ For healthcare services

In primary health care and other services where patients first present for management of heavy menstrual bleeding, ensure that guidelines and protocols are in place to support:

- Medical management as the first treatment option in the absence of significant pathology
- Offering initial oral treatment to relieve symptoms and limit complications (such as iron deficiency) even if the patient is being referred for further investigations or awaiting other treatment
- Clinicians to access relevant evidence-based prescribing guidelines for the choice of therapy and dosing.^{5,6,51}

Indicator for local monitoring

Indicator 3a: Proportion of patients with heavy menstrual bleeding who were offered medical management at their first presentation.

METEOR link: meteor.aihw.gov.au/content/788524

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

4

Quality statement 4 – Quality ultrasound

When a woman requires an ultrasound to investigate the cause of her heavy menstrual bleeding, she is offered a pelvic (preferably transvaginal) ultrasound, which assesses all pelvic structures, including the uterus and endometrium, and is ideally performed in days 5–10 of her menstrual cycle.

Purpose

To optimise the quality of imaging undertaken when screening for uterine and endometrial abnormalities to assist clinical decision-making.

What the quality statement means

■ For patients

You may have an ultrasound of your pelvic area to look for some common causes of heavy menstrual bleeding, such as polyps or fibroids, and to check the size and shape of your uterus. There are two ways of doing the ultrasound and they are often done together:

- **Transvaginal ultrasound**, where the ultrasound operator places a narrow ultrasound probe in your vagina – this is the preferred way because it provides a better picture of the uterus and pelvic structures
- **Transabdominal ultrasound**, where the ultrasound probe is placed on the outside of your lower abdomen, while you have a full bladder – this way does not show the uterus and pelvic structures as well as the transvaginal scan because the probe is not as close to the reproductive organs.

For some women, a transvaginal ultrasound may not be appropriate – for example, for women who have not been sexually active, those who have been sexually assaulted in the past, those who have experienced birth trauma, or those who decline for cultural reasons. If you do not want to have a transvaginal ultrasound for any reason, discuss this with your clinician when they are organising your referral.

It is best if you can book to have the scan done 5–10 days after the first day of your period. This is when the lining of the uterus is thinnest, and the reading will be most accurate. Talk to your clinician if timing the scan will be difficult for any reason – for example, because your periods are very irregular, or because you live in an area where it is not easy to access an ultrasound. Your clinician may offer you medicine that you can start straight away to provide relief while you wait for your appointment.

■ For clinicians

Based on the initial assessment, an ultrasound may be required to investigate structural causes of heavy menstrual bleeding, such as in patients:

- With an increased risk of malignancy based on history (for example, risk factors such as older age, personal or family history of endometrial or colorectal cancer, use of unopposed oestrogen or tamoxifen, obesity, young age at menarche or older age at menopause, nulliparity, diabetes or endometrial hyperplasia)
- With features suggestive of pathology on examination (for example, an enlarged or irregular uterus, suggesting fibroids)
- With symptoms such as deep dyspareunia, severe dysmenorrhoea or secondary heavy menstrual bleeding
- Who have not responded to a reasonable duration of medical management.

Whether ultrasound is required prior to insertion of the LNG-IUD depends on the patient's age and likelihood of pathology or of structural abnormalities that could influence appropriate positioning of the device.⁵²

When ultrasound is indicated, offer transvaginal ultrasound as first-line imaging to allow a more detailed assessment of the pelvic structures, including the uterus and endometrium. Transvaginal ultrasound is usually performed in conjunction with a transabdominal ultrasound.

Before a transvaginal ultrasound is conducted or requested, the patient should be advised about how it will be performed so they have the opportunity to decline. If transvaginal ultrasound is inappropriate, or the woman chooses not to have it, then offer transabdominal ultrasound alone; referring clinicians should note this on the request form.^{5,7} Transvaginal ultrasound may be inappropriate for some women – for example, non-sexually active adolescents and women, women with a history of sexual assault, women with an experience of birth trauma, or women who decline for cultural reasons.

Sonographers and sonologists should ensure that patients provide informed consent in relation to ultrasound.

When referring for ultrasound, request that it be performed on days 5–10 of the menstrual cycle. This allows the most accurate measurement of endometrial thickness, which is used in risk assessment for endometrial hyperplasia and malignancy^{53,54} and improves detection of polyps. Bear in mind that it may be difficult for some women to arrange an ultrasound at this time (for example, those with unpredictable or irregular cycles and those in areas with limited access to imaging services). When referring, communicate requirements to support appropriate access. Offer initial oral treatment where clinically appropriate to relieve symptoms and limit complications while the woman is waiting for an appointment.

■ For healthcare services

In healthcare services that refer for pelvic ultrasound, ensure that protocols, procedures and pathways:

- Support transvaginal ultrasound as the preferred method when pelvic ultrasound is recommended and clinically appropriate
- Ensure that patients are advised about how a transvaginal ultrasound is conducted and if they decline, or it is not appropriate for any other reason, then a transabdominal ultrasound only is requested
- Encourage patients to arrange for their ultrasound to be conducted in the first half of their menstrual cycle where possible, ideally on days 5–10, and clinicians to specify this in ultrasound requests
- Take into account any challenges patients may experience in accessing ultrasound locally
- Ensure that patients are offered initial oral treatment where clinically appropriate while waiting for appointments.

