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Further thanks and appreciation are extended to the representatives of those healthcare authorities that agreed to provide external commentaries upon this report.

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On behalf of the ACHS Board, it gives me great pleasure to present the fifth *ACHS National Report on Health Services Accreditation Performance 2011 – 2012*.

The purpose of this biennial Report is to provide consumers, the community and the healthcare industry with an overview of national accreditation performance, and to assist organisations to assess their own performance.

The Report contains aggregated information on the accreditation performance of ACHS member organisations, and assesses and reviews the impact of accreditation in hospitals and health services Australia-wide.

The focus of this Report is the performance of member organisations under the EQuIP5 accreditation program, which was introduced on 1 July 2011. However, performance under EQuIP 4 for the period 1 January – 30 June 2011 is also analysed.

A major aim of the *ACHS National Report on Health Services Accreditation Performance* is to identify both areas of high and improving organisational performance, and those where further improvement is required. This Report also includes membership statistics and the outcomes of ACHS member satisfaction surveys, in addition to its comprehensive analysis of overall accreditation outcomes.

A highlight of this Report is its examination of member performance against the new nutrition criterion, which was introduced in EQuIP5 as part of the Standard addressing consumer / patient safety. The essay Spotlight on Nutrition outlines the development of this criterion and describes the performance of member organisations in the vital area of nutritional care.

Accreditation is an important aspect of risk management and the improvement of systems and services in healthcare organisations. The outcomes described in this Report emphasise the need for a comprehensive, organisation-wide approach to the management of service delivery and safety systems. By publishing this in-depth analysis of the accreditation performance of its member organisations, ACHS hopes to provide relevant information and direction for future quality and safety initiatives.

I commend this report to you as a valuable contribution to the safety and quality debate.

Adjunct Associate Professor Karen J Linegar FACN JP
ACHS President
November 2013
KEY FINDINGS

The ACHS National Report on Health Services Accreditation Performance 2011 – 2012 (National Accreditation Report) describes the performance of healthcare organisations participating in the Australian Council on Healthcare Standards’ accreditation programs. This report focuses upon performance of member organisations during surveys conducted between 1 January 2011 – 31 December 2012, with an emphasis upon performance against EQuIP5 following its implementation on 1 July 2011. An analysis of performance during the final six months of EQuIP 4 is provided in Appendix A.

These Key Findings provide an overview of survey trends observed across 2011 – 2012, in addition to highlighting areas of high performance and areas of operation that continue to present a challenge to organisations.

Survey Trends

The positive trends reported in the previous edition of the National Accreditation Report (http://www.achs.org.au/media/4071/nar_report_2009_10.pdf) were continued and increased following the introduction of EQuIP5. While areas of challenge remain (see ‘Areas requiring Further improvement’, below), overall performance improved, with many organisations graduating from MA ratings to EA and OA, and others maintaining their high level of achievement. At the same time the incidence of AC60 surveys and HPrs was notably decreased.

Contributing factors to these positive outcomes may include improved organisational performance, implementation of surveyor suggestions for improvement, and increased familiarity with the standards. The revised EQuIP5 program was not significantly different from its predecessor, but after consultation with stakeholders was supported by more detailed and comprehensive guidelines. Through ACHS, organisations also had access to consultancy services, focused education and other resources.

Advanced Completion in 60 Days Surveys

7% (24/341) of organisations were required to undertake an Advanced Completion in 60 days survey (AC60) for at least one criterion, compared to 13% (67/509) of organisations in 2009 – 2010.

The rate of AC60 reviews decreased by 46%, indicating a positive trend.

High Priority Recommendations

7% (23/341) of organisations were issued a High Priority recommendation (HPr) for at least one criterion compared to 10% (52/509) of organisations in 2009 – 2010.

The rate of HPrs decreased by 30%, indicating a positive trend.

Extensive Achievement Ratings

Extensive Achievement (EA) ratings represented 19% (1882/9851) of total ratings awarded, compared to 14% (2425/17,046) awarded in 2009 – 2010.

The awarding of EA ratings increased by 36%, indicating a positive trend.

Outstanding Achievement Ratings

Outstanding Achievement (OA) ratings represented 0.8% (79/9851) of total ratings awarded, compared to 0.5% (90/17,046) awarded in 2009 – 2010.

The awarding of OA ratings increased by 60%, indicating a positive trend.

(Note: This improvement is based upon a small proportion of overall ratings)
Survey Outcomes

The great majority of organisations achieved accreditation at initial survey. The 16 organisations that received conditional accreditation were supported by ACHS customer service in their efforts to improve, and were reassessed after 12 months.

Accreditation Awards

- 89% (302/341) of organisations achieved full or continuing accreditation at initial survey. A further 6% (22/341) of organisations achieved full or continuing accreditation following an AC60 review.
- 4% (14/341) of organisations achieved one-year conditional accreditation at initial survey. A further 0.6% (2/341) of organisations achieved one-year conditional accreditation following an AC60 review.
- One organisation was not accredited.

Areas of High Performance

High performance was demonstrated in both clinical and non-clinical areas. Under EQuIP5, there was an increase in the number of individual criteria associated with OA ratings (35/47 criteria).

79 Outstanding Achievement (OA) ratings were awarded from 341 surveys under EQuIP5. Areas most awarded:

1. Continuous quality improvement* (n=9) Category: non-clinical
2. Governance of research (n=8) Category: non-clinical
3. Care evaluation* (n=4) Category: clinical
4. Waste and environmental management (n=4) Category: non-clinical

Three OA ratings were awarded in each of the following areas: clinical – care planning*, end-of-life care, skin integrity and pressure ulcer management, nutritional care; non-clinical – workplace health and safety*, learning and development.

*Denotes mandatory criterion

Areas Requiring Further Improvement

All four areas requiring improvement were mandatory criteria. For these criteria, it is considered that without Marked Achievement (evaluation), the quality of care and/or the safety of people within the organisation could be at risk.

AC60 surveys, with or without HPRs, were associated with 12 of the 47 EQuIP5 criteria. The four criteria most frequently associated with AC60 / HPR outcomes are classified as non-clinical. These findings demonstrate the importance of monitoring performance of non-clinical systems as part of a comprehensive, organisation-wide assessment.

33 Advanced Completion in 60 days surveys (AC60s) and 30 High Priority Recommendations (HPRs) were received from 341 surveys under EQuIP5. Areas most received:

1. Emergency and disaster management* (n=10 AC60s) (n=10 HPRs) Category: non-clinical
2. Workplace health and safety* (n=6 AC60s) (n=6 HPRs) Category: non-clinical
3. Risk management* (n=3 AC60s) (n=2 HPRs) Category: non-clinical
4. Credentialling and scope of practice* (n=3 AC60s) (n=2 HPRs) Category: non-clinical

*Denotes mandatory criterion
Introduction

Healthcare accreditation involves performance assessment against an industry agreed set of standards. It is “an internationally recognised evaluation process used to assess and improve the quality, efficiency, and effectiveness of healthcare organisations; it is also a way to publicly recognise that a healthcare organisation has met national quality standards.”

The Australian Council on Healthcare Standards (ACHS) is an independent, not-for-profit organisation that has been at the forefront of healthcare accreditation in Australia since 1974. Its member organisations reflect the changing structure and diversity of the Australian healthcare system, and include acute services in both the public and private sectors, day procedure services, community health organisations, non-government drug and alcohol services and peak bodies.

One of the major and continuing aims of ACHS is to adapt to a changing healthcare environment, in order to continue to offer the most relevant accreditation products and services to its member organisations. To 31 December 2012, ACHS’ accreditation services were centred predominantly upon the company’s Evaluation and Quality Improvement Program (EQuIP). On 1 January 2013, ACHS implemented EQuIP National, an accreditation program that encompasses the Australian Commission on Safety and Quality in Health Care’s (AQSQC’s) mandatory National Safety and Quality Health Service (NSQHS) Standards, while maintaining the organisation-wide accreditation perspective that was the basis of EQuIP.

Every two years, ACHS publishes the National Report on Health Services Accreditation Performance (National Accreditation Report). This 5th edition describes the combined accreditation performance of ACHS member organisations under EQuIP 4, and following the implementation of the revised EQuIP5 program on 1 July 2011. Viewing the ACHS data in this way provides an overview of Australian healthcare organisations, together with their collective strengths and opportunities for improvement.

The accreditation assessment data analysed here include surveys under EQuIP 4, for which reporting was finalised after the 31 March 2010 data cut-off point of the previous edition of the National Accreditation Report, and surveys conducted under EQuIP5 between 1 July 2011 and 31 December 2012, with a data cut-off point of 17 May 2013.

The 4th edition of the National Accreditation Report, which provides a wide-ranging and detailed analysis of accreditation performance by Australian healthcare organisations for the period 2007 – 2010, is available on the ACHS website:

Overview of ACHS accreditation programs and activities

The ACHS offers a variety of programs to meet the specific needs of its member organisations.

National Safety and Quality Health Service (NSQHS) Standards
ACHS is an approved accrediting agency for the NSQHS Standards, mandatory for hospitals, day procedure services and public dental services from 1 January 2013, and for the interim accreditation of new organisations which will ultimately require full accreditation against the NSQHS Standards.

EQuIP National
The ACHS EQuIP National accreditation program adds to the ten NSQHS Standards a further five Standards derived from the EQuIP program, which focus on the performance of non-clinical systems as part of a comprehensive, organisation-wide assessment for hospitals and public dental services.

EQuIP National Day Procedure Centres
In addition to the ten NSQHS Standards, this program provides a further five EQuIP-derived Standards which have been tailored to the needs of day procedure centres while offering an organisation-wide perspective.

**EQuIP**
The Evaluation and Quality Improvement Program (EQuIP) provides a framework for ensuring safe, quality care and services and achieving quality improvement for healthcare organisations not required to be accredited against the NSQHS Standards. The 5th edition of the program, EQuIP5, was implemented 1 July 2011.

**EQuIP Corporate Health Services**
For corporate offices of healthcare organisations, which support the provision of health care and services through centralised governance and leadership. EQuIP5 Corporate Health Services was implemented 1 July 2011.

**EQuIP Corporate Member Services**
An accreditation program intended for organisations that provide services for members or customers, including colleges, associations, peak bodies and health insurance agencies. A revised edition of the program, EQuIP5 Corporate Member Services, was implemented 1 January 2013.

**EQuIP Certification**
ACHS offers a one-year certification program for new healthcare organisations and for organisations not previously accredited, which are not required to be accredited under the NSQHS Standards. The certification program is a transitional step to full accreditation under EQuIP5.

**Medicare Locals Accreditation**
ACHS is an approved accrediting agency for the Medicare Locals Accreditation Standards, implemented from 1 June 2013 for all Medicare Locals.

**ACHS Quality for Divisions Network**
For the National Divisions of General Practice.

**Assessment against external standards**
Evaluation of clinical services against external (non-ACHS) standards, including the National Standards for Mental Health Services, the Department of Human Services Standards (Victoria) and the Common Community Care Standards (Victoria).

**In development**

**EQuIPNational Corporate Health Services**
An accreditation program intended to align corporate offices with health services accredited under EQuIPNational. The program retains the relevant actions from the ten NSQHS Standards and the five EQuIP-derived Standards of EQuIPNational, and provides guidelines to assist with the interpretation of those actions by the corporate office.

**ACHS International**
During the past year, the demand for ACHS services internationally has led to expansion into Ireland, Qatar, Malaysia and China. ACHS continues to provide accreditation services, consultation, speciality education and clinical indicator programs in Hong Kong, Macau, Sri Lanka, India, Saudi Arabia, Bahrain and the United Arab Emirates.

As a consequence of the demand for services and the recognition of the value of local knowledge, healthcare professionals from these countries were trained as ACHS surveyors to support the provision of services, with valuable outcomes.

ACHS also provided specialty workshops to visiting delegations from Romania, South Korea and Indonesia.
EXECUTIVE SUMMARY

This National Accreditation Report on the performance of healthcare organisations participating in the Australian Council on Healthcare Standards’ (ACHS’) Evaluation and Quality Improvement Program (EQuIP) reports on 457 organisations that underwent survey during 2011 – 2012 (341 under EQuIP5 and 116 under EQuIP 4), with accreditation outcomes finalised by 24 May 2013.


EQuIP 4 remained the main ACHS accreditation program until 30 June 2011, after which it was superseded with the implementation of the revised EQuIP5 program. The accreditation outcomes for EQuIP 4 from 1 January 2011 – 30 June 2011 are provided in Appendix A, however the emphasis of this report is upon the accreditation performance of healthcare organisations against the EQuIP5 standards between 1 July 2011 – 31 December 2012.

The findings in this report will assist organisations to consider their performance within a national context and provide information to support learning around improvement in health facilities. This information also provides an opportunity for health policy makers and other stakeholders to identify key issues, which may assist them to support healthcare providers in the delivery of safe, high quality health care.

