Oakden – South Australia

Between 28 November and 2 December 2016, ACHS undertook an Organisation Wide Survey (OWS) of a Local Health Network in South Australia that included Oakden Aged Care. The OWS would look at 19 sites over five days including a tertiary hospital, a general hospital and numerous community health services.

The Makk and McLeay Nursing Home was not in scope for the ACHS accreditation survey. In February 2016 Makk and McLeay had participated in the Commonwealth Aged Care Accreditation Program and this process was demonstrated to closely align to the National Standards and Mental Health Standards. Makk and McLeay were awarded three years’ accreditation to April 2019.

The much publicised Oakden Review was commissioned by the Chief Psychiatrist, SA Health on 20th December 2016. The review incorporated:

- 53 interviews with staff and also interviewed the Principal Community Visitor
- Extensive review of the clinical files of nine current and seven former consumers of Oakden – some files with as many as 11 volumes
- Briefly scanned 65,000 emails
- The review team were onsite for 17 days – 12-week review in total
- Two members of the review team visited services in Victoria and New South Wales.

The Oakden Review cites problems identified in Mid-Staffordshire in particular that responsibility was diffused and therefore not clearly owned. It notes that in relation to Oakden, there was confusion over leadership for Clinical Governance (CG) stating that ‘the fish rots from the head’ and that the ‘review’ went around and around hearing that it was someone else who was at fault.

Page 76 begins the discussion about accreditation and states that "one of the major focuses of the CG meetings appeared to be on the then forthcoming November 2016 accreditation by ACHS of the NALHN against the NSQHS Standards." The minutes indicated to the Review that Oakden appeared unprepared for accreditation against these standards and that the focus was on ensuring staff knew what to say during accreditation, rather than knowing how a service should provide high quality care.

One of the highlights of 2017 so far for ACHS has been the recent visit in April to Tokyo, Japan, to meet with Nihon Keiei, one of Japan’s premier consulting firms. ACHS CEO Dr Christine Dennis (centre) met with President Masatoshi Hirai, of Nihon Keiei Co., Ltd to further strengthen the business relationship. Dr Dennis and Dr Lena Low presented a series of workshops on accreditation, risk management, clinical governance and other critical quality and safety topics over three days. Nihon Keiei advises on hospitals and the health industry.

See Inside For:
- ACHS Improvement Academy
- 2017 Congress
- QI Awards
- ACHSI Update

#2017Congress
27 – 29 Sep 2017
Sydney Hilton
The Oakden Review refers to a **Boss on the Floor mentality** (page 93) as a distinctive form of communication that alerted staff that there was a person of authority in the building and that staff would be expected to act in a way that would reduce the likelihood of being scrutinised.

The standards applicable for this health service, like many, include the National Safety and Quality Health Service Standards, National Standards for Mental Health and the Aged Care Accreditation Standards (Quality of Care Principles 2014). With varying rotations, it is not surprising that many health service complain of lurching from one accreditation survey to the next and ... as the review states, “sometimes totally missing the intent of the standards”.

**Oakden, as a system, has missed the point of why there are standards and that the aim of standards is to point a system toward what is to be achieved at all times to provide quality of care, because it is important, rather than only when it is being accredited.**

Accreditation can only give a retrospective snapshot at a point in time; it cannot guarantee by itself a continuous approach to quality. The focus needs to be on sustainability and patient safety cultures.

The **Agency for Healthcare Research and Quality (AHRQ)** have identified the following key features of an organisation with a ‘culture of safety’:

- acknowledgment of the high-risk nature of an organisation's activities and the determination to achieve consistently safe operations;
- a blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment;
- encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems; and,
- organisational commitment of resources to address safety concerns.

Add to this, leadership that demonstrates their own ongoing commitment to safety and quality. There is no room in a culture of safety for those who uselessly point fingers or say, “Safety is not my responsibility, so I’ll file a report and wash my hands of it.” (Institute for Healthcare Improvement)

Global exponent of change management - Helen Bevan announced as a Keynote Speaker for Joint Congress 2017

Helen Bevan is acknowledged globally for her expertise and energy for large scale change in health and care. During her 25 years as a change leader in the English National Health Service, Helen has been at the forefront of many NHS improvement initiatives that have made a difference for thousands of patients and for the staff who care for them.