In healthcare services **performing** gynaecological ultrasound, ensure that policies, protocols and procedures support:

- Appropriate high-quality transvaginal and transabdominal ultrasound (see, for example, the Australasian Society for Ultrasound in Medicine guidelines)⁵⁵
- Optimal scheduling of appointments so that scans are taken on days 5–10 of a patient's menstrual cycle where possible
- Women to make informed decisions and provide informed consent in relation to their ultrasound, based on timely and accurate information about the process, including an understanding of how transvaginal ultrasound is conducted
- High-quality reporting of ultrasound results, taking into account the need to accurately measure and report endometrial thickness (in millimetres), uterine dimensions, including volume, and the presence and location of structural abnormalities.

Indicators for local monitoring

Indicator 4a: Evidence of local arrangements to support appropriate referral for investigative pelvic ultrasounds for heavy menstrual bleeding.

The local arrangements should specify the process to:

- Encourage patients to arrange for their ultrasound to be conducted in the first half of their menstrual cycle, ideally in days 5–10
- Support clinicians to specify the expected timing of the ultrasound in requests
- Support discussions with patients about transvaginal ultrasound as the preferred method when imaging is recommended and clinically appropriate
- Assess adherence to the local arrangements.

METEOR link: meteor.aihw.gov.au/content/788526

Indicator 4b: Evidence of local arrangements for conducting investigative pelvic ultrasounds for heavy menstrual bleeding. The local arrangements should specify the:

- Protocol or guideline to check the appointment timing with the patient and ideally book the appointment in days 5–10 of their menstrual cycle
- Consent policy that ensures patients are supported to make informed decisions about pelvic ultrasounds, including specific requirements for transvaginal ultrasounds
- Process to assess adherence to the local arrangements.

METEOR link: meteor.aihw.gov.au/content/788530

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

5

Quality statement 5 – Intrauterine hormonal devices

When medical management options are being considered, a woman is offered a 52 mg levonorgestrel-releasing intrauterine device if clinically appropriate, as it is currently the most effective medical option for managing heavy menstrual bleeding.

Purpose

To ensure that a 52 mg levonorgestrel-releasing intrauterine device is offered to a woman if it is clinically appropriate, so she has the opportunity to choose this treatment and can be referred if necessary.

What the quality statement means

■ For patients

If it is suitable for you, your clinician may suggest a 52 mg levonorgestrel-releasing intrauterine device (LNG-IUD). This is a hormonal treatment that is released from a small plastic device placed inside your uterus. It can be left in place for up to five years (and can be removed earlier if it is no longer a suitable option).

The LNG-IUD also acts as a contraceptive. It is usually recommended because it is the most effective medical treatment for treating heavy menstrual bleeding.

If it is suitable for you to consider, your clinician will explain how it works, and its benefits, risks and side effects to help you decide if you want to have it. They will explain that it may take three to six months or more to get the full benefit of the treatment.

The device needs to be placed in the uterus by a health professional who has been trained to insert intrauterine devices. This means that if you choose the LNG-IUD, you may be referred to another clinician to have it inserted. Depending on the services available in your area, you may be referred to a general practice, a family planning clinic or another specialist service.

Your clinician may recommend that you have an ultrasound before the device is inserted. If you have to wait for an ultrasound or other appointment before the device can be inserted, your clinician may offer you medicine that you can start straight away to provide relief while you wait.

■ For clinicians

When considering medical management:

- Offer a 52 mg levonorgestrel-releasing intrauterine device (LNG-IUD) to the patient whenever it is clinically suitable – evidence supports the use of the LNG-IUD to treat heavy menstrual bleeding in patients without malignancy or other significant pathology because it is more effective and provides greater improvements in quality of life compared with other medical treatments^{5,6,56,57}
- Discuss the benefits and risks of the LNG-IUD and explain what to expect, including that it may take three to six months or more to experience the full benefit of the treatment (see Therapeutic Guidelines⁵ or *Australian Medicines Handbook*⁵¹ for more information)
- If necessary, refer the patient to a trained practitioner for insertion of the LNG-IUD.

Consider whether pelvic ultrasound is indicated before or at the same time as inserting the LNG-IUD, such as when other treatments have not been effective or if the patient has risk factors for gynaecological disease, including age or findings on examination or history.⁵²

If the patient requires an ultrasound and/or further assessment before the LNG-IUD is inserted, offer initial oral treatment where clinically appropriate to relieve symptoms and limit complications (such as iron deficiency) while they wait. (See [Quality statement 3 – Initiating medical management](#).)