ACHS accredited organisations

- Between 1 July 2011 – 31 December 2012, 341 organisations participated in an EQuIP5 Organisation-Wide Survey (OWS) or Periodic Review (PR), with an accreditation outcome finalised by 24 May 2013
- Of these, 89% gained full accreditation or had ongoing full accreditation confirmed at survey
- A further 6% of organisations gained or maintained full accreditation after addressing issues of concern within 60 days of the OWS or PR at an Advanced Completion in 60 days (AC60) survey
- Conditional (one-year) accreditation, with or without an AC60 survey outcome, was granted to 4.6% of organisations because of inadequate systems to manage a variety of risks
- One organisation was non-accredited
- Outstanding Achievement (OA) ratings were awarded on 79 occasions to 39 different organisations
- Extensive Achievement (EA) ratings were awarded at a rate of 23% for mandatory criteria and 15% for non-mandatory criteria
- For the non-mandatory criteria, Little Achievement (LA) ratings were awarded at a rate of 0.4%, and Some Achievement (SA) ratings at a rate of 2%

Areas of high performance

- Areas in which ACHS members performed well, based upon OA ratings awarded, included:
  - continuous quality improvement
  - governance of research
  - care evaluation
  - waste and environmental management
- Outstanding Achievement (OA) ratings represented 0.8% of all ratings
- Under EQuIP5, there was a shift towards the awarding of OA ratings for mandatory rather than non-mandatory criteria
- Outstanding Achievement practices included:
  - care evaluation that was accurate, consistent and collaborative, supported by a strong and systematic approach to outcomes measurement, engaged consumers / patients and families / carers, and was driven by internal evaluation and external benchmarking
  - continuous quality improvement as an aspect of organisational culture and driven by strong and enthusiastic governance, with clinician leadership, staff encouraged and resourced to participate, the full integration of quality improvement and risk management, and a focus on consumer / patient needs
  - research programs supported by strong governance, involving partnerships with external organisations, a focus on risk minimisation, resourcing of staff as well as dedicated researchers, and the translation of research outcomes into innovative care and services
  - waste and environmental management systems with a dual focus on safety and sustainability, waste minimisation strategies, participation in emissions monitoring, and energy saving choices and innovations including installation of solar energy units and waste-water flushing systems
Extensive Achievement (EA) ratings represented 19% of all ratings. Organisations were more likely to receive an EA rating in a mandatory criterion than a non-mandatory criterion. Extensive Achievement practices included:

- Assessment that is comprehensive, best-evidence based and tailored to the consumer/patient cohort, in which assessment and care planning are fully integrated, regular reassessment occurs along with adjustment of the care plan, referral systems are regularly evaluated, staff are encouraged to identify possible gaps in existing processes and to suggest innovations, and new practices are embedded via the development of guidelines.
- Infection control systems supported by robust Infection Control Plans, with multidisciplinary management, comprehensive staff education, testing of outbreak action plans, vigilance around food safety and kitchen operation, high levels of compliance with respect to hand hygiene and staff immunisation, regular auditing and participation in benchmarking.
- Risk management in which clear governance directives encompassed all identified clinical and non-clinical risk and risk management processes were embedded in all aspects of operation, with integration of risk management and quality improvement, proactive management of risk that encouraged staff participation, clinician leadership, and the refinement of systems and processes through regular auditing, benchmarking and research.
- Incident management that is systematic and timely in its review of and response to incidents, comprehensive in its communication to stakeholders and support for consumers and staff involved, and where a culture of openness and learning is embraced including around the principles and practice of open disclosure.

Areas requiring further improvement

Areas most commonly identified as requiring improvement, based upon Advanced Completion in 60 days surveys (AC60s) and High Priority Recommendations (HPRS), were related to:

- Emergency and disaster management
- Workplace health and safety
- Risk management
- Credentialling and scope of practice.

Under EQuIP5, required improvements were most often identified in connection with key safety and quality areas (mandatory criteria):

- Emergency and disaster management systems governed by a current, tested and regularly evaluated plan, under which all fire safety requirements, including responses to recommendations, are met, and all staff undergo education and practical training to ensure necessary competence on all shifts and across all areas.
- Workplace health and safety systems supported by proactive governance and comprehensive planning and a risk register, in which policies and procedures addressing hazardous activities are implemented and regularly evaluated, there is staff participation and consultation, staff complete all relevant training, and action is taken to reduce identified risks including those associated with electrical and biomedical equipment via a testing and tagging program.
- Risk management systems that are integrated with the quality improvement program, in which identified risks are eliminated or mitigated, risk registers are correctly maintained, frequently updated and inform improved safety practices, and there is regular evaluation of systems and processes.
- Credentialling and scope-of-practice policy and procedures that cover all aspects of credentialling, the determination of scope of practice and the introduction of new equipment, interventions and treatments, which encompass all clinicians including allied health professionals and in which recredentialling is linked to performance appraisal, and is comprehensively documented.
- Infection control programs that include comprehensive systems for outbreak management, hand hygiene, food safety, sterilisation practices and surveillance, and in which infection management is incorporated into building works and redesign.
- Medication management systems that are regularly evaluated and improved with an emphasis upon error reduction, reconciliation, pharmacy involvement, and storage and dispensing practices.
Advanced Completion in 60 days (AC60) surveys
The Advanced Completion in 60 days (AC60) survey is an option which helps to ensure that risks identified during survey are eliminated or mitigated in the shortest possible time. Under eQuiP5:
abus 7% of organisations surveyed (n=24) received an AC60 outcome due to identified risks; 92% (n=22) of these achieved full or continuing accreditation after identified issues were addressed, and 8% (n=2) received conditional (one-year) accreditation
abus 4% (n=14) of organisations achieved conditional (one-year) accreditation at initial survey
abus one organisation was non-accredited
abus more AC60 outcomes were issued during Periodic Review (75%) than during Organisation-Wide Survey (25%)
abus a large organisation (≥200 beds) was more likely to receive an AC60 outcome than a smaller organisation
abus issues most frequently resulting in an AC60 outcome related to:
• emergency and disaster management (staff training, fire safety, response to recommendations)
• workplace health and safety (evaluation of policy and procedures, completion of training, electrical safety)
• risk management (evaluation of systems, current risk register, mitigation of identified risks)
• credentialling and scope of practice (correct and comprehensive documentation, linking of credentialling to safe practice, correct composition and conduct of committees)

Spotlight on Nutrition
abus A new non-mandatory criterion was introduced in EQuiP5: 1.5.7 - The organisation ensures that the nutritional needs of consumers / patients are met.
abus 1.5% of organisations received an LA rating against this criterion, indicating a failure to translate policy around nutritional care into practice or the absence of such policy
abus 15% of organisations received an SA rating, indicating that implemented policy and processes governing nutritional care were not being regularly evaluated to identify areas for potential improvement
abus Areas of required improvement highlighted by surveyor recommendations included:
• regular evaluation of policy and procedures
• translation of assessment of nutritional status into care planning
• introduction of staff education around good nutritional care and the individual roles and responsibilities of healthcare providers

Member satisfaction with ACHS services
ACHS requests, collates and analyses feedback data from its members, in order to assess its own performance and identify its own areas for improvement. Members are surveyed regarding the EQuiP standards and criteria, the support received from ACHS, their surveys, their survey coordinators and surveyors, the survey report and the self-assessment process (see ‘Member satisfaction’, below).

In most cases, members declared themselves ‘satisfied’ or ‘highly satisfied’ at a level of 95% or greater. The highest levels of satisfaction during 2011 – 2012 were recorded for the conduct of the survey coordinators and issues around the survey report.

The most marked areas of improvement were with regard to the ACHS Electronic Assessment Tool (EAT) and the self-assessment process, both of which had undergone significant revision in response to member feedback.

Conversely, during 2012 there was a marked decrease in member satisfaction with respect to the length of survey. At this time, in anticipation of the implementation of the National Safety and Quality Health Service (NSQHS) Standards, ACHS offered members undergoing EQuiP survey the opportunity to include in the process a gap analysis against the new Standards. To facilitate this, an extra day was added to each survey. However, the gap analyses took longer than anticipated to complete; the resultant time pressure was noted and commented upon by members and surveyors alike.
For this edition of the *National Accreditation Report*, as a means of external validation, ACHS has requested commentaries upon its performance data from representatives of relevant healthcare authorities, in addition to a commissioned response from an academic with experience in the area of healthcare accreditation research. ACHS thanks these contributors for their time and expertise.

The *ACHS National Report on Health Services Accreditation Performance 2011 – 2012* details the performance of healthcare organisations that are participating in the Australian Council of Healthcare Standards’ accreditation program. This document reports on trends evident in the accreditation data. This review was performed by Associate Professor Keith Townsend in June 2013 and commissioned by the Australian Council on Healthcare Standards (ACHS).

**Advanced Completion in 60 Days surveys**

In the 2007 – 2008 surveys, 16.5 per cent (77 of 468) of organisations were required to undertake what ACHS refers to as an ‘Advanced Completion in 60 Days’ outcome (AC60) for at least one criterion. In 2009 – 2010, this was reduced to 13 per cent. In the most recent period (2011 – 2012), this decline has continued. Throughout this period there were 33 AC60 outcomes in 24 different organisations (total number 341 organisations). This represents less than seven per cent of sites.

What is an important consideration in these data is the dramatically higher proportion of public sector organisations (21/24 at 88 per cent) compared with the private sector (3/24 at 12 per cent). Larger organisations are also more likely to receive AC60s and it is likely that there would be some correlation between the public sector and the larger organisations.

Importantly, only two of the 22 organisations that received AC60s were unable to receive full (or continuing) accreditation and were placed on one-year conditional accreditation. These results are substantially improved from previous reporting periods. Importantly, ACHS notes that typically organisations receive a HPR (High Priority Recommendation) as a precursor to the AC60s so there is a clear process in place to allow improvements in a timely fashion.

With less than seven per cent of organisations receiving AC60s, and most of these only receiving one, the evidence indicates that the participating organisations are ensuring effective systems and processes are in place to meet accreditation standards. Where there is more than one AC60 at an organisation, face value suggests there may be systemic problems at the site – for example, at one particular organisation there seems to be a clear failing in the communication and recording of information at various different stages throughout the continuum of patient care.

It is of concern that the majority of criteria associated with AC60s were in the areas of emergency and disaster management (3.2.4), workplace health and safety (3.2.1), and risk management (2.1.2). Emergency and disaster management and risk management were also the main standards that presented AC60 outcomes in previous reporting periods. For ACHS, it is a pleasing result that there is a low number of organisations in these categories, but strong statistical analysis and correlations would consequently be impossible. Hence, face-value comparisons to previous years will need to be completed to note any ongoing criteria of concern.

Figure 11 clearly demonstrates that all States / Territories are reducing the number of AC60s, although the presentation of the data could perhaps be improved to have two bars in each State – one for percentages and one for total number, to demonstrate, for example, that while Tasmania has a dramatically higher percentage, there are really only 2 of 8 organisations there. A graphical representation of both percentages and numbers will provide an easy-to-see perspective.
Extensive and Outstanding Achievement

It can be difficult at times to maintain high levels of achievement in continuous improvement systems like the ACHS accreditation. However, evidence from the 2011-2012 data suggests that certain Australian healthcare organisations are taking the opportunities to improve their systems and processes, with all stakeholders being the ultimate beneficiaries. From 11.4 per cent in 2007 – 2008 (11 per cent EA and 0.4 per cent OA) to 14.8 per cent in the 2009 – 2010 reporting period (14 per cent EA and 0.8 per cent OA), the 2011 – 2012 period has also demonstrated improvements. While OA ratings have improved marginally to 0.8 per cent, there has been a strong improvement in EA ratings to 19 per cent.

Importantly though, these data do suggest that with almost 80 per cent of criteria sitting in the MA range, there is a great deal of compliance-driven activity in healthcare organisations. With the incoming National Safety and Quality Health Service Standards changing the requirements for healthcare organisations to achieve accreditation, this compliance culture must be monitored to identify any long-term implications for the sector that may arise. It would be worth ACHS considering if there was a practical and functional way to have greater differentiation in the “compliant 80 per cent” to encourage organisational decision-makers to maintain a culture of improvement.

Other considerations

It would be interesting and important to compare the areas that received SA ratings in the 2011 – 2012 reporting period. There may be identifiable patterns emerging that may assist organisations in to the future. For example, 14 per cent of organisations received SA ratings in criterion 1.5.7 (nutritional needs). Are there patterns here? Are they in similar-sized organisations, concentrated in one sector, concentrated in one State / Territory? Again, most of the numbers in this category are quite small and strong statistical patterns might be difficult to identify, but where there are numbers of five or more healthcare organisations receiving SA ratings it would be worth investigating patterns to see if early intervention programs are appropriate.

Additionally, face value analysis of Figures 15 and 16 (EA and OA ratings) suggests that some organisations might be ‘investing’ in particular areas of excellence as some form of strategic decision-making. ACHS could investigate if there are areas where patterns are forming – for example, healthcare organisations performing extremely well in all areas of staff training and management, leading to high levels of performance in other areas of practice.

Commentary

The Australian Healthcare and Hospitals Association is pleased to note the improvements in overall performance of Australia’s healthcare organisations in the two years to December 2012 against EQuIP5. Particularly gratifying is the number of organisations that graduated to Extensive Achievement and Outstanding Achievement ratings during this period. The fall in the number of organisations required to undertake remediation in order to achieve accreditation is also to be commended.