The ACHS and ACHSM are delighted to announce that Helen will be a headline speaker at the **Joint Congress 2017** to be held in at the Hilton Sydney on 27 – 29 September.

“We are particularly delighted as Helen is currently leading the Horizons team, which is a source of ideas and knowledge to enable the spread of improvements at scale.” said ACHS CEO Dr Christine Dennis.

“The Horizons team uses a variety of different tools and approaches including social movement thinking, community organising, improvement science, accelerated design and digital connectivity. It champions the role of emerging leaders, students and trainees at the forefront of radical change.

Currently part of NHS England, the Horizons team is seeking to become the first team to move out of a national NHS body and reinvent itself as a staff-led mutual. The team believes that the mutual sector will be the venue of some the most radical and impactful change practice for social good in coming years.

It is these changes that Dr Bevan will share, under the congress theme of ‘The winds of change – adjust your sails’. Visit [www.achsm.org.au/congress](http://www.achsm.org.au/congress) for further information on the congress.
ACHS has organised four graduation celebrations for our lead program courses graduates in Sydney and Melbourne since March.

A total of 45 graduates have worked through to their final presentation and succeeded in graduating from either the Patient Safety Lead Course or the Quality Improvement Lead Training Course.

“We are extremely proud of the work produced by the graduates in their final presentations,” said ACHS CEO Dr Christine Dennis.

“The Panel members were impressed by the depth and range of the subjects covered and their keenness to demonstrate the key learnings from the courses and incorporate them into their projects.

“The areas of work where they have utilised the concepts into everyday quality and safety work practices is admirable. There are now many hospitals and health organisations across the country who will benefit firsthand from the improvements – and the participants’ enthusiasm is palpable,” she said.

Ms Bernie Harrison, Director of the Improvement Academy who ran the four courses with a cohort of quality and safety specialists said that the presentations at the graduation ceremonies validated the participants’ input over the last year.

“After 11 months involvement the level of thinking behind their projects and the effort which went into them is pleasing,” she said. “Importantly these projects are concerned with real-life practices, and judging by the standard of the presentations, they are already starting to make a strong difference to patient’s lives.”

Ms Harrison said the feedback from the participants about what they got out of the courses speaks the loudest:

 Participant Feedback

“I got a lot out of the course, and the difference in the organisations here is wonderful and being able to find out what is going on in large health services. Networking, being able to listen and engage with other people and having the tools that I can now use. Doing the project has given me an idea of the importance of the collaboration and engagement with stakeholders, and the diagnostics involved with the process.” Bev McLaine Kyabram

“Cathy Balding was fabulous, we have all had great presenters. One thing I got a lot out was from Lynne Maher from NZ, I think it was all worthwhile, even in our busy lives.” Shayne Larymore

“It is connecting everything I have learnt.” Rhiann Davies

“I’ve loved it. I wanted more sessions. I came into quality without doing a course, and while all the books are great, the learning difference with this course was to make information presentable as well as meeting the new people and making friends here, I’m really impressed. Cathy Balding was a great consolidator yesterday, and would love to have more sessions from Lynn Maher. Really great. Totally recommend it.” Samantha Sinclair

First graduation of our Patient Safety Lead Program graduates on 24 March in Sydney.

The Patient Safety Lead Program Graduation Ceremony held on 5 May in Melbourne.
**Abstract:** What was the original idea/purpose of the project?

Over-transfusion of donor red blood cells (RBCs) was evident following total knee replacement (TKR) at the Whitlam Joint Replacement Centre (WJRC), Fairfield Hospital (SWSLHD) where the study was undertaken. Over-transfusion manifested as a high rate of transfusion (proportion of people receiving RBCs after TKR) and a relatively high average number of units given per transfused patient (units/per transfused patient).

**Introduction / Overview:** What is the health problem/issue that you were trying to be address or remedy?

A high utilisation rate of donor RBCs is problematic for several reasons, namely expense to the health service and use of a relatively scarce resource. At the time of the study, there was also some evidence to suggest morbidity and mortality were greater in some patient groups if donor RBCs were given liberally [1]; that is, if the transfusion trigger was a haemoglobin level around 100 g/l and multiple units were given at the outset. Today (12 years on), the evidence relating donor RBC transfusion to morbidity and mortality remains debateable, but there is good evidence that restrictive transfusion thresholds are safe and conserve donor blood [1].