■ For healthcare services

In primary health care and other services where medical management may be initiated, ensure that:

- Guidelines and protocols are in place to support patients being offered a 52 mg levonorgestrel-releasing intrauterine device (LNG-IUD) if it is clinically appropriate
- Arrangements are in place to provide the LNG-IUD, either within the service or through referral to an appropriate practitioner.

Indicators for local monitoring

Indicator 5a: Proportion of patients with heavy menstrual bleeding deemed clinically suitable for a 52 mg levonorgestrel-releasing IUD, who had one inserted or were referred to another clinician for insertion.

METEOR link: meteor.aihw.gov.au/content/788536

Indicator 5b: Evidence of local arrangements to refer or recommend patients with heavy menstrual bleeding to a clinician trained to insert levonorgestrel-releasing intrauterine devices. (Only applicable to services without a clinician trained in intrauterine device insertion.)

METEOR link: meteor.aihw.gov.au/content/788540

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

6

Quality statement 6 – Specialist referral

A woman with heavy menstrual bleeding is referred for early specialist review when there is a suspicion of malignancy or other significant pathology based on clinical assessment or ultrasound. Referral is also offered to a woman who has not responded to medical management.

Purpose

To ensure timely and appropriate referral when there is an increased risk of malignancy or inadequate response to medical management.

What the quality statement means

■ For patients

Heavy menstrual bleeding can often be managed in primary care, usually by a general practitioner (GP) or family planning doctor. However, you may be referred to another clinician if your ultrasound or other history suggests further assessment would be helpful. For example, the ultrasound might identify fibroids or polyps, which are common types of non-cancerous growths that may be contributing to your bleeding. While it is rare for heavy menstrual bleeding to be caused by cancer, your clinician may also want to order tests or other investigations to rule this out.

You might also be referred to a specialist if your bleeding is not improving with prescribed medical treatments. It may take time to get the full benefit of some treatment options. If you are concerned about your treatment at any time, go back to your primary care clinician and discuss your situation.

■ For clinicians

From primary care, offer early referral to appropriate specialist care for patients with:

- Suspicious clinical findings on assessment or ultrasound.^{6,53} Consider risk factors for endometrial cancer such as^{6,58,59}
 - age, with increased suspicion warranted in a woman aged over 45
 - personal or family history of endometrial cancer or colorectal cancer
 - use of unopposed oestrogen or tamoxifen
 - obesity
 - young age at menarche or older age at menopause
 - nulliparity
 - diabetes
 - endometrial hyperplasia
- Significant pelvic pathology on ultrasound such as large fibroids or endometrial polyps
- Severe symptoms at initial presentation.^{5,6}

Early referral is also warranted if medical management is unsuitable, or if a patient requests procedural treatment options.

For patients who have not responded to medical management, offer referral for further investigation and treatment.

When referring to specialist care, arrange for appropriate investigations, including cervical screening and ultrasound, to be completed.

■ For healthcare services

In primary healthcare services, establish protocols and pathways to ensure that:

- Patients with possible or suspected malignancy, or with significant pelvic pathology, are offered early referral to an appropriate specialist for review
- Patients who have not responded to medical management are offered referral to an appropriate specialist for assessment and treatment.

In secondary health services with referral protocols or criteria, use those protocols to advise referring clinicians of referral requirements and timeframes.

Related resources

Clinician resources

- Cancer Australia – [Diagnostic guide for GPs and gynaecologists for abnormal vaginal bleeding](#)⁵³

Indicator for local monitoring

Indicator 6a: Evidence of protocols or pathways to ensure timely and appropriate referral of patients with heavy menstrual bleeding.

The protocols or pathways should specify the process to:

- Offer early referral to an appropriate specialist when there is suspicion of malignancy or other significant pathology
- Offer a referral to an appropriate specialist when the patient has not had a satisfactory response to medical management
- Assess adherence to the protocols or pathways.

METEOR link: meteor.aihw.gov.au/content/788543

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

7

Quality statement 7 – Uterine-preserving alternatives to hysterectomy

A woman who has heavy menstrual bleeding of benign causes and who is considering non-medical management is offered uterine-preserving procedures that may be suitable (such as endometrial ablation, uterine artery embolisation or surgical removal of local pathology). She is supported to make an informed decision and is referred appropriately.

Purpose

To ensure that a woman with heavy menstrual bleeding has the opportunity to consider the most appropriate, least invasive non-medical procedures for her clinical situation and, if necessary, is referred to a suitable practitioner for individual assessment and treatment.