Continuous quality improvement, excellence in research governance and care evaluation, and a commitment to best practice in waste and environmental management were the hallmarks of the best-performing healthcare organisations in this report, and provide commendable goals for all healthcare organisations. A focus on non-clinical systems and management of risks, including emergencies and disasters, and workplace health and safety will drive improvement for those organisations not yet at the peak of their performance.

This work is important to maintain the excellent quality of Australia’s healthcare organisations into the future. Thank you for providing me with the opportunity to comment on the report.

Alison Verhoeven
Chief Executive, Australian Healthcare & Hospitals Association
Commentary

I am grateful for the opportunity to provide this commentary on the Australian Council on Healthcare Standards’ National Report on Health Services Accreditation Performance 2011 – 2012 (National Accreditation Report). The Australian Institute of Health and Welfare (AIHW) also publishes information on the performance of the national healthcare system, and detailed consideration of the National Accreditation Report will assist the AIHW with considerations about its performance reports. It is hoped that this commentary, informed by the AIHW’s experience, will also be useful to the ACHS.

Reflecting the role of accreditation of healthcare organisations, the AIHW routinely reports on the proportions of public and private hospitals that are accredited, and on the proportions of beds and hospital activity that are in accredited hospitals, as a performance indicator relevant to the effectiveness of hospitals (AIHW 2013). Also reflecting this role, the AIHW recommended to health ministers that the proportion of health and aged care services that are accredited be used as an indicator for healthcare agreements (AIHW 2008), and recommended that it be a national indicator of safety and quality (AIHW 2009).

The National Accreditation Report is presented in a user-friendly manner, with the Key Findings allowing readers easy access to the important messages in the report, and good background information about the ACHS and the accreditation processes that will help readers use the report. The AIHW has found that including formal, structured Data Quality Statements in its reports (for example, AIHW 2013) can assist readers in understanding the limitations of the data. The ACHS could consider including a section focused on data quality in future reports, for example to assist readers in understanding the impact of the changing numbers of participants between survey periods.

The range of criteria used in the accreditation assessments is very wide and usefully structured into a framework with clinical, support and corporate groupings. The AIHW’s performance reporting is often based on frameworks such as the National Health Performance Framework (NHPF) in its Australia’s Health series (for example, AIHW 2012). The NHPF includes six dimensions relating to performance measurement for the health system: Effectiveness, Continuity of care, Accessibility, Responsiveness, Safety, Efficiency and sustainability. National health performance reporting is also based on a balance of process indicators (whether appropriate processes are being followed) and outcome indicators for patients and the community – the type of indicators favoured where possible (COAG 2012).

The ACHS EQuIP criteria seem to cover all six dimensions of the NHPF and also cover both processes and outcomes. It could be an interesting and useful exercise, however, to map the criteria to the NHPF dimensions and to consider which are process and outcome criteria. This would facilitate relating the National Accreditation Report to national health sector performance reports, and may highlight NHPF dimensions that are less well-covered by the criteria.

It is interesting that a nutrition criterion is included in the surveys, and the ‘spotlight on nutrition’ is included in the National Accreditation Report. The AIHW recommended that ‘malnutrition in hospitals and residential aged care facilities’ be included as a national indicator of safety and quality of care in response to stakeholder views about the importance of this aspect of care delivery (AIHW 2009). The ACHS reporting of performance in this area may contribute to further consideration of more routine reporting about nutrition care in the future.

Appendix C seems to have useful information on high performing provider organisations that could be used by other organisations to improve practice. This aspect of the report ensures that the benchmarking learnings are easily accessible to both participating organisations and others, and provides a contrast with most national performance reporting which is not accompanied by that type of information.

Jenny Hargreaves
Senior Executive, Hospitals, Classifications and Performance Group, Australian Institute of Health and Welfare

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ACHS accreditation programs

The ACHS EQuIP accreditation programs are designed to guide healthcare organisations to identify and prioritise their opportunities for improvement. Accreditation is also a form of external recognition for high-performing healthcare organisations and the people who work within them, and provides an opportunity for organisations and their staff to demonstrate what they do well.

The National Accreditation Report 2011 – 2012 describes survey data collected both under EQuIP 4, for surveys conducted up to 30 June 2011 not reported on in the previous edition of this report, and under EQuIP5, for the period 1 July 2011 – 31 December 2012.

The development of the EQuIP 4 program, its final content, and the surveys conducted under this program between 2007 – 2010 are described in detail in the previous edition of this report, the National Accreditation Report 2009 – 2010, which is available on the ACHS website:

Furthermore, analysis of EQuIP 4 data for surveys collected and/or finalised after 31 March 2011 are included in this report in Appendix A.

The ACHS accreditation programs are reviewed at least every four years in order to incorporate the most recent evidence on providing and improving health services, and to ensure their relevance to the Australian healthcare system. The review of EQuIP 4 was conducted in 2009, resulting in a revised EQuIP5 program of 3 functions, 13 standards and 47 criteria; the review process is described in more detail in Appendix B.

EQuIP5 accreditation outcomes

In the five-tier EQuIP accreditation system, a Little Achievement (LA) rating indicates that organisations are aware of the requirements (jurisdictional, legislative and otherwise) for a particular area of operations, while a Some Achievement (SA) rating indicates that appropriate systems and processes have been implemented. To achieve a Marked Achievement (MA) rating, organisations must be able to demonstrate that they evaluate the effectiveness of their systems and processes and that, based upon this evaluation, they make improvements as required. Organisations demonstrating that they have progressed beyond the internal evaluation of their systems into research, external benchmarking, advanced management strategies or leadership may be awarded an Extensive (EA) or Outstanding (OA) Achievement rating.

On survey under EQuIP5, organisations are assessed against 47 different criteria that consider aspects of both their clinical and non-clinical operation (see Figure 1). There are 15 mandatory criteria under EQuIP5. To be accredited, organisations are required to receive an MA rating at survey in all mandatory criteria. Performance against the mandatory criteria is assessed at both Organisation-Wide Survey (OWS) and Periodic Review (PR), while non-mandatory criteria are assessed at OWS only.

The survey data analysed for this report are from 341 surveys conducted between 1 July 2011 – 31 December 2012, with accreditation status finalised by 24 May 2013. Of the organisations surveyed, 178 (52%) were in the public sector, and 163 (48%) were in the private sector. The type of survey conducted was determined by each member organisation’s stage in the four-year EQuIP cycle: 148 surveys (43%) were OWSs and 193 (57%) were PRs.

Following a successful OWS, an organisation is awarded accreditation for four years, with its ongoing performance reviewed after two years during PR, when accreditation can be continued, withdrawn or changed to a one-year conditional accreditation, depending on the survey team’s findings. Of the organisations undergoing OWS or PR during this survey period, 89% (302/341) achieved full or continuing accreditation at survey, while another 6% (22/341) achieved full or continuing accreditation after first addressing issues raised via an Advanced Completion in 60 days (AC60) survey (see Figure 5).
A further 14 organisations (4%) received one-year conditional accreditation at survey, while 2 (0.6%) received conditional accreditation after AC60 outcomes were addressed. One organisation was not accredited.

**Performance against individual criteria**

The data in Figures 6, 7 and 8 represent the overall outcomes against each of the 47 EQuIP5 criteria for surveys conducted between 1 July 2011 – 31 December 2012. Mandatory criteria are surveyed at both OWS and PR, while non-mandatory criteria are surveyed at OWS only. During the review of EQuIP 4, a decision was taken to categorise criterion 1.5.1, dealing with medication safety, as mandatory, resulting in 15 mandatory criteria in the EQuIP5 accreditation program.

In the mandatory criteria, there was a trend towards improved performance compared to that under the EQuIP 4 accreditation period, with an increased percentage of organisations receiving either an EA or an OA rating, and a decrease in organisations failing to reach the required MA rating at initial survey. Of the 15 mandatory criteria, 13 were associated with OA ratings. The criterion for which organisations were most frequently awarded an OA rating was that governing continuous quality improvement (2.1.1). The mandatory criteria for which the highest number of EA ratings were awarded were those governing infection control (1.5.2), continuous quality improvement (2.1.1) and care evaluation (1.1.4).

Improved performance was also evident with respect to the non-mandatory criteria, as indicated by increases in the number of OA and EA ratings awarded, and a decrease in the percentage of LA and SA ratings. The non-mandatory criterion for which the most OA ratings were awarded was that governing research (2.5.1), while at the EA level there were strong performances in the areas of consumer participation (1.6.1), learning and development (2.2.4), end-of-life care (1.1.7), falls prevention (1.5.4) and health promotion (2.4.1).

The LA and SA ratings awarded with respect to the non-mandatory criteria can indicate areas of performance which organisations find challenging. The newly-introduced criterion governing nutrition (1.5.7) attracted the highest number of SA ratings, indicating that 14% (21/148) of organisations were not evaluating their nutritional services. A further two organisations received an LA rating against this criterion. Other areas in which SA ratings were indicative of a failure to evaluate implemented systems include the governance of research (2.5.1), management of external service providers (3.1.4) and information and data management systems (2.3.2).
## EQuIP5 ACCREDITATION PERFORMANCE

### Figure 1: EQuIP5 functions, standards and criteria

<table>
<thead>
<tr>
<th>1. CLINICAL</th>
<th>2. SUPPORT</th>
<th>3. CORPORATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Consumers / patients are provided with high quality care throughout the care delivery process.</td>
<td>2.1 The governing body leads the organisation in its commitment to improving performance and ensures the effective management of corporate and clinical risks.</td>
<td>3.1 The governing body leads the organisation’s strategic direction to ensure the provision of quality, safe services.</td>
</tr>
<tr>
<td>1.1.1 The assessment system ensures current and ongoing needs of the consumer / patient are identified.</td>
<td>2.1.1 The organisation’s continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.</td>
<td>3.1.1 The organisation provides quality, safe care through strategic and operational planning and development.</td>
</tr>
<tr>
<td>1.1.2 Care is planned and delivered in partnership with the consumer / patient and when relevant, the care to achieve the best possible outcomes.</td>
<td>2.1.2 The integrated organisation-wide risk management framework ensures that corporate and clinical risks are identified, minimised and managed.</td>
<td>3.1.2 Governance is assisted by formal structures and delegation practices within the organisation.</td>
</tr>
<tr>
<td>1.1.3 Consumers / patients are informed of the process, understand and provide consent for their health care.</td>
<td>2.1.3 Healthcare incidents are managed to ensure improvements to the systems of care.</td>
<td>3.1.3 Processes for credentialling and defining the scope of clinical practice support safe, quality health care.</td>
</tr>
<tr>
<td>1.1.4 Care is evaluated by health care providers and when appropriate with the consumer / patient and carers.</td>
<td>2.1.4 Healthcare complaints and feedback are managed to ensure improvements to the systems of care.</td>
<td>3.1.4 External service providers are managed to maximise quality care and service delivery.</td>
</tr>
<tr>
<td>1.1.5 Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.</td>
<td>2.1.5 Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff.</td>
<td>3.1.5 Documented corporate and clinical policies assist the organisation to provide quality care.</td>
</tr>
<tr>
<td>1.1.6 Systems for ongoing care of the consumer / patient are coordinated and effective.</td>
<td>2.2.1 Workforce planning supports the organisation’s current and future ability to address needs.</td>
<td>3.2 The organisation maintains a safe environment for employees, consumers / patients and visitors.</td>
</tr>
<tr>
<td>1.1.7 The care of dying and deceased consumers / patients is managed with dignity and comfort and family and carers are supported.</td>
<td>2.2.2 The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meets the needs of the organisation.</td>
<td>3.2.1 Safety management systems ensure safety and wellbeing for consumers / patients, staff, visitors and contractors.</td>
</tr>
<tr>
<td>1.1.8 The health record ensures comprehensive and accurate information is recorded and used in care delivery.</td>
<td>2.2.3 The continuing employment and performance development system ensures the competence of staff and volunteers.</td>
<td>3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.</td>
</tr>
<tr>
<td>1.2 Consumers / patients / communities have access to health services and care appropriate to their needs.</td>
<td>2.2.4 The learning and development system ensures the skill and competence of staff and volunteers.</td>
<td>3.2.3 Waste and environmental management systems support safe practice and a safe environment.</td>
</tr>
<tr>
<td>1.2.1 The community has information on, and access to, health services and care appropriate to its needs.</td>
<td>2.2.5 Employee support systems and workplace relations assist the organisation to achieve its goals.</td>
<td>3.2.4 Emergency and disaster management supports safe practice and a safe environment.</td>
</tr>
<tr>
<td>1.2.2 Access and admission / entry to the system of care is prioritised according to healthcare needs.</td>
<td>2.3.1 Health records management systems support the collection of information and meet the consumer / patient and organisation’s needs.</td>
<td>3.2.5 Security management supports safe practice and a safe environment.</td>
</tr>
<tr>
<td>1.3 Appropriate care and services are provided to consumers / patients.</td>
<td>2.3.2 Corporate records management systems support the collection of information and meet the organisation’s needs.</td>
<td></td>
</tr>
<tr>
<td>1.3.1 Health care and services are appropriate and delivered in the most appropriate setting.</td>
<td>2.3.3 Data and information are collected, stored and used for strategic, operational and service improvement purposes.</td>
<td></td>
</tr>
<tr>
<td>1.4 The organisation provides care and services that achieve expected outcomes.</td>
<td>2.3.4 The organisation has an integrated approach to the planning, use and management of information and communication technology (ICT).</td>
<td></td>
</tr>
<tr>
<td>1.4.1 Care and services are planned, developed and delivered based on the best available evidence in the most effective way.</td>
<td>2.4 The organisation promotes the health of the population.</td>
<td></td>
</tr>
<tr>
<td>1.5 The organisation provides safe care and services.</td>
<td>2.5 The organisation encourages and adequately governs the conduct of health and medical research to improve the safety and quality of health care.</td>
<td></td>
</tr>
<tr>
<td>1.5.1 Medications are managed to ensure safe and effective care / patient outcomes.</td>
<td>2.5.1 The organisation’s research program develops the body of knowledge, protects staff and consumers / patients and has processes to appropriately manage the organisational risk associated with research.</td>
<td></td>
</tr>
<tr>
<td>1.5.2 The infection control system supports safe practice and ensures a safe environment for consumers / patients and health care workers.</td>
<td>2.5.2 The organisation encourages and adequately governs the conduct of health and medical research to improve the safety and quality of health care.</td>
<td></td>
</tr>
<tr>
<td>1.5.3 The incidence and impact of breaks in skin integrity, pressure ulcers and other non-surgical wounds are minimised through wound prevention and management programs.</td>
<td>2.5.3 The organisation’s research program develops the body of knowledge, protects staff and consumers / patients and has processes to appropriately manage the organisational risk associated with research.</td>
<td></td>
</tr>
<tr>
<td>1.5.4 The incidence of falls and fall injuries is minimised through a falls management program.</td>
<td>2.5.4 The organisation encourages and adequately governs the conduct of health and medical research to improve the safety and quality of health care.</td>
<td></td>
</tr>
<tr>
<td>1.5.5 The system to manage sample collection, blood, blood components / blood products and patient blood management ensures safe and appropriate practice.</td>
<td>2.5.5 The organisation’s research program develops the body of knowledge, protects staff and consumers / patients and has processes to appropriately manage the organisational risk associated with research.</td>
<td></td>
</tr>
<tr>
<td>1.5.6 The organisation ensures that the correct consumer / patient receives the correct procedure on the correct site.</td>
<td>2.5.6 The organisation ensures that the nutritional needs of consumers / patients are met.</td>
<td></td>
</tr>
<tr>
<td>1.5.7 The organisation ensures that the nutritional needs of consumers / patients are met.</td>
<td>2.5.7 The organisation ensures that the nutritional needs of consumers / patients are met.</td>
<td></td>
</tr>
<tr>
<td>1.6 The governing body is committed to consumer participation.</td>
<td>2.6.1 Consumers / patients, carers and the community participate in the planning, delivery and evaluation of the health service.</td>
<td></td>
</tr>
<tr>
<td>1.6.1 Consumers / patients, carers and the community participate in the planning, delivery and evaluation of the health service.</td>
<td>2.6.2 Consumers / patients are informed of their rights and responsibilities.</td>
<td></td>
</tr>
<tr>
<td>1.6.2 Consumers / patients are informed of their rights and responsibilities.</td>
<td>2.6.3 The organisation meets the needs of consumers / patients and carers with diverse needs and from diverse backgrounds.</td>
<td></td>
</tr>
</tbody>
</table>