**What was your Aim?**

To reduce the rate of donor RBC transfusion from 41% to 25%, and to promote the use of single-unit transfusion without compromising other patient or service outcomes.

**What was the Method?**

We applied a pre-post intervention study whereby we monitored the rate of donor RBC and number of units per patient transfused before and after the introduction of restrictive transfusion practices. The practices included assessment of the need for blood based on a blood haemoglobin value and presence and signs of anaemia. Single or multiple units were endorsed depending on the indication. The intervention also included regular medical and nursing education, and use of a transfusion stamp (now a sticker) to both guide the decision and improve documentation around the use of donor RBCs.

**What were the Project Outcomes?**

- RBC utilisation rate decreased from 41% to 25%
- A trend for greater use of single-unit transfusion
- No overt adverse consequences for the patient or the health service
- Combined, these outcomes suggested that restrictive blood transfusion practices were a safe, frontline strategy for improving the appropriate use of a scare and expensive resource.

**Where does this project stand now in 2017? Has it been elevated or expanded elsewhere?**

Restrictive transfusion practices continue to be followed within the SWSLHD. In 2015, the rate of RBC transfusion following TKA was < 6.7% [2]. Since 2012, the appropriate use of RBCs following TKR at the WJRC has also been greatly facilitated by the use of tranexamic acid – an antifibrinolytic agent which helps prevent blood clots from breaking down. The two approaches together conserve donor blood as they reduce the amount of blood lost (via the prevention of clot breakdown) and improve the appropriate prescription of RBCs (via restrictive transfusion criteria).

**What was its reach? Did any other agency, organisation or facility pick up on it? Was any further analytical research conducted to test its performance?**

The reach of a project is improved through publication of...
findings in credible sources, presentation of findings at meetings, and endorsement of findings through policy and practice. This project and its findings were promoted in a number of ways:

1. The project was awarded a NSW Health Award (Baxter Health Care Award) in the same year it was awarded the ACHS award - **Joint Winner Baxter Health Care Awards (Effectiveness) 2005 - Restrictive blood transfusion practices following primary unilateral TKR** *(Naylor JM, Dietsch S, Gray L, Nouh F, Cunningham J)*.

2. The project was presented as a plenary talk in the 2006 Australasian Quality and Safety Conference in Melbourne.

3. In 2006-2007, the CEC consulted with the team to help inform the ‘Blood Watch” program which was being rolled-out across NSW [3]. The aim of Blood Watch was to improve the appropriate use of RBC transfusions and this was achieved through a variety of means including the employment of transfusion CNCs, local transfusion policies including promotion of restrictive practices, and education and regular audit.

Below is an excerpt from a CEC publication regarding the use of RBCs across NSW LHDs between 2004-05 to 2006-07 [3].

“Other area health services’ relative use (Greater Western, Northern Sydney, Sydney South West), was above the state average prior to the establishment of the Blood Watch program, however these three health services have used a series of interventions to bring utilisation levels below the state average as measured when the program commenced. The interventions included regular audit and feedback to specific clinical specialties, tightening of ordering processes, minimal vetting of transfusion request, and the rollout of targeted education sessions to relevant staff. The overall ten percent reduction in utilisation in 2006-07 indicates that the Blood Watch program had gained momentum at the ground level and the clinical practice improvement initiatives were having an impact. With this dataset it was possible to calculate that the 10% reduction in total red blood cell transfusion (9168 units) equates to a direct product cost of approximately $2,383,855 savings across the State (based on AUD$260 per unit). This figure is inclusive of the Australian Government’s 63 per cent contribution to the State’s blood budget. Implications: Reductions in red cell usage have two significant implications for NSW: i) an overall improvement in appropriate transfusion practice with positive outcomes for patients; and, ii) considerable cost reductions for area health services’ blood budgets”.


**What did you learn, personally from conducting and submitting the project? How do you feel about it now?**

The orthopaedic unit learnt the value of reviewing practices and implementing change though a structured
Evidence that the ‘learnings’ have been long-lasting is that the unit continues to review practices regularly, initiate quality improvement activities, and engage in structured research.

Figure 1 (on page 5) illustrates the rate of RBC transfusion following TKR at the WJRC across time since 2012. The rates have been routinely captured through ACORN (Arthroplasty Clinical Outcome Registry National) since inception of the registry in 2012. In 2012, the rate was 12% - indicating that the reductions achieved in 2005 had been improved and sustained. In 2016, the rate was < 5%. The low rates at the WJRC are attributed to the use of tranexamic acid (introduced in 2012) and the use of restrictive transfusion practices, and overall reflect a commitment by the Centre to monitor their practices and outcomes.