What the quality statement means

■ For patients

If you are considering options other than medicines for your heavy menstrual bleeding, the first procedures to consider are those that will leave your uterus in place. The procedures that may be suitable for you will depend on the cause of your bleeding and other factors such as whether you want to be able to get pregnant in the future. Depending on your situation, suitable options may include:

- **Endometrial ablation**, which is a common procedure that involves removing or destroying the lining of the uterus (the endometrium) using heat. A long, narrow instrument is put inside the uterus (through the vagina) to apply heat or cut out the uterus lining. After this procedure, it is not safe to get pregnant, so you must avoid any future pregnancy by using effective contraception.
- **Uterine artery embolisation (UAE)**, which may be suitable for women with fibroids larger than 3 cm. UAE involves blocking off the blood flow to the fibroids so that the fibroids shrink in size and produce less bleeding. A small tube is placed in an artery near the groin or wrist to access the blood vessels to the uterus. The tube delivers particles to block the blood vessel and is removed after the procedure. You can be referred to an interventional radiologist to discuss UAE in more detail. If you wish to become pregnant in the future you should discuss the specific risks with your doctor.
- **Myomectomy**, which is an operation to surgically remove fibroids from the uterus. It leaves the uterus intact and it may be suitable for women who are planning to have children. There are different types of myomectomy depending on how the surgeon accesses the uterus including abdominal (through a cut made in your lower abdomen), laparoscopic (through a keyhole incision) or hysteroscopic (through the vagina – see also **Hysteroscopic removal** below).
- **Hysteroscopic removal**, which is a procedure to remove any growths such as polyps or fibroids that may be causing the heavy menstrual bleeding, or to remove the lining of the uterus. A thin, flexible instrument with a small camera (a hysteroscope) is inserted into the uterus through the vagina and specialised instruments are used through the hysteroscope to cut, burn or destroy the growths.

The suitability of these procedures will differ for each woman. Your clinician will discuss the benefits and risks with you, and other features such as recovery times, based on your individual situation. Some specialists may not conduct these procedures themselves, in which case they may instead refer you to another specialist for further assessment and treatment.

■ For clinicians

When non-medical management options are being considered, discuss uterine-preserving procedures that may be suitable for the patient's clinical situation. These may include:

- **Endometrial ablation** – a minimally invasive surgical procedure for women without substantive structural uterine pathology and who have no desire for future pregnancy. It involves the removal or destruction of the endometrium including the basal layer using one of a variety of techniques including resection and/or ablation, laser, bipolar radiofrequency or thermal balloon ablation. Women must be informed about the need for contraception following endometrial ablation.⁶⁰
- **Uterine artery embolisation (UAE)** – a minimally invasive treatment option for women with fibroids. The procedure is done by an interventional radiologist. It involves a small incision in the groin or wrist through which a catheter is taken to the uterine arteries. Embolisation is performed by injecting particles to the arteries supplying the fibroids. Successful pregnancy may be possible after UAE. However, myomectomy is preferred, if clinically appropriate, for women who desire future pregnancy. Women considering UAE and desiring fertility should be counselled based on current available evidence regarding future pregnancy and potential risks.^{61,62}
- **Myomectomy** – the surgical removal of uterine fibroids. Myomectomy preserves the uterus and is an option for women who wish to retain their fertility. Myomectomy can be conducted using laparotomy, laparoscopy, or hysteroscopy.⁶³
- **Hysteroscopic resection** of intracavitary pathology (such as polyps or myomas) where these are considered to be causing or contributing to heavy menstrual bleeding. In this procedure, a hysteroscope is passed into the uterine cavity through the vagina. Pathology can be removed using electrosurgical, mechanical, laser or thermal energy.

Consider appropriateness, contraindications and possible complications for each procedure in the context of the patient's specific uterine pathology and clinical presentation, and their preferences and priorities, including their desire for future fertility.

Discuss the relevant options fully with the patient. If they would prefer to consider a treatment choice that you are unable to provide, offer referral for assessment, and/or to discuss the procedure, with a suitably qualified specialist or service.

■ For healthcare services

In primary and secondary healthcare services where women are considering non-medical management of their heavy menstrual bleeding, ensure that protocols and pathways are in place to:

- Provide patients with access to appropriate uterine-preserving procedures, including endometrial ablation, hysteroscopic resection, myomectomy or uterine artery embolisation, as clinically appropriate, either within the healthcare service or by referral to an appropriately skilled clinician
- Support the provision of information about the benefits, risks and probable outcomes of potential treatments.

In healthcare services that provide surgical and non-surgical procedures to patients with heavy menstrual bleeding, ensure that protocols and pathways are in place so that patients can access uterine-preserving alternatives to hysterectomy as appropriate.

Indicator for local monitoring

Indicator 7a: Proportion of patients with heavy menstrual bleeding of benign cause(s) who received uterine-preserving procedural alternatives to hysterectomy.

METEOR link: meteor.aihw.gov.au/content/788546

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

8

Quality statement 8 – Hysterectomy

Hysterectomy to manage heavy menstrual bleeding is considered when other treatment options are ineffective or are unsuitable, or at the woman's request. A woman considering a hysterectomy is fully informed about the potential benefits and risks of the procedure before making a decision.

Purpose

To support the judicious use of hysterectomy for women with heavy menstrual bleeding and ensure that women understand the potential benefits and risks before choosing to have the procedure.

What the quality statement means

■ For patients

Hysterectomy (surgery to remove the uterus) stops heavy menstrual bleeding because it permanently stops your periods. Hysterectomy involves removing part or all of the uterus, often with the fallopian tubes. When it is considered clinically appropriate, the ovaries may also be removed.