---

**Standards** 13

**Mandatory criteria** 15

**Criteria** 47
**Figure 2: EQuIP5 OWS and PR surveys by State / Territory**
(2011 – 2012, accreditation achieved by 24 May 2013, n=341)

- NSW (33%)
- Vic (30%)
- Qld (19%)
- WA (9%)
- SA (7%)
- Tas (2%)
- NT (1%)
- ACT (1%)

**Figure 3: EQuIP5 OWS and PR surveys by bed number**
(2011 – 2012, accreditation achieved by 24 May 2013, n=341)

- 0 - 49 (35%)
- 50 - 99 (21%)
- 100 - 199 (19%)
- 200 - 499 (16%)
- >500 (8%)

**Figure 4: EQuIP5 OWS and PR surveys by organisation type**
(2011 – 2012, accreditation achieved by 24 May 2013, n=341)

- Hospitals (51%)
- Health Services (26%)
- Multiple Sites (5%)
- Drug and Alcohol (5%)
- Community Health (3%)
- Mental Health (2%)
- Multipurpose Service (2%)
- Day Procedure Centre (2%)
- Palliative Care (1%)
- Oral Health (1%)
- Correctional Health (1%)
- Other Speciality Service (0.6%)

(* "Other speciality service" includes corporate health and population health)

**Figure 5: Accreditation outcomes of EQuIP5 surveys**
(2011 – 2012, accreditation achieved by 24 May 2013, n=341)

- Full / continuing (95%)
- One-year conditional (4.7%)
- Non-accredited (0.3%)
Figure 6: Distribution of ratings across all EQuIP5 criteria (1 July 2011 – 31 December 2012, n=341)

<table>
<thead>
<tr>
<th>Rating</th>
<th>Mandatory criteria (341 surveys)</th>
<th>Non-mandatory criteria (148 surveys)</th>
<th>All criteria (341 surveys)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OA</td>
<td>32</td>
<td>47</td>
<td>79 (0.8%)</td>
</tr>
<tr>
<td>EA</td>
<td>1158</td>
<td>724</td>
<td>1882 (19%)</td>
</tr>
<tr>
<td>MA</td>
<td>3893</td>
<td>3707</td>
<td>7600 (77%)</td>
</tr>
<tr>
<td>SA</td>
<td>28</td>
<td>127</td>
<td>155 (2%)</td>
</tr>
<tr>
<td>LA</td>
<td>0</td>
<td>4</td>
<td>4 (0.04%)</td>
</tr>
<tr>
<td>N/A*</td>
<td>4</td>
<td>127</td>
<td>131 (1%)</td>
</tr>
<tr>
<td>Totals</td>
<td>5115</td>
<td>4736</td>
<td>9851</td>
</tr>
</tbody>
</table>

(* N/A = not applicable)

Figure 7: Ratings for EQuIP5 mandatory criteria surveyed at OWS and PR from 1 July 2011 – 31 December 2012 (n=341, organisations accredited by 24 May 2013; shading indicates a mandatory criterion new to EQuIP5)

<table>
<thead>
<tr>
<th>Criterion No.</th>
<th>Related to</th>
<th>N/A*</th>
<th>LA</th>
<th>SA</th>
<th>MA</th>
<th>EA</th>
<th>OA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.1</td>
<td>Assessment system</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>78%</td>
<td>22%</td>
<td>1%</td>
</tr>
<tr>
<td>1.1.2</td>
<td>Care planned and delivered in partnership with consumer / patient</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>78%</td>
<td>21%</td>
<td>1%</td>
</tr>
<tr>
<td>1.1.3</td>
<td>Consent</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>88%</td>
<td>12%</td>
<td>0%</td>
</tr>
<tr>
<td>1.1.4</td>
<td>Care evaluation</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>67%</td>
<td>32%</td>
<td>1%</td>
</tr>
<tr>
<td>1.1.5</td>
<td>Discharge and transfer of care</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>80%</td>
<td>19%</td>
<td>0%</td>
</tr>
<tr>
<td>1.1.8</td>
<td>Health record</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>82%</td>
<td>18%</td>
<td>0%</td>
</tr>
<tr>
<td>1.5.1</td>
<td>Medication safety</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>81%</td>
<td>17%</td>
<td>1%</td>
</tr>
<tr>
<td>1.5.2</td>
<td>Infection control</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>62%</td>
<td>36%</td>
<td>1%</td>
</tr>
<tr>
<td>2.1.1</td>
<td>Continuous quality improvement</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>61%</td>
<td>35%</td>
<td>3%</td>
</tr>
<tr>
<td>2.1.2</td>
<td>Risk management: corporate and clinical</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>72%</td>
<td>27%</td>
<td>0%</td>
</tr>
<tr>
<td>2.1.3</td>
<td>Incidents management</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>76%</td>
<td>23%</td>
<td>0%</td>
</tr>
<tr>
<td>3.1.3</td>
<td>Credentialling and scope of clinical practice</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>82%</td>
<td>18%</td>
<td>0%</td>
</tr>
<tr>
<td>3.1.5</td>
<td>Corporate and clinical policies</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>81%</td>
<td>19%</td>
<td>0%</td>
</tr>
<tr>
<td>3.2.1</td>
<td>Workplace health and safety (including dangerous goods, hazardous substances and radiation, manual handling)</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>74%</td>
<td>24%</td>
<td>1%</td>
</tr>
<tr>
<td>3.2.4</td>
<td>Emergency and disaster management</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>81%</td>
<td>17%</td>
<td>1%</td>
</tr>
</tbody>
</table>

(* N/A = not applicable)
Figure 8: Ratings for EQuIP5 non-mandatory criteria surveyed at OWS from 1 July 2011 – 31 December 2012 (n=148, organisations accredited by 24 May 2013; shading indicates a new criterion)

<table>
<thead>
<tr>
<th>Criterion No.</th>
<th>Related to</th>
<th>N/A</th>
<th>LA</th>
<th>SA</th>
<th>MA</th>
<th>EA</th>
<th>OA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.6</td>
<td>Ongoing care and management of chronic disease</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
<td>77%</td>
<td>20%</td>
<td>1%</td>
</tr>
<tr>
<td>1.1.7</td>
<td>Decision making at end of life</td>
<td>12%</td>
<td>0%</td>
<td>1%</td>
<td>61%</td>
<td>24%</td>
<td>2%</td>
</tr>
<tr>
<td>1.2.1</td>
<td>Information about services</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>82%</td>
<td>16%</td>
<td>1%</td>
</tr>
<tr>
<td>1.2.2</td>
<td>Access is appropriate to needs and prioritised according to clinical need</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>80%</td>
<td>19%</td>
<td>1%</td>
</tr>
<tr>
<td>1.3.1</td>
<td>Right care and services are provided in the right setting</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>86%</td>
<td>11%</td>
<td>1%</td>
</tr>
<tr>
<td>1.4.1</td>
<td>Care and services are best evidence based and processes are effective</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>78%</td>
<td>20%</td>
<td>1%</td>
</tr>
<tr>
<td>1.5.3</td>
<td>Skin integrity and pressure ulcer management</td>
<td>10%</td>
<td>0%</td>
<td>3%</td>
<td>61%</td>
<td>23%</td>
<td>2%</td>
</tr>
<tr>
<td>1.5.4</td>
<td>Falls prevention and management</td>
<td>1%</td>
<td>1%</td>
<td>5%</td>
<td>69%</td>
<td>24%</td>
<td>1%</td>
</tr>
<tr>
<td>1.5.5</td>
<td>Blood management</td>
<td>27%</td>
<td>0%</td>
<td>3%</td>
<td>57%</td>
<td>12%</td>
<td>1%</td>
</tr>
<tr>
<td>1.5.6</td>
<td>Correct patient, procedure, site</td>
<td>3%</td>
<td>0%</td>
<td>1%</td>
<td>90%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>1.5.7</td>
<td>Nutritional care</td>
<td>6%</td>
<td>1%</td>
<td>14%</td>
<td>67%</td>
<td>9%</td>
<td>2%</td>
</tr>
<tr>
<td>1.6.1</td>
<td>Involvement of consumers</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>72%</td>
<td>26%</td>
<td>1%</td>
</tr>
<tr>
<td>1.6.2</td>
<td>Rights and responsibilities</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>91%</td>
<td>9%</td>
<td>0%</td>
</tr>
<tr>
<td>1.6.3</td>
<td>Cultural and special needs</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>74%</td>
<td>23%</td>
<td>2%</td>
</tr>
<tr>
<td>2.1.4</td>
<td>Complaints and feedback management</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>79%</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>2.2.1</td>
<td>HR system</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>82%</td>
<td>16%</td>
<td>0%</td>
</tr>
<tr>
<td>2.2.2</td>
<td>Recruitment, selection and appointment</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>89%</td>
<td>10%</td>
<td>0%</td>
</tr>
<tr>
<td>2.2.3</td>
<td>Continuing employment / professional development</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
<td>90%</td>
<td>6%</td>
<td>1%</td>
</tr>
<tr>
<td>2.2.4</td>
<td>Learning and development system</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>73%</td>
<td>24%</td>
<td>2%</td>
</tr>
<tr>
<td>2.2.5</td>
<td>Support and workplace relations</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>87%</td>
<td>12%</td>
<td>0%</td>
</tr>
<tr>
<td>2.3.1</td>
<td>Records management</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
<td>82%</td>
<td>16%</td>
<td>0%</td>
</tr>
<tr>
<td>2.3.2</td>
<td>Information and data management systems</td>
<td>0%</td>
<td>0%</td>
<td>8%</td>
<td>92%</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>2.3.3</td>
<td>Data and information used effectively</td>
<td>0%</td>
<td>0%</td>
<td>4%</td>
<td>86%</td>
<td>9%</td>
<td>1%</td>
</tr>
<tr>
<td>2.3.4</td>
<td>Information and communications technology</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>84%</td>
<td>14%</td>
<td>1%</td>
</tr>
<tr>
<td>2.4.1</td>
<td>Health promotion, health protection and surveillance</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>74%</td>
<td>24%</td>
<td>1%</td>
</tr>
<tr>
<td>2.5.1</td>
<td>Encouraging and governing research</td>
<td>24%</td>
<td>0%</td>
<td>8%</td>
<td>47%</td>
<td>16%</td>
<td>5%</td>
</tr>
<tr>
<td>3.1.1</td>
<td>Strategic and operational planning</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>79%</td>
<td>18%</td>
<td>1%</td>
</tr>
<tr>
<td>3.1.2</td>
<td>Governance structures, delegations &amp; financial management</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
<td>82%</td>
<td>16%</td>
<td>0%</td>
</tr>
<tr>
<td>3.1.4</td>
<td>Non-clinical external service providers</td>
<td>0%</td>
<td>1%</td>
<td>7%</td>
<td>89%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>3.2.2</td>
<td>Buildings, plant, equipment, supplies, utilities and consumables</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>88%</td>
<td>9%</td>
<td>1%</td>
</tr>
<tr>
<td>3.2.3</td>
<td>Waste and environment</td>
<td>0%</td>
<td>0%</td>
<td>6%</td>
<td>72%</td>
<td>19%</td>
<td>3%</td>
</tr>
<tr>
<td>3.2.5</td>
<td>Security management</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>85%</td>
<td>13%</td>
<td>0%</td>
</tr>
</tbody>
</table>