References

A majority of previous QI Award Winners have been contacted to ascertain their interest in providing an update on their winning entry. Please contact Ian McManus on imcmanus@achs.org.au if you would like to submit a QI Awards retrospective update.
Welcome to Dr Hao Zheng

ACHS would like to extend a very warm welcome to Dr Hao Zheng who has recently commenced as the Manager – Performance and Outcome Service to be responsible for the Clinical Indicator Program, following the resignation of Myu Nathan.

Dr Zheng has a triple background in clinical medicine, science, and public health in China, Europe and USA. After qualifying as a medical doctor at the Wuhan University School of Medicine, Dr Zheng completed an MSc in Immunology and Microbiology at the Huazhong University of Science and Technology Tongji Medical School and a PhD in Neurobiology at the University of Houston, Texas. She also completed patient safety training at the Johns Hopkins University and has an MBA from the University of Geneva. Welcome Dr Zheng.

Thumbs up to Goulburn Valley

Goulburn Valley Hospice Care Service (GVHCS) recently underwent an accreditation review.

Surveyors visited the site in March and assessed the service against a range of criteria. Clinical, Support and Corporate aspects of the service were reviewed and the surveyors were very impressed with the organisation’s performance.

There were many areas of quality improvement that demonstrated this service is a leader in providing palliation services. Staff are supported by a Board and management team who demonstrate the same passion and commitment. Overall, the service provides excellence in palliative care to the community and is highly-regarded for this. Accreditation was awarded for four years.

Congratulations to GVHCS for their recent accreditation success.

Certificate Presentations in Taiwan

Certificate presentations were held at two NephroCare clinics in Taiwan: Central Clinic Hospital Dialysis Clinic and Lee Fooh Clinic Dialysis Clinic. The events were held on 4 and 5 May. ACHS International was represented by Dr Desmond Yen, Executive Director - International Business and Ms Dianna Kenrick, Director Clinical Quality (Asia Pacific) attended on behalf of NephroCare/ Fresenius Asia Pacific.

Goulburn Valley Hospice Care Service (GVHCS) recently underwent an accreditation review.

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Congratulations to GVHCS for their recent accreditation success.
Leveraging the full value and impact of accreditation

WENDY NICKLIN, TRIONA FORTUNE, PAUL VAN OSTENBERG, ELAINE O’CONNOR, and NICOLA MCCAULEY

International Society for Quality in Health Care, 7-8 Upper Mount Street, Dublin 2, D02 FT59, Ireland

Address reprint requests to: Triona Fortune, International Society for Quality in Health Care, 7-8 Upper Mount Street, Dublin 2, D02 FT59, Ireland. Tel: +35316706750; E-mail: tfortune@isqua.org

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Abstract

Providing high quality and safe patient care is a challenge in the current rapidly changing and complex health care environment. A variety of independent tools and methodologies contribute to this effort, e.g. regulatory requirements, quality improvement tools and accreditation methodologies. A concern is that each alone will not achieve the tipping point in health care quality that is required. This paper suggests that the methodology and application of accreditation have the potential to be the force to bring these approaches into alignment and ultimately measurably improve the quality of care.

Key words: accreditation, external evaluation, quality improvement, patient safety, person-centered care, continuous improvement, health care

Introduction

Health care services accreditation is a quality improvement and external evaluation methodology that has been widely implemented in over 70 countries [1, 2]. Over the years, the accreditation methodology has been widely studied in efforts to understand and document its value and impact on the quality and safety of health care organizations and person-centered care. Studies have shown accreditation to be positively associated with the establishment of organizational structures and processes [3], the promotion of quality and safety cultures [4], improvements in patient care [5] and professional development [1] amongst other key benefits [6]. It is, however, also widely recognized that, due to the complexity and multi-factorial nature of health care quality, further evaluation is required to fully measure how the impact of accreditation can be optimized [7].