Hysterectomy can be done in different ways, including abdominal (through a cut in the lower abdomen), laparoscopic (keyhole surgery performed through small cuts in your abdomen), or vaginal (surgery performed through your vagina). Hysterectomy is a major surgical operation, and it has a higher risk of complications than other treatments for heavy menstrual bleeding.

Hysterectomy will be discussed as an option to consider if alternative treatments are not suitable for your situation, if alternatives have not worked for you, or if it is your preference. Your doctor will explain what the surgery involves, the types of hysterectomy available to you, the expected benefits and the possible complications or unwanted effects. This is so you can make an informed choice about whether to go ahead with the procedure.

After a hysterectomy, you can no longer become pregnant. While complications are uncommon, there is a risk of infection, blood loss, damage to the ovaries, bowel or bladder, and other surgical complications. If your ovaries are removed, then you will experience early menopause. Different risks may apply according to your situation and the way the hysterectomy is done, and your doctor will discuss these with you.

■ For clinicians

When discussing the range of treatment options for heavy menstrual bleeding, support the patient to consider less invasive alternatives prior to considering hysterectomy, as appropriate to their clinical situation and personal circumstances.

Hysterectomy is generally considered when alternative medical and procedural options are unsuitable, have proven to be ineffective or intolerable, or when it is the patient's preference.

When the patient is considering hysterectomy, ensure that they understand the benefits, risks and probable outcomes of the surgery. Discuss minimally invasive approaches to hysterectomy (vaginal or laparoscopic) where clinically appropriate.

When the patient is making their decision, allow them the time and opportunity to consider this information.

The discussion should cover the irreversible nature of the surgery, consequences for childbearing, risks including infection, organ damage and blood loss, the time in hospital and the recovery period. Explain any particular risks associated with the type(s) of hysterectomy being considered.

■ For healthcare services

In services where women may be considering their treatment options, ensure that systems and processes are in place to:

- Support the systematic consideration of less invasive alternatives to hysterectomy, as appropriate to a woman's clinical needs and preferences, in a way that is meaningful to her, so that she can make an informed choice about hysterectomy
- Provide women with information about the benefits, risks and consequences of hysterectomy, and about suitable approaches to hysterectomy
- For women who choose hysterectomy, support consideration of minimally invasive approaches (vaginal or laparoscopic) whenever clinically appropriate.

Related resources

Patient information resources

- Royal Australian and New Zealand College of Obstetricians and Gynaecologists – [Hysterectomy](#)⁶⁴
- Jean Hailes for Women's Health – [Hysterectomy](#)⁶⁵

Overall indicator

Indicator 9a: Hospital rate of hysterectomy per 100 episodes.

Note: To enable calculation of this rate, the Commission will supply a tool for use by healthcare services, for calculation of local age-standardised rates and comparison against national reference rates. This tool is available on the Commission's [website](#).

METEOR link: meteor.aihw.gov.au/content/788550

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

Appendix A: General principles of care

This clinical care standard aligns with key principles that are the foundation for achieving safe, high-quality care. When implementing this clinical care standard, healthcare services should ensure quality improvement activities support these principles.

Person-centred care

Person-centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers.^{15,66}

Clinical care standards support the key principles of person-centred care, namely:

- Treating patients with dignity and respect
- Encouraging patient participation in decision-making (see **Shared decision making** below)
- Communicating with patients about their clinical condition and treatment options
- Providing patients with information in a format that they understand and encouraging them to participate in decision-making.

Shared decision making

Shared decision making involves discussion and collaboration between a consumer and their clinician. It is about bringing together the consumer's values, goals and preferences with the best available evidence about benefits, risks and uncertainties of treatment, to reach the most appropriate healthcare decisions for that person.

Involving support people

The [Australian Charter of Healthcare Rights](#) (second edition)⁶⁷ describes the rights that consumers, or someone they care for, can expect when receiving health care.

Patients have the right to involve the people they want in planning and making decisions about their health care and treatment. This could be a family member, carer, friend or a consumer advocate such as a social worker. Many health services employ different types of liaison officers, such as Aboriginal and/or Torres Strait Islander liaison officers, who can provide patients with advocacy, information and support.

This clinical care standard does not specifically refer to carers and family members, but statements which refer to clinicians' discussions with patients about their care should be understood to include support people if this is what the patient wishes, or a substitute decision-maker if the person is unable to provide their consent.

Informed consent

Informed consent is a person's voluntary and informed decision about a healthcare treatment, procedure or intervention that is made with adequate knowledge and understanding of the benefits and risks to them, the alternative options available, and any potential financial costs. See the [Informed Consent in Health Care fact sheet](#), developed by the Commission.

Action 2.04 in the National Safety and Quality Health Service (NSQHS) Standards requires healthcare services to ensure that informed consent processes comply with legislation and best practice.¹⁵

Appendix B: Indicators to support local monitoring

The Commission has developed a set of indicators to support clinicians and health services in monitoring how well they implement the care described in this clinical care standard. The indicators are a tool to support local quality improvement activities. No benchmarks are set for any indicator.