(*) N/A = not applicable
Advanced Completion in 60 days surveys (AC60s)

At Organisation-Wide Survey (OWS) or Periodic Review (PR), if the survey team assigns an LA or SA rating in a mandatory criterion, or makes a High Priority Recommendation (HPR) for any criterion, or if high risk is identified in a non-mandatory area, full (following OWS) or continuing (following PR) accreditation cannot be awarded. In any of these situations, the organisation may be offered an Advanced Completion in 60 days survey (AC60) to improve performance. In this event, the survey outcome is not finalised until after a review of the action taken by the organisation to address the AC60, which is carried out by the ACHS surveyors within 60 days of the initial survey.

If the organisation is considered to have addressed the identified issue(s), accreditation can be awarded or continued either for the full term or for a one-year conditional period, depending on the outcome of the review. If the surveyors consider that the AC60 issue has not been satisfactorily addressed within the assigned timeframe, accreditation is not achieved by the organisation.

An AC60 outcome has the dual result of drawing attention to a shortcoming in an organisation’s operation, while simultaneously providing the organisation with an opportunity to work in partnership with ACHS and its surveyors to improve the systems in question. ACHS regards the AC60 review as a successful system that maintains a high level of performance and supports organisations to achieve the required accreditation standards in a timely manner, resulting in a positive outcome for organisations and consumers.

During the survey period under consideration in this report, there were 24 instances of organisations being required to undertake an AC60 review for at least one criterion. Following review, 22 of the organisations achieved full or accrediting accreditations, while the remaining 2 received one-year conditional accreditation. This outcome represents a significant improvement in performance compared to the results achieved under EQuIP 4, with a reduction in the percentage of organisations receiving an AC60 outcome during survey from 15% to 7%. A total of 33 AC60 outcomes were issued across the 24 organisations in question, with 17 organisations receiving a single AC60, six organisations receiving two, and one organisation receiving four (see Figure 12).

Under EQuIP5, there was an alteration in the pattern of AC60 outcomes, with the majority of AC60s issued following a PR rather than an OWS (18/24, 75%, at PR, compared to 6/24, 25%, at OWS). Previously, AC60 outcomes were more often associated with an OWS. A higher proportion of surveys resulted in an AC60 outcome in the public sector than in the private sector (21/24, 88%, in the public sector, compared to 3/24, 12%, in the private sector; see Figure 9), which is consistent with previous results. Larger organisations were again more likely to receive an AC60, with those classified as having 500 beds or more attracting 25% of the AC60 outcomes. However, it should be noted that only 28 of the 341 organisations surveyed fell into this category, with 7 of those issued with an AC60 (see Figure 10). The majority of organisations surveyed during the reporting period were classified as having 0–49 beds (121/341 organisations, 35%); 3 AC60 outcomes (2%) were recorded for this category.

Across the States/Territories, Tasmania had the highest percentage of AC60 surveys (25%), however only 8 organisations were surveyed. No survey resulted in an AC60 outcome in either the Northern Territory (0/6) or the ACT (0/5), with only one in South Australia (1/24, 4%) (see Figure 11). All States and Territories improved their performance in this area under EQuIP5, most markedly the Northern Territory (0%, compared to 15% under EQuIP 4), NSW (6%, compared to 18% under EQuIP 4), Queensland (8%, compared to 19% under EQuIP 4), and South Australia (4%, compared to 15% under EQuIP 4).

Of the 47 EQuIP5 criteria against which organisational performance was assessed during this survey period, 12 were associated with at least one AC60 survey outcome (see Figure 13), including 10 of the 15 mandatory criteria. The four criteria most frequently associated with an AC60 outcome are indicated by shading in Figure 13.

Criteria in all three EQuIP5 functions (Clinical, Support, Corporate) were associated with an AC60 outcome. Of these 12 criteria, 10 were mandatory, indicating that organisations may find challenging even those areas of operation most fundamental to the safe delivery of care and services.

Seven out of the 12 criteria for which an AC60 was allocated were positioned within the Clinical function; four were Corporate; and one was in the Support function. However, while a majority of the criteria associated with AC60 outcomes were Clinical, the four criteria that attracted the highest number of AC60s and High Priority Recommendations (HPRs) were from the Corporate and
Support functions: emergency and disaster management (3.2.4), workplace health and safety (3.2.1), risk management (2.1.2) and credentialling (3.1.3). The Corporate criterion governing policies and procedures (3.1.5) was also amongst those for which AC60s were issued. All five of these criteria are mandatory, underscoring their importance to the creation of a safe environment within which high quality care and services may be delivered.

Five of the seven Clinical criteria for which AC60s were issued were also mandatory: medication safety (1.5.1), infection control (1.5.2), consent (1.1.3), the assessment system (1.1.1) and the health record (1.1.8). The non-mandatory criteria governing appropriateness (1.3.1) and correct patient / procedure / site (1.5.6) were also associated with an AC60 outcome.
High-performing organisations

Organisations that are considered to have reached a significantly high level of performance in an area of operation may be awarded an EA (Extensive Achievement) or an OA (Outstanding Achievement) rating at survey.

To be assessed at an EA level, there must be evidence across the organisation of advanced implementation systems and outcomes related to that criterion. An EA rating requires that the organisation is participating in external benchmarking or research in the area, or other equivalent methods to validate their level of performance.

For all criteria surveyed between 1 July 2011 – 31 December 2012 (341 surveys), a rating of extensive Achievement represented 19% (1882/9851) of the total individual ratings, an increase from 13% (3860/29,798) under EQuiP 4. Mandatory criteria were assessed at the EA level on 1158 occasions from 341 surveys, and non-mandatory criteria on 741 occasions from 148 surveys.

During the same survey period, an Outstanding Achievement award represented 0.8% of total individual ratings (79/9851), with mandatory criteria assessed at the OA level on 32 occasions from 341 surveys, and non-mandatory criteria on 47 occasions from 148 surveys.
The awarding of OA ratings for performance against the mandatory criteria was also more frequent under EQuIP5, with an increase from 0.4% of total individual ratings to 0.6% (32/5115). The criterion for which the greatest number of OA ratings was awarded was that governing continuous quality improvement (2.1.1).

Other areas of strong performance were care planning (1.1.2) and workplace health and safety (3.2.1).

It is disappointing to note that the strong OA level performance during 2009 – 2010 against the medication safety criterion (1.5.1), which became a mandatory criterion during the review of EQuIP5, was not maintained to the same degree during this survey period. However, two organisations did receive an OA rating against this criterion.

Non-mandatory criteria

Performance in the EQuIP5 non-mandatory criteria was assessed during 148 Organisation-Wide Surveys. A rating of Outstanding Achievement was awarded on 47 occasions, representing 1% of the total survey outcomes, an improvement from 0.4% during the 2009 – 2010 survey period. An Extensive Achievement rating was awarded on 724 occasions from the 148 surveys, representing 15% of total outcomes, compared to 11% during the previous survey period.

While there was improvement across the non-mandatory criteria at the EA level, it was less marked for individual criteria. Furthermore, certain criteria showed a relative decrease in the frequency of EA ratings awarded, including information and data management systems (2.3.2) and correct patient / procedure / site (1.5.6). Improved performance was not confined to any one area of organisational operation, although certain results reflect governmental and societal priorities. For example, a greater emphasis upon the care journey as a whole and the avoidance of unnecessary hospitalisation may account for the improved performance noted for access to care (1.2.2), ongoing care (1.1.6) and health promotion (2.4.1); while that in the area of cultural and special needs (1.6.3) may reflect organisations embracing the need to work in partnership with their communities. Improvement at the EA level was also recorded for a number of non-clinical, systemic areas, including workforce planning (2.2.1) and recruitment (2.2.2), employee support systems and workplace relations (2.2.5), and security management (3.2.5).
The non-mandatory criterion governing research was that most frequently awarded an OA rating; this is an area of consistent high achievement for EQuIP members. Other areas of strong performance during this survey period included waste and environmental management (3.2.3), end-of-life care (1.1.7), skin integrity and pressure ulcer management (1.5.3), cultural and special needs (1.6.3), and learning and development systems (2.2.4).

It is of note that three OA ratings were awarded for the newly-introduced criterion governing nutrition (1.5.7). For more information on performance against this new criterion, see ‘Spotlight on Nutrition’, below.

Outstanding Achievement
An OA is the highest assessment rating that an ACHS survey team can allocate to an individual criterion. To achieve an OA rating, the requirements of the elements of LA, SA, MA and EA need to be met (see Figure 30), in conjunction with a demonstration of leadership. An organisation that receives an OA rating for a particular criterion is considered to be a leading organisation in the relevant field. This does not necessarily mean that the organisation is the best in Australia. It may mean that the organisation can demonstrate that it is the best or is outstanding amongst peers.

During the survey period 1 July 2011 – 31 December 2012, ACHS survey teams awarded 79 OA ratings, which were associated with 35 of the 47 EQuIP5 criteria. The ratings were distributed to 39 organisations across the States and Territories, in both the public and private sectors and rural and metropolitan areas, and to a variety of healthcare organisations including hospitals, community health centres, rehabilitation services, mental health facilities, drug and alcohol services and palliative care services.

A list of the organisations awarded one or more OA ratings and extracts from the relevant surveyor reports have been included in this report to provide insight into the varied means by which organisations demonstrated leadership in different areas of operation (see Appendix C: OA summaries by criterion).

Figure 15: EQuIP5 mandatory criteria assessed at EA and OA levels (1 July 2011 – 31 December 2012, n=341)
Figure 16: EQuiP5 non-mandatory criteria assessed at EA and OA levels
(1 July 2011 – 31 December 2012, n=148; shading indicates a new criterion)