The thesis of this paper is to present the case that the optimal impact and value of the accreditation methodology will be achieved when it is fully recognized as an ongoing capacity building tool; as a knowledge mobilization tool; as an investment rather than an expense; and as a quality improvement and patient safety evaluation tool. This assumes that the methodology is applied at the organizational level and includes all systems of clinical services and management. With this recognition, accreditation becomes complementary to an organization’s quality management and improvement program and complementary to co-existing regulatory processes. The potential of the impact of accreditation is clearly diminished if it is viewed as an academic, stand-alone project or exercise that only appears in the budget and comes into relevance every few years. Thus, the value and impact of accreditation are optimized when the tools of accreditation, most notably the standards and their application to assess quality of care and service, are utilized on an ongoing basis and integral to the organization’s overall quality improvement program.

The questions and responses that follow expand on the need for rethinking how the full value and impact of accreditation can be leveraged to optimize the quality of patient care in a health care provider organization.

Why is this an important issue now when accreditation has been in existence for decades?

Firstly, while hospital accreditation has been a reality for over a century [8], in recent years there has been a rapidly escalating emphasis and attention to patient safety and the quality of health care services. This has resulted in an increase in the number of quality improvement programs in health care organizations, and increasing
regulatory requirements intended to improve patient safety and the quality of clinical services [9]. Regulation is mandatory and tends to focus on basic safety elements to protect the public. Health care leaders and clinicians are challenged to identify and apply initiatives that will improve quality, decrease the risks associated with clinical variation and improve process efficiency. The number of initiatives, from Lean management to Six Sigma, is increasing and the burden of implementation, staff training and data collection is too great for many organizations. Efforts need to be taken to minimize the audit burden and the overlap of quality programs while optimizing the benefits which accreditation offers. One of those benefits is that the accreditation methodology is an inclusive framework that can absorb and bring synergy to many disparate and seemingly distinctly separate methodologies.

Secondly, WHO’s Sustainable Development Goal 3 has mandated that we achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all by 2030 [10]. Achieving universal health coverage will require effective alignment between governments, payers, providers and service users. Accreditation has the potential to help to guide the way and provides a framework that facilitates the provision of high quality patient care.

Accreditation in health care commenced in the acute care sector, particularly in organizations that were linked to academia. Some countries have developed governmental programs of accreditation alongside of their licensure and other regulatory programs; in others, accreditation has remained close to the private sector and academia; and in others, independent health service accreditation organizations have been established [9]. Globally, the growth of accreditation programs has been slow and uneven with some of the principal challenges including lack of professional/stakeholder support, unrealistic expectations and limited finances and/or incentives [9, 11]. To ensure that health services are delivered in a sustainable and consistent manner, it is important that action is taken to ensure that the full value of accreditation is realized.

The days of approaching accreditation as a separate project, a separate process or a separate program must disappear. The tools of accreditation, in particular the standards that are core, are available to the accredited organization on an ongoing basis. These standards have the flexibility to integrate different quality methodologies such as the collection of clinical outcome measures, Lean, Six Sigma, and client and employee experience surveys. Thus, with an organization’s ongoing quality improvement program, accreditation standards facilitate ongoing identification of areas of strength or needed improvement. This is in sharp contrast to the use of the standards every 3–4 years to prepare for an accreditation ‘event’. Simultaneously, areas for improvement and strengths are identified through other complementary quality improvement strategies such as the monitoring of outcomes and experience tool results. Organizations must ‘own’ the standards as well as the improvement process and not wait for an external body to come and evaluate them every few years. This is not about doing something ‘for accreditation’, it is about doing something to improve quality of care and patient safety. The imperative is to move away from the traditional view—one of viewing accreditation as an ‘event’ or ‘project’.

Many countries use quality indicators to measure the performance of their health services. However, governments or organizations that focus solely on indicators as measures of quality of care face a major risk. By the time an indicator highlights a negative trend; the damage is already occurring or has occurred. It may be too late to salvage the organization or program and likely realizing the positive results of the turnaround strategy will be prolonged and slow. By using accreditation standards, and other quality improvement and patient safety tools, on an ongoing basis, real time assessment against normative standards can result in effective and timely improvement strategies. Quality measurement via indicators is not a substitute for external evaluation methodologies such as accreditation. Both standards and measurement play important and complementary roles with the standards describing what should be in place and the measures validating the actual situation [12].