The process to develop the indicators specified in this document comprised:

- A review of existing Australian and international indicators
- Prioritisation, review and refinement of the indicators with the topic working group.

The data underlying these indicators are collected from local sources through prospective data collection, retrospective chart audits or review of policies and protocols.

In this document, the indicator titles and hyperlinks to the specifications are included with the relevant quality statement under the heading 'Indicator(s) for local monitoring'. Full specifications for the *Heavy Menstrual Bleeding Clinical Care Standard* indicators can be found in the Metadata Online Registry (METEOR) at meteor.aihw.gov.au/content/788514.

METEOR is Australia's web-based repository for national metadata standards for the health, community services and housing assistance sectors. Hosted by the Australian Institute of Health and Welfare, METEOR provides users with online access to a wide range of nationally endorsed data and indicator definitions.

Appendix C: Measuring and monitoring patient experiences

Systematic, routine monitoring of patients' experiences of, and outcomes from, health care is an important way to ensure that the patient's perspective drives service improvements and patient-centred care. This is the case in all health services.

Patient-reported outcome measures

In Australia, patient-reported outcome measures (PROMs) are an emerging method of assessing the quality of health care. The Commission is leading a national work program to support the consistent and routine use of PROMs to drive quality improvement.

PROMs are standardised, validated questionnaires that patients complete without any input from healthcare providers. They are often administered at least twice to an individual patient – at baseline and again after an intervention – or at regular intervals during a chronic illness. The information contributed by patients filling out PROMs questionnaires can be used to support and monitor the movement of health systems towards person-centred, value-based health care.

PROMs are being used to evaluate healthcare effectiveness at different levels of the health system, from the individual level to service and system levels. There is growing interest across Australia and internationally in the routine interrogation of patient-reported outcome information for evaluation and decision-making activities at levels of the health system beyond the clinical consultation.

Appendix D: Integration with national safety and quality standards

National Safety and Quality Health Service Standards

Monitoring the implementation of this clinical care standard will help healthcare services to meet some of the requirements of the National Safety and Quality Health Service (NSQHS) Standards (second edition).¹⁵

The NSQHS Standards aim to protect the public from harm and improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

Within the NSQHS Standards, the Clinical Governance Standard and the Partnering with Consumers Standard combine to form the clinical governance framework for all healthcare services that applies to all other standards:

- The Clinical Governance Standard aims to ensure that systems are in place within healthcare services to maintain and improve the reliability, safety and quality of health care
- The Partnering with Consumers Standard aims to ensure that consumers are partners in the design, delivery and evaluation of healthcare systems and services, and that patients are given the opportunity to be partners in their own care, to the extent that they choose.

Actions 1.27b and 1.28

Under the Clinical Governance Standard, healthcare services are expected to support clinicians to use the best available evidence, including clinical care standards (Action 1.27b), and to monitor and respond to unwarranted clinical variation (Action 1.28).

Healthcare services are expected to implement the NSQHS Standards in a way that is appropriate to the clinical services provided and their associated risks.

Information about the NSQHS Standards is available at the [NSQHS Standards website](#).

National Safety and Quality Primary and Community Healthcare Standards

The National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards aim to protect the public from harm and improve the quality of health care delivered.¹⁶

The NSQPCH Standards are aligned to the NSQHS Standards. Both standards highlight the importance of clinical governance and consumer partnerships in effective, safe and high-quality health care, wherever health care is delivered.

Primary and community services can be subject to multiple sets of standards. It is intended that the NSQPCH Standards are used as the core safety and quality component of each set of standards, thus minimising the compliance burden across multiple sets of standards.

Information about the NSQPCH Standards is available at the [NSQPCH Standards website](#).

Glossary

Term	Definition
Aboriginal Community Controlled Health Organisations (ACCHOs)	Primary healthcare services initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health care to the community that controls it, through a locally elected Board of Management. ⁶⁸
abnormal uterine bleeding	<p>Any variation from the normal menstrual cycle, including changes in regularity and frequency of menstruation, duration of flow, or amount of blood loss. It may be acute or chronic.^{7,24,25}</p> <p>Chronic abnormal uterine bleeding is bleeding from the uterine corpus (the body of the uterus) that is abnormal in duration, volume, and/or frequency and has been present for the majority of the past six months. See also 'acute abnormal uterine bleeding'.</p> <p>The use of terms such as 'dysfunctional uterine bleeding' and 'menorrhagia' is no longer recommended.²⁵</p>
acute abnormal uterine bleeding	Acute abnormal uterine bleeding is an episode of bleeding, in a woman of reproductive age who is not pregnant, that is of sufficient quantity to require immediate intervention to prevent further blood loss. ²⁵
adverse effects	See ' side effects '.
assessment	A clinician's evaluation of a disease or condition, based on the patient's subjective report of the symptoms and course of the illness or condition, the clinician's objective findings (including data obtained through tests, physical examination and medical history) and information reported by carers, family members and other members of the healthcare team. ¹⁵
benign	Not malignant (that is, not cancerous).
bimanual pelvic examination	An internal examination of the pelvis, using both hands. With one hand placed on the outside of the woman's lower abdomen, the fingers of the other hand are inserted into the vagina, allowing the clinician to feel the size, shape and position of the uterus using both hands.
carer	A person who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail or aged. An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are paid, a volunteer for an organisation, or caring as part of a training or education program. ⁶⁹
clinical guidelines	A set of recommended actions that are developed using the best available evidence. They provide clinicians and peer workers with evidence-informed recommendations that support their practice, and guide clinician, peer worker and service user decisions about appropriate health care in specific clinical practice settings and circumstances. ¹⁵