<table>
<thead>
<tr>
<th>Criterion No.</th>
<th>Related to</th>
<th>EA</th>
<th>OA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.6</td>
<td>Ongoing care and management of chronic disease</td>
<td>30</td>
<td>1</td>
</tr>
<tr>
<td>1.1.7</td>
<td>Decision making at end of life</td>
<td>35</td>
<td>3</td>
</tr>
<tr>
<td>1.2.1</td>
<td>Information about services</td>
<td>24</td>
<td>2</td>
</tr>
<tr>
<td>1.2.2</td>
<td>Access is appropriate to needs and prioritised according to clinical need</td>
<td>28</td>
<td>1</td>
</tr>
<tr>
<td>1.3.1</td>
<td>Right care and services are provided in the right setting</td>
<td>17</td>
<td>2</td>
</tr>
<tr>
<td>1.4.1</td>
<td>Care and services are best evidence based and processes are effective</td>
<td>30</td>
<td>2</td>
</tr>
<tr>
<td>1.5.3</td>
<td>Skin integrity and pressure ulcer management</td>
<td>34</td>
<td>3</td>
</tr>
<tr>
<td>1.5.4</td>
<td>Falls prevention and management</td>
<td>35</td>
<td>1</td>
</tr>
<tr>
<td>1.5.5</td>
<td>Blood management</td>
<td>18</td>
<td>1</td>
</tr>
<tr>
<td>1.5.6</td>
<td>Correct patient, procedure, site</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>1.5.7</td>
<td>Nutritional care</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>1.6.1</td>
<td>Involvement of consumers</td>
<td>38</td>
<td>1</td>
</tr>
<tr>
<td>1.6.2</td>
<td>Rights and responsibilities</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>1.6.3</td>
<td>Cultural and special needs</td>
<td>34</td>
<td>3</td>
</tr>
<tr>
<td>2.1.4</td>
<td>Complaints and feedback management</td>
<td>29</td>
<td>0</td>
</tr>
<tr>
<td>2.2.1</td>
<td>HR system</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td>2.2.2</td>
<td>Recruitment, selection and appointment</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>2.2.3</td>
<td>Continuing employment / professional development</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>2.2.4</td>
<td>Learning and development system</td>
<td>36</td>
<td>3</td>
</tr>
<tr>
<td>2.2.5</td>
<td>Support and workplace relations</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>2.3.1</td>
<td>Records management</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td>2.3.2</td>
<td>Information and data management systems</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>2.3.3</td>
<td>Data and information used effectively</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>2.3.4</td>
<td>Information and communications technology</td>
<td>21</td>
<td>2</td>
</tr>
<tr>
<td>2.4.1</td>
<td>Health promotion, health protection and surveillance</td>
<td>35</td>
<td>2</td>
</tr>
<tr>
<td>2.5.1</td>
<td>Encouraging and governing research</td>
<td>23</td>
<td>8</td>
</tr>
<tr>
<td>3.1.1</td>
<td>Strategic and operational planning</td>
<td>27</td>
<td>1</td>
</tr>
<tr>
<td>3.1.2</td>
<td>Governance structures, delegations &amp; financial management</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td>3.1.4</td>
<td>Non-clinical external service providers</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>3.2.2</td>
<td>Buildings, plant, equipment, supplies, utilities and consumables</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>3.2.3</td>
<td>Waste and environment</td>
<td>28</td>
<td>4</td>
</tr>
<tr>
<td>3.2.5</td>
<td>Security management</td>
<td>19</td>
<td>0</td>
</tr>
</tbody>
</table>

|                | **Total**                                                                 | **724** | **47** |
provision of all necessary assistance at meal-times, and education for staff regarding the roles and responsibilities of healthcare providers. Furthermore, it emphasises the need for sound governance and multidisciplinary oversight of nutrition, the use of validated screening tools, the identification of those with existing nutritional issues and those at risk, the provision of timely referrals where needed, and the integration of nutrition into consumer / patient care planning.

EQuIP5 was implemented on 1 July 2011. Organisations undergoing Organisation-Wide Survey (OWS) beyond this date were therefore assessed for their nutritional care; 6% of organisations were exempted from this assessment on the grounds of 'not applicable'.

As might be anticipated for a new criterion, a wide variety of organisational situations were encountered by surveyors, with members receiving ratings across the spectrum from LA to OA (see Figure 8). However, it is pleasing to note that 116 (83%) of the 139 organisations surveyed against the nutrition criterion during OWS were awarded a rating of MA or better. Forty-one (29%) of the 139 organisations received a total of 67 recommendations from surveyors highlighting areas of concern in their management of nutritional care and/or offering suggestions for improvement. There were no High Priority recommendations given against the nutrition criterion.

Of the 139 organisations assessed for their nutritional care, surveyors identified shortfalls in 23 (17%). Of these, 21 received an SA rating, indicating that while the governance and practice of nutritional care was satisfactory, systems were not being tested nor areas for potential improvement identified through regular evaluation. Two organisations received an LA rating, indicating a failure to implement policy in a meaningful way or even an absence of policy addressing nutritional care.

While at this early stage of implementation, surveyors identified a range of challenges and opportunities for improvement with respect to the management of nutritional care, three significant areas of under-performance were highlighted. In a subset of organisations there was a fundamental lack of governance in the area of nutrition, and a failure to implement an appropriate, organisation-wide program of nutritional care. This was exacerbated in organisations with multiple facilities, where there was a lack of consistency in the approach to nutritional care from site to site. Surveyor recommendations in this area stressed the need
for overarching governance and the development of a comprehensive plan to meet consumer / patient needs, the implementation of policy and procedures, and oversight of nutritional care via a multidisciplinary committee.

In a number of organisations there was a failure to integrate nutritional care into consumer / patient assessment and care planning. A validated screening tool was not always employed, assessments were not always translated into care planning, and in some instances there was a failure to ‘follow through’ with regards to specific issues identified during assessment, including with respect to the provision of appropriate referrals. In particular there was a lack of specialised care planning for those identified as being malnourished, or as having a diagnosis that included nutritional issues. In some cases the availability of specialised services was inadequate for the needs of the consumer / patient cohort, with no permanent, onsite dietitian in spite of a high incidence of at-risk consumers / patients.

Another area in which organisations under-performed was staff education. It was noted by surveyors that there was a tendency to assume that healthcare providers understood both the role of nutrition within consumer / patient care and their own responsibilities in this respect, rather than staff being proactively provided with specialised education. The need to provide general education in this area to all relevant staff, to clarify individual roles and responsibilities and to highlight the multidisciplinary nature of good nutritional care, was stressed.

It was noted that many organisations were not weighing consumers / patients, or doing so only upon admission. In light of the incidence of hospital-acquired malnutrition, surveyors emphasised the need for monitoring both consumer / patient weight during their care episode, and food and fluid intake. Consumer / patient weight loss and/or clinical deterioration related to poor nutrition was not always treated as a reportable clinical incident nor investigated as such.

Those organisations rated at SA against the nutrition criterion were providing good nutritional care but not evaluating their systems and processes. Many surveyor recommendations in this area highlighted the potential for significant improvements in this area of care delivery, via evaluation of:

- compliance with State / Territory policy, where applicable
- the use of evidence-based best practice
- the effectiveness of the links between assessment and care planning
- the provision and uptake of referrals
- specialised care delivery, for example, in paediatric, rehabilitation or geriatric services
- consumer / patient outcomes.

The majority of the 139 organisations surveyed against the nutrition criterion achieved an MA rating or better. Of these, 99 (71%) received an MA rating for their performance against the nutrition standard, indicating that they had in place systems and processes for nutritional care, appropriate education, and the recognition of nutrition-related deterioration as a clinical incident, that they carried out regular evaluations of these systems and processes, and that improvements in these areas of performance were made as required.

The remaining organisations surveyed were noted by surveyors as having embraced nutritional care as part of standard practice, and as striving to make improvements and to find innovative ways of meeting consumer / patient needs in this area. The 14 (10%) organisations that received an EA rating were notable for the organisation-wide implementation of robust policies and procedures, the provision of sound and ongoing education programs shaped to local needs, and the multidisciplinary oversight of nutrition management, often via committees with significant dietitian and consumer involvement. Enthusiastic nutrition ‘champions’ were a common feature. These organisations also participated in external benchmarking around nutrition, and often partnered with other organisations to become involved in research relevant to their care and services.

These high-performing organisations were notable for the thorough integration of nutritional care into consumer / patient assessment and care planning, and for their processes for the identification and management of malnourished and at-risk consumers / patients. Nutritional status and weight were reassessed throughout each consumer / patient’s episode of care, and the care plan adjusted to accommodate any identified alteration in status. Deterioration in this respect was reported and managed as a clinical incident. Weight and body mass index readings were recorded in the health record, which was reformatted to accommodate the inclusion of nutrition-related data. Auditing of outcomes of nutritional care and related referral services was regularly carried out.
Many organisations introduced a ‘protected’ or ‘quarantined’ mealtime for consumers / patients, who were assessed for their need for assistance and/or feeding issues. Effort was put into designing meals balancing nutrition with consumer / patient appeal, and in some organisations, particularly those with prolonged lengths of-stay, individual preferences were built into menus. Specialised meals were designed for those with feeding issues or in need of a high-protein diet. The cultural and other special dietary needs of consumers / patients were determined and fulfilled. There was involvement in population health programs around issues of nutrition.

Innovations of note in this area included the procurement of specialised equipment so that immobile or bariatric consumers / patients were appropriately monitored, the development and provision of additional education to specialised groups, including nurses and families / carers, and the use of food diaries where appropriate to the consumer / patient cohort. Staff became involved in education programs and/or advocacy around nutrition outside of the organisation.

Despite the recent introduction of nutrition into the EQuiP5 program, three of the organisations surveyed were awarded an OA rating during their first assessment against the criterion. For the surveyors’ comments with respect to these ratings, see Appendix C.

Criterion 1.5.7 addresses nutrition as an aspect of multidisciplinary care delivery, and this position is reflected by a variety of surveyor recommendations in which other criteria are directly or indirectly referenced. For example, recommendations around the need to monitor the weight of consumers / patients across an episode of care also addressed the need for the design of the health record (1.1.8) to allow for the regular recording of this information. The conditions under which food is prepared and delivered were discussed with reference to both infection control (1.5.2) and the design, maintenance and cleaning of food preparation areas (3.2.2). The need for consumer / patient consultation (1.6.1) with regards to menu planning was addressed, as was the responsibility of organisations to provide meals suitable for consumers / patients with special needs and cultural requirements (1.6.3). It was noted that many organisations had implemented health promotion programs (2.4.1) with a focus upon healthy eating, weight management and the control of certain health conditions, and that this was an area with strong consumer / patient involvement.

Research

ACHS is involved in collaborative research examining the impact of healthcare accreditation. It is one of the partners in the Accreditation Collaborative for the Conduct of Research, Evaluation and Designated Investigations through Teamwork (ACCREDIT) Project, along with the Centre for Clinical Governance Research and the Centre for Health Systems and Safety Research, in the Australian Institute of Health Innovation at the University of New South Wales. Other project partners are the Australian General Practice Accreditation Limited; the Aged Care and Standards Accreditation Agency; the Australian Commission on Safety and Quality in Health Care; and the New South Wales Clinical Excellence Commission. The collaboration is implementing a study comprising four aims, summarised as: (i) evaluate current accreditation processes; (ii) analyse the costs and benefits of accreditation; (iii) improve future accreditation via evidence; and (iv) develop and apply new standards of consumer involvement in accreditation. The four aims are being addressed in 12 interrelated studies funded by a Linkage Grant (LP100200586) from the Australian Research Council.

Associate Professor Keith Townsend from Griffith University (GU) is leading a multidisciplinary research team, partnered with ACHS. This Australian Research Council-funded project draws on expertise from Human Resource Management (Townsend; Professor Adrian Wilkinson, GU; Dr Ashlea Kellner, GU), organisational behaviour (Dr Sandra Lawrence, GU), and accreditation (Dr David Greenfield, UNSW) to investigate the systems and processes that are common to ‘high-performing’ hospitals. The research team’s focus is to better understand how hospitals use accreditation to improve their performance in the various components of human resources management and how this impacts upon overall performance in patient outcomes. This study develops and tests two hypotheses: 1) a dynamic model of the critical organisational systems utilised in hospital settings, as a means to improving clinical health performance over time; and 2) the specific influence of feedback and system interventions on system effectiveness and clinical performance outcomes over time, using human resource management systems as a focal point.
Key citations

Peer-reviewed journal articles:


Peer-reviewed conference abstracts:


MEMBER SATISFACTION

There are many events within the EQuIP cycle for which ACHS provides services directly to its members. ACHS regularly monitors members’ satisfaction with its services by evaluating feedback requested from members following their survey, survey reports and self-assessment reports. Member feedback is an important component of ACHS’ performance management system for surveyors, and informs internal ACHS improvement strategies and improvements to its services as required.

The following data reflect member feedback for the years 2009 – 2012, during survey under both the EQuIP 4 and EQuIP5 standards; EQuIP5 was implemented on 1 July 2011.

Originally evaluation was conducted using submission of completed paper forms by members, however at the beginning of 2011 an electronic submission form replaced the previous paper-based feedback system.

One area of performance included in previous evaluations, “Organisation’s satisfaction the survey coordinator managed the team in a professional manner”, could not be provided in this report as, due to a problem with the software upon its initial installation, these data were not consistently collected.

For the period 2011 – 2012, member satisfaction remained at ≥95% in most areas of ACHS performance. It was pleasing to note that in two areas where members previously expressed a significant degree of dissatisfaction, the Electronic Assessment Tool (EAT) and the format and content of the self assessment, satisfaction had increased to 99% and 98%, respectively, by the conclusion of the survey period (31 December 2012). In both of these areas, ACHS processes were revised in response to member comments.

Conversely, during 2012 there was a marked decrease in member satisfaction with respect to the length of survey. At this time, in anticipation of the implementation of the National Safety and Quality Health Service (NSQHS) Standards, ACHS offered members undergoing EQuIP survey the opportunity to include in the process a complimentary gap analysis against the new Standards. To facilitate this, an extra day was added to each survey. However, the gap analyses took longer than anticipated to complete; the resultant time pressure was noted and commented upon by members and surveyors alike.