What needs to change? Both the perspectives held regarding accreditation and how the organization applies the accreditation methodology

It has been difficult to study and understand the relationship between accreditation, quality improvement programs/methodologies/patient safety strategies and health care regulations. It is the sum total of these separate yet intertwined approaches that provides the full value and impact on the quality of care and services, as each influences aspects of the other. Thus, the imperative described in this perspective is related to the necessity for effective alignment of accreditation, quality improvement and regulation in health services to achieve the continuous, incremental and sustainable impact on health care quality and safety and on the effective performance of the organization as a whole. It is essential that overlap is minimized. This requires a planned integrated quality strategy for the organization and strong quality leadership. The accreditation process is important in helping organizations choose the correct method, collect valid data, use the data for improvement and sustain the improvement. The focus of accreditation is thus on the system and how it effectively operates, from clinical care delivery through to effective governance.

What unique elements does the accreditation methodology bring to improvement that other methodologies do not?

One important and unique contribution of accreditation is the onsite visit by external peer reviewers (surveyors). While an organization may report its indicators internally and/or externally and may submit reports to authorities as to their compliance with particular standards and regulatory requirements, this does not confirm that a particular process, or the degree to which it is met, is indeed in place. The tremendous value of this onsite visit approach is a hallmark of accreditation. Historically the leaders and clinical staff of health care organizations have responded positively to evidence-based guidance, self-assessment and peer opinions. The evaluation by the third party accreditation surveyors feeds into this desire to learn and do better.

In addition, at the time of the onsite visit, these external surveyors/evaluators share their knowledge as to what they have witnessed elsewhere and thereby engage in valuable conversation with the organization, with staff at all levels, from governance to care delivery.

Another critical unique aspect of health care services accreditation is the inclusion of standards and assessment methodologies in the area
of governance and leadership. The accreditation methodology evaluates the primary ‘systems’ in an organization and how they work together to provide safe, quality services. Leadership is one of the most important elements in health care organizations. It is recognized that strong governance and leadership are essential for a high performing sustainable organization and that the absence of such can lead to serious breaches in patient safety [13]. Other external evaluation methodologies ignore this critical element, and ignore it at their peril.

What role does data play in the different evaluation and improvement methodologies?

What cannot be measured, cannot be improved. All improvement methodologies have their foundation in good data. The one source of data that has not been fully utilized is that coming from the process of accreditation. The data that is obtained from the accreditation process is both qualitative and quantitative, and made available to each organization. This is valuable feedback to the organization with which to make improvements. Data about compliance with accreditation standards, data showing strengths and areas for improvement, data that can be rolled-up and enables comparison across sector or regions have great potential. For example, accreditation data on infection control systems for all hospitals in a country may point to national and regional vulnerabilities for infectious disease outbreaks. This data when coupled with results from certification, indicators and regulation paints a very powerful quality picture. National, government-sponsored, mandatory programs are in the best position to collect and use this type of data.

The measurement demands by the World Health Organization and other national and international agencies have thus far frustrated health care organizations with overlapping reporting demands, non-standardized measures and the proliferation of the sense that measurement is a burden to most organizations. Simplifying, aligning and strengthening national and international measurement methodologies have thus far proven challenging and further efforts are required to fully leverage the value of this data.

Conclusion

The time has come to recognize and apply health care services accreditation as an integral ongoing component of an organization’s quality improvement and patient safety program. Within this new context, and along with regulations that focus on mandatory basic requirements that protect the public, the full framework of quality improvement, from governance through to front-line care, comes into focus and can produce sustainable change. Health care leadership, at all levels, has the responsibility to lead this shift, from viewing accreditation and its requirements as a cyclic program, to one of critical ongoing value.

This document has outlined the imperative that necessitates the appropriate alignment of accreditation, quality improvement and regulation in health care services to achieve the continuous, incremental and sustainable impact on patient quality and safety and on the effective performance of the organization as a whole.

References

ACHS was saddened to hear of the passing away of Surveyor Karen Parish on 19 March, 2017.

Karen was the Operational Services Executive at Eldercare SA, a role she commenced in July 2015. She was the inaugural Co-Chair of the Older Person’s Clinical Network in South Australia which provided leadership for the development of a range of strategic initiatives to enhance aged care services in SA.

Holding a keen interest in research, her publications were in relation to the quality of end-of-life care in the acute hospital setting and the care trajectory of elderly patients in the acute hospital setting.