Term	Definition
clinician	A trained health professional, including registered and non-registered practitioners, who provides direct clinical care to patients. Clinicians may provide care within a healthcare service as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They include nurses, midwives, medical practitioners, allied health professionals, Aboriginal and Torres Strait Islander health workers and practitioners, and other clinicians who provide health care, and students who provide health care under supervision.
consumer	A person who has used, or may potentially use, health services, or is a carer for a patient using health services. A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision-making processes. ⁷⁰
developmental disability	Disabilities that relate to 'differences in neurologically based functions that have their onset before birth or during childhood and are associated with significant long-term difficulties'. All intellectual disabilities are developmental disabilities, but not all developmental disabilities are associated with an intellectual disability. For example cerebral palsy is a developmental disability that may or may not be associated with intellectual disability. ⁷¹
endometrial ablation	The targeted destruction or removal of the entire endometrial surface (inner lining of the uterus), using one of several surgical techniques or devices. ⁷²
endometrium	The inner lining of the uterus. ⁴⁵
endorsed midwife	A midwife endorsed by the Nursing and Midwifery Board of Australia to prescribe some medications and order diagnostic interventions. Endorsed midwives provide autonomous care within their scope of practice and can provide direct referral to other healthcare professionals.
fibroids	Non-cancerous growths that form within the muscular wall of the uterus, also called myomas or leiomyomas. They are often asymptomatic, but signs and symptoms can include heavy or long periods, iron deficiency anaemia, pressure and pain. Fibroids vary greatly in size, from millimetres to tens of centimetres. ^{63,73}
healthcare record	Includes a record of the patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care. ¹⁵
healthcare service	A separately constituted health service that is responsible for implementing clinical governance, administration and financial management of a service unit or service units providing health care at the direction of the governing body. A service unit involves a group of clinicians and others working in a systematic way to deliver health care to patients. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms. ¹⁵
health literacy	The skills, knowledge, motivation and capacity of a consumer to access, understand, assess and apply information to make effective decisions about health and health care, and take appropriate action. ¹⁵

Term	Definition
heavy menstrual bleeding	Defined as ‘excessive menstrual blood loss which interferes with a woman’s physical, social, emotional, and/or material quality of life, and which can occur alone or in combination with other symptoms’. ⁶ While heavy menstrual bleeding may also be a symptom of other conditions, in this document it refers to bleeding of benign causes.
hospital	A licensed facility providing healthcare services to patients for short periods of acute illness, injury or recovery. ¹⁵
hysterectomy	Surgical removal of the uterus. There are different types of surgery. Surgery may be performed through an incision in the abdomen, via the vagina or laparoscopically (‘keyhole surgery’ conducted through small incisions in the abdomen). Hysterectomy may involve the removal of part, or all, of the uterus. The fallopian tubes, ovaries, cervix and surrounding tissue are sometimes removed at the same time, depending on the type of operation. ⁷⁴
hysteroscopy, hysteroscopic	A hysteroscopy is an examination of the uterus using an instrument called a hysteroscope that allows the doctor to see the inside the uterus. The hysteroscope is carefully passed through the vagina and cervix and into the uterus. Hysteroscopic techniques and procedures are performed using the hysteroscope to view the inside of the uterus while conducting the procedure (for example, hysteroscopic resection). ⁷⁵
informed consent	Informed consent is a person’s decision, given voluntarily, to agree to a healthcare treatment, procedure or other intervention that is made: <ul style="list-style-type: none"> ■ Following the provision of accurate and relevant information about the healthcare intervention, alternative options available and any potential financial costs ■ With adequate knowledge and understanding of the benefits and material risks of the proposed intervention relevant to the person who would be having the treatment, procedure or other intervention.⁷⁶
leiomyomas	See ‘ fibroids ’.
levonorgestrel	A synthetic form of the hormone progesterone, a female hormone that plays a role in the menstrual cycle.
medical management	Treatment based on pharmacological therapy as distinct from surgical or procedural approaches. In this clinical care standard, medical management refers to hormonal and non-hormonal pharmacological treatment, including the 52 mg levonorgestrel-releasing intrauterine device.
medical practitioner	A medically qualified person whose primary role is the diagnosis and treatment of physical and mental illnesses, disorders and injuries. They include general practitioners, medical specialists, interns and residents.
medical record	See ‘ healthcare record ’.
medicine	A chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental wellbeing of people. These include prescription, non-prescription, investigational, clinical trial and complementary medicines, regardless of how they are administered. ⁷⁷