Standards and criteria

Members were surveyed regarding their ability to interpret and apply the standards

<table>
<thead>
<tr>
<th>Year</th>
<th>Satisfied / Very satisfied (%)</th>
<th>Dissatisfied / Very dissatisfied (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>91</td>
<td>9</td>
</tr>
<tr>
<td>2010</td>
<td>93</td>
<td>7</td>
</tr>
<tr>
<td>2011</td>
<td>94</td>
<td>6</td>
</tr>
<tr>
<td>2012</td>
<td>98</td>
<td>2</td>
</tr>
</tbody>
</table>

Members were surveyed regarding their satisfaction with the mandatory criteria

<table>
<thead>
<tr>
<th>Year</th>
<th>Satisfied / Very satisfied (%)</th>
<th>Dissatisfied / Very dissatisfied (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>92</td>
<td>4</td>
</tr>
<tr>
<td>2010</td>
<td>96</td>
<td>4</td>
</tr>
<tr>
<td>2011</td>
<td>96</td>
<td>8</td>
</tr>
<tr>
<td>2012</td>
<td>94</td>
<td>2</td>
</tr>
</tbody>
</table>

Support

Members were surveyed regarding their satisfaction with the support provided to their organisation by their ACHS Customer Services Manager

<table>
<thead>
<tr>
<th>Year</th>
<th>Satisfied / Very satisfied (%)</th>
<th>Dissatisfied / Very dissatisfied (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>2010</td>
<td>94</td>
<td>6</td>
</tr>
<tr>
<td>2011</td>
<td>96</td>
<td>4</td>
</tr>
<tr>
<td>2012</td>
<td>95</td>
<td>5</td>
</tr>
</tbody>
</table>

Members were surveyed regarding their satisfaction with the ACHS Electronic Assessment Tool

<table>
<thead>
<tr>
<th>Year</th>
<th>Satisfied / Very satisfied (%)</th>
<th>Dissatisfied / Very dissatisfied (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>85</td>
<td>15</td>
</tr>
<tr>
<td>2010</td>
<td>86</td>
<td>14</td>
</tr>
<tr>
<td>2011</td>
<td>92</td>
<td>2</td>
</tr>
<tr>
<td>2012</td>
<td>98</td>
<td>2</td>
</tr>
</tbody>
</table>
Members were surveyed regarding their satisfaction with the length of their survey

Satisfied / Very satisfied (%) | Dissatisfied / Very dissatisfied (%)
--- | ---
2009: 94 | 6
2010: 90 | 10
2011: 94 | 6
2012: 72 | 8

Members were surveyed regarding their satisfaction with the survey Summation Conference

Satisfied / Very satisfied (%) | Dissatisfied / Very dissatisfied (%)
--- | ---
2009: 95 | 5
2010: 93 | 7
2011: 96 | 4
2012: 96 | 4

Members were surveyed as to whether their surveyors presented as a cohesive team (note: solo surveying phased out after 2010)

Solo surveyor (%) | Dissatisfied / Very dissatisfied (%) |Solo Surveyor (%)
--- | --- |---
2009: 64 | 4 | 6
2010: 4 | 1 | 4
2011: 4 | 1 | 4
2012: 4 | 1 | 4

Members were surveyed regarding their satisfaction with the Survey Coordinator’s negotiation around the survey timetable

Satisfied / Very satisfied (%) | Dissatisfied / Very dissatisfied (%)
--- | ---
2009: 93 | 7
2010: 97 | 3
2011: 94 | 3
2012: 98 | 2

Members were surveyed regarding their satisfaction with the clarification of relevant issues with organisational staff by the Survey Coordinator prior to survey

Satisfied / Very satisfied (%) | Dissatisfied / Very dissatisfied (%)
--- | ---
2009: 96 | 4
2010: 97 | 3
2011: 97 | 3
2012: 99 | 1

Members were surveyed regarding their satisfaction that the Survey Coordinator appropriately managed surveyor communication and interaction with organisational staff during survey

Satisfied / Very satisfied (%) | Dissatisfied / Very dissatisfied (%)
--- | ---
2009: 94 | 6
2010: 96 | 4
2011: 98 | 2
2012: 99 | 1
Members were surveyed regarding their satisfaction that surveyors read the pre-survey information:

<table>
<thead>
<tr>
<th>Year</th>
<th>Satisfied / Very satisfied (%)</th>
<th>Dissatisfied / Very dissatisfied (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>96</td>
<td>4</td>
</tr>
<tr>
<td>2010</td>
<td>97</td>
<td>3</td>
</tr>
<tr>
<td>2011</td>
<td>99</td>
<td>1</td>
</tr>
<tr>
<td>2012</td>
<td>95</td>
<td>2</td>
</tr>
</tbody>
</table>

Members were surveyed regarding their satisfaction that surveyors had a good understanding of the organisation:

<table>
<thead>
<tr>
<th>Year</th>
<th>Satisfied / Very satisfied (%)</th>
<th>Dissatisfied / Very dissatisfied (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>94</td>
<td>6</td>
</tr>
<tr>
<td>2010</td>
<td>96</td>
<td>4</td>
</tr>
<tr>
<td>2011</td>
<td>97</td>
<td>3</td>
</tr>
<tr>
<td>2012</td>
<td>96</td>
<td>3</td>
</tr>
</tbody>
</table>

Members were surveyed regarding their satisfaction that surveyors had a flexible approach suitable for different situations and people:

<table>
<thead>
<tr>
<th>Year</th>
<th>Satisfied / Very satisfied (%)</th>
<th>Dissatisfied / Very dissatisfied (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>93</td>
<td>7</td>
</tr>
<tr>
<td>2010</td>
<td>94</td>
<td>6</td>
</tr>
<tr>
<td>2011</td>
<td>96</td>
<td>4</td>
</tr>
<tr>
<td>2012</td>
<td>96</td>
<td>4</td>
</tr>
</tbody>
</table>

Members were surveyed regarding their satisfaction that surveyors surveyed to the standards:

<table>
<thead>
<tr>
<th>Year</th>
<th>Satisfied / Very satisfied (%)</th>
<th>Dissatisfied / Very dissatisfied (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>95</td>
<td>4</td>
</tr>
<tr>
<td>2010</td>
<td>96</td>
<td>4</td>
</tr>
<tr>
<td>2011</td>
<td>97</td>
<td>3</td>
</tr>
<tr>
<td>2012</td>
<td>96</td>
<td>2</td>
</tr>
</tbody>
</table>

Members were surveyed regarding their satisfaction that surveyors discussed opportunities for improvement in a positive manner:

<table>
<thead>
<tr>
<th>Year</th>
<th>Satisfied / Very satisfied (%)</th>
<th>Dissatisfied / Very dissatisfied (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>94</td>
<td>6</td>
</tr>
<tr>
<td>2010</td>
<td>97</td>
<td>7</td>
</tr>
<tr>
<td>2011</td>
<td>97</td>
<td>3</td>
</tr>
<tr>
<td>2012</td>
<td>96</td>
<td>6</td>
</tr>
</tbody>
</table>

Members were surveyed regarding their satisfaction that surveyors provided useful suggestions for greater achievement:

<table>
<thead>
<tr>
<th>Year</th>
<th>Satisfied / Very satisfied (%)</th>
<th>Dissatisfied / Very dissatisfied (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>94</td>
<td>4</td>
</tr>
<tr>
<td>2010</td>
<td>96</td>
<td>4</td>
</tr>
<tr>
<td>2011</td>
<td>96</td>
<td>3</td>
</tr>
<tr>
<td>2012</td>
<td>96</td>
<td>4</td>
</tr>
</tbody>
</table>
MEMBER SATISFACTION

Members were surveyed regarding their satisfaction that surveyors conducted the survey in a professional manner.

 Survey report

Members were surveyed regarding whether the survey report was well written and easy to read.

Members were surveyed regarding whether they were satisfied that surveyors listened to and understood what staff said.

Members were surveyed regarding their satisfaction that comments and recommendations in the survey report were relevant and reasonable.

Members were surveyed regarding their satisfaction that the survey report contained useful ideas for improvement.
Members were surveyed regarding their satisfaction that the survey report acknowledged outstanding achievement

Members were surveyed regarding their satisfaction that areas requiring improvement were mentioned during the Summation Conference

Members were surveyed regarding their satisfaction with the consistency of the survey report

Members were satisfied regarding their satisfaction that the survey report may be used as an effective management tool to support the promotion of continuous improvement

Self assessment

Members were surveyed regarding their satisfaction with the current self-assessment format and questions
APPENDIX A

THE EQUIP 4 ACCREDITATION PROGRAM AND OUTCOMES

Figure 17: EQuIP 4 functions, standards and criteria

<table>
<thead>
<tr>
<th>1. CLINICAL</th>
<th>2. SUPPORT</th>
<th>3. CORPORATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Consumers / patients are provided with high quality care throughout the care delivery process.</td>
<td>2.1.1 The organisation’s continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.</td>
<td>3.1.1 The governing body leads the organisation’s strategic direction to ensure the provision of quality, safe services.</td>
</tr>
<tr>
<td>1.1.1 The assessment system ensures current and ongoing needs of the consumer / patient are identified.</td>
<td>2.1.1 The governing body leads the organisation’s strategic direction to ensure the provision of quality, safe services.</td>
<td>3.1.1 The organisation provides quality, safe care through strategic and operational planning and development.</td>
</tr>
<tr>
<td>1.2 Care is planned and delivered in partnership with the consumer / patient and when relevant, the care to achieve the best possible outcomes.</td>
<td>2.1.2 The organisation’s continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.</td>
<td>3.1.2 Governance is assisted by formal structures and delegation practices within the organisation.</td>
</tr>
<tr>
<td>1.1.3 Consumers / patients are informed of the consent process, understand and provide consent for their health care.</td>
<td>2.1.3 Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.</td>
<td>3.1.3 Processes for credentialing and defining the scope of clinical practice support safe, quality health care.</td>
</tr>
<tr>
<td>1.2.1 The organisation demonstrates its commitment to delivering safe and effective care.</td>
<td>2.1.4 The organisation’s continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.</td>
<td>3.1.4 External service providers are managed to maximise quality care and service delivery.</td>
</tr>
<tr>
<td>1.1.4 Care is evaluated by health care providers and when appropriate with the consumer / patient and care to achieve the best possible outcomes.</td>
<td>2.1.5 Human resources planning supports the organisation’s current and future ability to address needs.</td>
<td>3.1.5 Documented corporate and clinical policies assist the organisation to provide quality care.</td>
</tr>
<tr>
<td>1.1.5 Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.</td>
<td>2.2.1 Human resources planning supports the organisation’s current and future ability to address needs.</td>
<td>3.2. The organisation maintains a safe environment for employees, consumers / patients and visitors.</td>
</tr>
<tr>
<td>1.1.6 Systems for ongoing care of the consumer / patient are coordinated and effective.</td>
<td>2.2.2 The recruitment, selection and appointment system ensures the skill mix and competence of staff, and mix of volunteers, meets the needs of the organisation.</td>
<td>3.2.1 Safety management systems ensure safety and wellbeing for consumers / patients, staff, visitors and contractors.</td>
</tr>
<tr>
<td>1.1.7 Systems exist to ensure that the care of dying and deceased consumers / patients is managed with dignity and comfort.</td>
<td>2.2.3 The continuing employment and performance development system ensures the competence of staff and volunteers.</td>
<td>3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.</td>
</tr>
<tr>
<td>1.1.8 The health record ensures comprehensive and accurate information is recorded and used in care delivery.</td>
<td>2.2.4 The learning and development system ensures the skill and competence of staff and volunteers.</td>
<td>3.2.3 Waste and environmental management systems support safe practice and a safe environment.</td>
</tr>
<tr>
<td>1.2 Consumers / patients / communities have access to health services and care appropriate to their needs.</td>
<td>2.2.5 Employee support systems and workplace relations assist the organisation to achieve its goals.</td>
<td>3.2.4 Emergency and disaster management supports safe practice and a safe environment.</td>
</tr>
<tr>
<td>1.2.2 Access and admission to the system of care is prioritised according to clinical need.</td>
<td>2.3.1 Records management systems support the collection of information and meet the organisation’s goals to be met.</td>
<td>3.2.5 Security management supports safe practice and a safe environment.</td>
</tr>
<tr>
<td>1.2.3 Information management systems enable the organisation’s goals to be met.</td>
<td>2.3.2 The organisation provides care and services that achieve expected outcomes.</td>
<td>3.2.6 The organisation promotes the health of the population.</td>
</tr>
<tr>
<td>1.2.4 The organisation’s continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.</td>
<td>2.3.3 Waste and environmental management systems support safe practice and a safe environment.</td>
<td>3.3. The organisation promotes the health of the population.</td>
</tr>
<tr>
<td>1.3 Appropriate care and services are provided to consumers / patients.</td>
<td>2.3.4 The organisation has an integrated approach to the planning, use and management of information and communication technology (I&amp;CT).</td>
<td>3.3.1 Medications are managed to ensure safe and effective practice.</td>
</tr>
<tr>
<td>1.3.1 Health care and services are provided to consumers / patients.</td>
<td>2.4. The organisation promotes the health of the population.</td>
<td>3.3.2 The organisation’s research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research.</td>
</tr>
<tr>
<td>1.4.1 Care and services are planned, developed and delivered based on the best available evidence and in the most effective way.</td>
<td>3.4.1 The organisation’s research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research.</td>
<td>3.3.3 The organisation’s research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research.</td>
</tr>
<tr>
<td>1.5 The organisation provides safe care and services.</td>
<td>2.4.1 The organisation promotes the health of the population.</td>
<td>3.4. The organisation has an integrated approach to the planning, use and management of information and communication technology (I&amp;CT).</td>
</tr>
<tr>
<td>1.5.1 Medications are managed to ensure safe and effective practice.</td>
<td>2.5. The organisation encourages and adequately governs the conduct of health and medical research to improve the safety and quality of health care.</td>
<td>3.4.1 The organisation’s research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research.</td>
</tr>
<tr>
<td>1.5.2 The infection control system supports safe practice and ensures a safe environment for consumers / patients and health care workers.</td>
<td>2.5.1 The organisation’s research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research.</td>
<td>3.4.2 The organisation’s research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research.</td>
</tr>
<tr>
<td>1.5.3 The incidence and impact of pressure ulcers are minimised through a pressure ulcer prevention and management strategy.</td>
<td>2.5.2 The organisation’s research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research.</td>
<td></td>
</tr>
</tbody>
</table>
The EQuIP 4 accreditation program was implemented from 1 January 2007 – 30 June 2011. The program consisted of 3 functions, 13 standards and 45 criteria, including one developmental criterion; 14 of the 45 criteria were mandatory.