Karen held senior positions across the Adelaide metropolitan area including Executive Director of Nursing at the Repatriation General Hospital, Executive Director of Nursing and Midwifery at Adelaide Health Service and Director of Nursing at Calvary Public Hospital in the ACT. Karen was appointed as the Chief Nursing and Midwifery Officer of the Northern Territory from 2012-2014. ACHS extends its condolences to Karen’s son Tim, her family and friends.

Farewell to Karen Parish

Vale Ross Holland

One of ACHS’s earliest Chairmen, Professor Ross Holland has passed away at age 89.

Professor Holland served as ACHS Chairman from 1981-1983 during a period of serious economic challenges when the Council’s goals were only just becoming clearer to the Australian Health community.

In his own words from the “ACHS 30 Years” publication Professor Holland recalled that era as “We moved from being a bit of a fringe player to an accepted part of the health scene. It had now become a situation where instead of saying who cares about accreditation, the hospital community was saying yes, well, it does matter and we had better get our act together.” In his time on Council he represented the RACS and the Faculty of Anaesthetists i.e. both surgeons and anaesthetists, as the Faculty was not established as a separate College until 1992.

Professor Holland credited his contemporaries of the time Dr Lionel Wilson (the previous Chairman) and the first executive director, Errol Pickering for the success of the organisation. A key achievement during his terms was ACHS hosting Australia’s first Voluntary Hospital Accreditation Invitational Seminar, a one-day event held in collaboration with co-sponsors the US Joint Commission on Accreditation of Hospitals, the Canadian Council on Hospital Accreditation and the WK Kellogg Foundation. Delegates attended from the US, Canada, the UK, New Zealand, the Netherlands, Spain, Mexico as well as Australia.

Professor Ross Holland retired in 2013 from the Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) having been a member since its inception in 1950, and was largely responsible for its establishment. This committee is acknowledged internationally as the most experienced body in the field. In 1992, he was awarded the Robert Orton Medal for his contribution to anaesthesia. He was awarded the ACHS Medal in 2006.

A full obituary has been published in ANZCA and can be found here.
Registrations Close soon for Root Cause Analysis – 14 June 2017 Perth CBD

Don’t miss this opportunity to take part in one of ACHS’s best-known Improvement Academy courses - Root Cause Analysis. You need to register by 1 June 2017.

Course Objectives include:
- Understand legislative requirements for root cause analysis (RCA)
- Understand the purpose of RCA
- Understand when to undertake an RCA based on understanding of special and common cause variation
- Have a practical understanding of the steps of the RCA process
- Develop skills in conducting staff interviews to identify the sources of process failure
- Be able to develop recommendations which can be implemented to improve care processes
- Have developed sufficient knowledge in order to actively participate and contribute to an RCA team, if lead by an experienced practitioner.

Patient Safety Lead – Brisbane – Starts 29 June 2017

Our 12 month program with face-to-face workshops commences on 29 June, with registration close off on 14th June 2017.

Be a part of one of ACHS’s ‘LEAD’ courses aimed at senior clinicians and managers. As part of the course participants undertake a significant patient safety project in their own organisation, aimed at building safety into the design of clinical processes.

The program offers new paradigms for patient safety and their successful applications in healthcare settings. Ideal for clinical managers and medical heads of departments, surgical and procedural team leaders, directors of patient safety, patient safety officers and staff who lead open disclosure processes.

Course Objectives include:
- New paradigms for patient safety and their successful applications in healthcare settings;
- Clinical risk from the patient’s perspective, and clinical governance responsibilities for quality and safety
- Legislative responsibilities in relation to patient harm and reportable incidents – to name just 3 of the 10 key objectives
- Project based

All registrants will be required to undertake a work-based project, using their learnings from the course, as well as a 15-minute verbal presentation.

Quality Improvement Lead – Brisbane – Starts 20 July 2017

Quality Improvement Lead training program Brisbane 2017 - 12 Month Program (with face-to-face workshops and webinars). Closing Date for registrations is 5th July 2017.

Quality improvement is becoming the foundation stone of contemporary healthcare across the world. The Quality Improvement Lead program is an emersion in improvement science and service redesign with a strong focus on patient centred care.

Course Objectives include:
- Understand how to organise a whole-of-system approach to quality and safety at the different organisational levels.
- Understand the theory of improvement science
- Develop skills in diagnostic tools – to name just 3 of the 10 key objectives

All registrants will be required to undertake a work-based project, using their learnings from the course, as well as a 15-minute verbal presentation.