Term	Definition
menarche	When a woman starts having menstrual periods, during puberty.
nurse practitioner	A nurse practitioner is a registered nurse with the experience and expertise to diagnose and treat people of all ages with a variety of acute or chronic health conditions. Nurse practitioners have completed additional university study at Master's degree level and are the most senior clinical nurses in our healthcare system. ⁷⁸
patient	A person who is receiving care in a healthcare service. ¹⁵
polyp	Uterine (endometrial) polyps are small growths that develop in the lining of the uterus (endometrium). Most polyps are benign (non-cancerous) but occasionally they can become cancerous; this is more likely in older women. ^{45,79}
primary health care	Primary health care is generally the first point of contact for individuals, families and communities with healthcare services and brings health care as close as possible to where people live and work. It constitutes a large and essential part of the healthcare system. Primary health care includes health promotion, prevention, early intervention, treatment of acute conditions, management of chronic conditions and end-of-life care. ¹⁶
quality improvement	The combined efforts of the workforce and others – including consumers, patients and their families, researchers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development. ⁸⁰ Quality improvement activities may be sequential, intermittent or continuous. ¹⁵
quality of life	An overall assessment of a person's wellbeing, which may include physical, emotional and social dimensions, as well as mental health, stress level, sexual function and self-perceived health status. ⁸¹ Specific quality-of-life considerations that relate to heavy menstrual bleeding include limitations on work, exercise and social functioning. ⁸²
reasonable adjustments	Changes or adjustments made in the delivery of health care to overcome barriers experienced by people with disability. Reasonable adjustments improve care for people with disability by: <ul style="list-style-type: none"> ■ Minimising adverse outcomes, including trauma related to medical procedures ■ Enabling a more positive experience for the person and their family or support people, and for those delivering health care ■ Ensuring equitable access to healthcare interventions.⁴²
risk factor	A characteristic, condition or behaviour that increases the possibility of disease, injury or loss of wellbeing.
rural generalist	A general practitioner who has specific expertise in providing medical care for rural and remote or isolated communities. Rural generalists understand and respond to the diverse needs of rural communities: this includes applying a population approach, providing safe primary, secondary and emergency care, culturally engaged Aboriginal and Torres Strait Islander people's health care as required, and providing specialised medical care in at least one additional discipline. ⁸³

Term	Definition
shared decision making	A consultation process in which a clinician and a patient jointly participate in making a health decision, having discussed the options and their benefits and harms, and having considered the patient's values, preferences and circumstances. ⁴⁰
side effects	Unintended effects from a medicine, treatment or device.
specialist	Includes specialist general practitioners (GPs) including rural generalists, and other non-GP specialists as recognised by the Medical Board of Australia.
system	The resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish a stated goal. A system: <ul style="list-style-type: none"> ■ Brings together risk management, governance, and operational processes and procedures, including education, training and orientation ■ Deploys an active implementation plan; feedback mechanisms include agreed protocols and guidelines, decision support tools and other resource materials ■ Uses several incentives and sanctions to influence behaviour and encourage compliance with policy, protocol, regulation and procedures.¹⁵
transabdominal ultrasound	A way of conducting a pelvic ultrasound that involves imaging the uterus and pelvic organs by placing the ultrasound transducer (a handheld probe with a broad flat end) on the outside of the abdomen. This method does not show the uterus and pelvic structures as well as the transvaginal method.
transvaginal ultrasound	A way of conducting a pelvic ultrasound that involves imaging the uterus and pelvic organs by placing a special ultrasound transducer (a special smooth, thin, handheld device) into the vagina. This method shows the uterus and pelvic structures better than the transabdominal method. ⁸⁵
ultrasound	The use of high-frequency sound waves to produce an image that shows the inside of the body. ⁸⁵
uterine artery embolisation	A minimally invasive treatment option for women with fibroids. It involves a small incision in the groin or wrist through which a catheter is taken to the uterine arteries. Embolisation is performed by injecting particles into the arteries that supply the fibroids, causing the fibroids to shrink.
uterus	The womb. It is located in a woman's pelvis, between the bladder and the rectum. The narrow, lower portion of the uterus is the cervix (the neck); the broader, upper part is the corpus (the body). The corpus is made up of two layers of tissue (myometrium and endometrium). ⁷⁵

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The above artwork used throughout the document was designed by Ms Lani Balzan, a Wiradjuri artist from the south coast of New South Wales. The central symbol is the logo for the clinical care standards program, which began at the Commission in 2013. The outer four circles of the artwork represent the four priority areas of patient safety; partnering with patients, consumers and communities; quality, cost and value; and supporting health professionals to provide care that is informed, supported and organised to deliver safe and high-quality health care. The outer dots represent growth, healing, change and improvement.





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