The majority of the survey data collected under EQuIP 4 was described in the previous edition of the National Accreditation Report, which is available on the ACHS website: http://www.achs.org.au/media/4071/nar_report_2009_10.pdf

The present edition of the National Accreditation Report describes a further 116 EQuIP 4 surveys which were conducted after 31 December 2010, or for which the survey report was finalised after 31 March 2011.

**EQuIP 4 accreditation outcomes**

For the period up to 30 June 2011, 116 surveys were conducted and/or finalised under the EQuIP 4 accreditation program.

Of the organisations undergoing Organisation-Wide Survey (OWS) or Periodic Review (PR) during this period, 75% (87/116) achieved full or continuing accreditation at the time of the initial survey, and a further 21% (24/116) after addressing issues raised via an Advanced Completion in 60 days (AC60) survey (see Figure 20). A further four organisations (3%) received one-year conditional accreditation, two following an AC60 survey, and one organisation (1%) was non-accredited.

The survey outcomes by rating and for individual criteria were comparable to those achieved for the majority of surveys under EQuIP 4, as described in the National Accreditation Report 2009 – 2010 (see Figures 22 and 23). The most significant difference was with respect to AC60 survey outcomes, with 28 (24%) organisations being required to undertake an AC60 review for at least one criterion, compared to 13% during the previous reporting period. However, these data are skewed by the fact that a number of organisations which were still addressing issues raised via an AC60 outcome at the time of data cut-off were not included in the previous report, but carried over to the current edition. The percentage of organisations finally achieving full or continuing accreditation, with or without an AC60 outcome, was comparable in both reporting periods (95% in 2007 – 2010, 96% to 30 June 2011).

During these 116 surveys, 39 AC60 outcomes were issued to 26 organisations, associated with 13 of the 45 EQuIP 4 criteria (see Figure 27). Trends highlighted in the National Accreditation Report 2009 – 2010 were also observed during this shorter reporting period, with nine out of these 13 criteria positioned within the non-clinical Support and Corporate functions, and three out of the four criteria most often associated with an AC60 being non-clinical. A similar pattern was observed in the issuing of High Priority Recommendations (HPRs).

By a considerable margin, the criterion most often associated with AC60 outcomes and HPRs was mandatory criterion 3.2.4, which addresses emergency and disaster management (see Figure 27). The predominant area of concern was inadequate staff training, including failure to carry out evacuation drills, while surveyors also highlighted failures to implement recommendations from fire inspections and/or conduct regular checks of safety equipment, and issues with absent or insufficient signage.

Mandatory criteria 3.2.1 and 3.1.5, addressing workplace health and safety and organisational policies and procedures, respectively, were also associated with AC60 outcomes and HPRs. Mandatory criterion 1.5.2, addressing infection control, was the clinical criterion for which AC60 outcomes and HPRs were most frequently issued.

During this reporting period, an Outstanding Achievement (OA) rating was awarded 11 times to seven organisations (11/3452 rating outcomes, 0.3%). These outcomes also followed the trends described in the National Accreditation Report 2009 – 2010, with more OA ratings awarded for non-mandatory than mandatory criteria (see Figure 28). For a list of the organisations that were awarded an OA rating and a summary of surveyors’ comments regarding these ratings, see Appendix C.

**Figure 18: EQuIP 4 OWS and PR surveys by State / Territory (surveys completed and/or finalised 1 January 2011 – 30 June 2011, n=116)**
APPENDIX A
THE EQUIP 4 ACCREDITATION PROGRAM AND OUTCOMES

Figure 19: EQUIP 4 OWS and PR surveys by health sector (surveys completed and/or finalised 1 January 2011 – 30 June 2011, n=116)

Figure 20: Accreditation outcomes of EQUIP 4 surveys (surveys completed and/or finalised 1 January 2011 – 30 June 2011, n=116)

Figure 21: Distribution of EQUIP 4 ratings across all criteria during survey (surveys completed and/or finalised 1 January 2011 – 30 June 2011, n=116)

<table>
<thead>
<tr>
<th>Rating</th>
<th>Mandatory criteria (116 surveys)</th>
<th>Non-mandatory criteria (59 surveys)</th>
<th>All criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>OA</td>
<td>4</td>
<td>7</td>
<td>11 (0.3%)</td>
</tr>
<tr>
<td>EA</td>
<td>309</td>
<td>179</td>
<td>488 (14.1%)</td>
</tr>
<tr>
<td>MA</td>
<td>1304</td>
<td>1542</td>
<td>2846 (82.4%)</td>
</tr>
<tr>
<td>SA</td>
<td>5</td>
<td>35</td>
<td>40 (1.2%)</td>
</tr>
<tr>
<td>LA</td>
<td>0</td>
<td>0</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>N/A</td>
<td>2</td>
<td>65</td>
<td>67 (1.9%)</td>
</tr>
<tr>
<td>Totals</td>
<td>1624</td>
<td>1828</td>
<td>3452</td>
</tr>
</tbody>
</table>

Figure 22: Ratings for EQUIP 4 mandatory criteria surveyed at OWS and PR (surveys completed and/or finalised 1 January 2011 – 30 June 2011, n=116)

<table>
<thead>
<tr>
<th>Criterion No.</th>
<th>Related to</th>
<th>N/A</th>
<th>LA</th>
<th>SA</th>
<th>MA</th>
<th>EA</th>
<th>OA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.1</td>
<td>Assessment system</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>76%</td>
<td>24%</td>
<td>0%</td>
</tr>
<tr>
<td>1.1.2</td>
<td>Planned &amp; delivered in partnership with consumer / patient</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>83%</td>
<td>17%</td>
<td>0%</td>
</tr>
<tr>
<td>1.1.3</td>
<td>Consent</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>96%</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>1.1.4</td>
<td>Care evaluation</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>68%</td>
<td>31%</td>
<td>1%</td>
</tr>
<tr>
<td>1.1.5</td>
<td>Discharge and transfer of care</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>83%</td>
<td>17%</td>
<td>0%</td>
</tr>
<tr>
<td>1.1.8</td>
<td>Health record</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>91%</td>
<td>7%</td>
<td>1%</td>
</tr>
<tr>
<td>1.5.2</td>
<td>Infection control</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>65%</td>
<td>34%</td>
<td>0%</td>
</tr>
<tr>
<td>2.1.1</td>
<td>Continuous quality improvement</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>72%</td>
<td>27%</td>
<td>1%</td>
</tr>
<tr>
<td>2.1.2</td>
<td>Risk management</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>78%</td>
<td>22%</td>
<td>0%</td>
</tr>
<tr>
<td>2.1.3</td>
<td>Incident and complaints management</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>74%</td>
<td>26%</td>
<td>0%</td>
</tr>
<tr>
<td>3.1.3</td>
<td>Credentialling and scope of clinical practice</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>89%</td>
<td>10%</td>
<td>0%</td>
</tr>
<tr>
<td>3.1.5</td>
<td>Corporate and clinical policies</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>87%</td>
<td>13%</td>
<td>0%</td>
</tr>
<tr>
<td>3.2.1</td>
<td>Workplace Health and Safety (including dangerous goods, hazardous substances and radiation, manual handling)</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>79%</td>
<td>19%</td>
<td>1%</td>
</tr>
<tr>
<td>3.2.4</td>
<td>Emergency and disaster management</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>84%</td>
<td>15%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Figure 23: Ratings for EQuIP 4 non-mandatory criteria surveyed at OWS and PR (surveys completed and/or finalised 1 January 2011 – 30 June 2011, n=116)

<table>
<thead>
<tr>
<th>Criterion No.</th>
<th>Related to</th>
<th>N/A</th>
<th>LA</th>
<th>SA</th>
<th>MA</th>
<th>EA</th>
<th>OA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.6</td>
<td>Ongoing care and management of chronic disease</td>
<td>3%</td>
<td>0%</td>
<td>0%</td>
<td>92%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>1.1.7</td>
<td>Decision making at end of life</td>
<td>14%</td>
<td>0%</td>
<td>2%</td>
<td>69%</td>
<td>14%</td>
<td>2%</td>
</tr>
<tr>
<td>1.2.1</td>
<td>Information about services</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>92%</td>
<td>8%</td>
<td>0%</td>
</tr>
<tr>
<td>1.2.2</td>
<td>Access is appropriate to needs and prioritised according to clinical need</td>
<td>2%</td>
<td>0%</td>
<td>0%</td>
<td>88%</td>
<td>10%</td>
<td>0%</td>
</tr>
<tr>
<td>1.3.1*</td>
<td>Right care and services are provided in the right setting</td>
<td>2%</td>
<td>0%</td>
<td>0%</td>
<td>93%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>1.4.1</td>
<td>Care and services are best evidence based and processes are effective</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>85%</td>
<td>14%</td>
<td>2%</td>
</tr>
<tr>
<td>1.5.1</td>
<td>Medication safety</td>
<td>3%</td>
<td>0%</td>
<td>3%</td>
<td>80%</td>
<td>14%</td>
<td>0%</td>
</tr>
<tr>
<td>1.5.3</td>
<td>Skin integrity and pressure ulcer management</td>
<td>19%</td>
<td>0%</td>
<td>3%</td>
<td>71%</td>
<td>7%</td>
<td>0%</td>
</tr>
<tr>
<td>1.5.4</td>
<td>Falls prevention and management</td>
<td>10%</td>
<td>0%</td>
<td>2%</td>
<td>71%</td>
<td>17%</td>
<td>0%</td>
</tr>
<tr>
<td>1.5.5</td>
<td>Blood management</td>
<td>31%</td>
<td>0%</td>
<td>3%</td>
<td>53%</td>
<td>14%</td>
<td>0%</td>
</tr>
<tr>
<td>1.5.6</td>
<td>Correct patient, procedure, site</td>
<td>7%</td>
<td>0%</td>
<td>2%</td>
<td>83%</td>
<td>8%</td>
<td>0%</td>
</tr>
<tr>
<td>1.6.1</td>
<td>Involvement of consumers</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>80%</td>
<td>19%</td>
<td>0%</td>
</tr>
<tr>
<td>1.6.2</td>
<td>Rights and responsibilities</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>88%</td>
<td>12%</td>
<td>0%</td>
</tr>
<tr>
<td>1.6.3</td>
<td>Cultural and special needs</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>90%</td>
<td>10%</td>
<td>0%</td>
</tr>
<tr>
<td>2.2.1</td>
<td>HR system</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>93%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>2.2.2</td>
<td>Recruitment, selection and appointment</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
<td>93%</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>2.2.3</td>
<td>Continuing employment / professional development</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
<td>92%</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>2.2.4</td>
<td>Learning and development system</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>85%</td>
<td>14%</td>
<td>0%</td>
</tr>
<tr>
<td>2.2.5</td>
<td>Support and workplace relations</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>97%</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>2.3.1</td>
<td>Records management</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
<td>81%</td>
<td>15%</td>
<td>0%</td>
</tr>
<tr>
<td>2.3.2</td>
<td>Information and data management systems</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>92%</td>
<td>8%</td>
<td>0%</td>
</tr>
<tr>
<td>2.3.3</td>
<td>Data and information used effectively</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
<td>92%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>2.3.4</td>
<td>Information and communications technology</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>90%</td>
<td>10%</td>
<td>0%</td>
</tr>
<tr>
<td>2.4.1</td>
<td>Health promotion, health protection and surveillance</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>83%</td>
<td>15%</td>
<td>2%</td>
</tr>
<tr>
<td>2.5.1</td>
<td>Encouraging and governing research</td>
<td>20%</td>
<td>0%</td>
<td>10%</td>
<td>53%</td>
<td>14%</td>
<td>3%</td>
</tr>
<tr>
<td>3.1.1</td>
<td>Strategic and operational planning</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>83%</td>
<td>15%</td>
<td>0%</td>
</tr>
<tr>
<td>3.1.2</td>
<td>Governance structures, delegations &amp; financial management</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>86%</td>
<td>14%</td>
<td>0%</td>
</tr>
<tr>
<td>3.1.4</td>
<td>Non-clinical external services providers</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
<td>95%</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>3.2.2</td>
<td>Buildings, plant, equipment, supplies, utilities and consumables</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>92%</td>
<td>8%</td>
<td>0%</td>
</tr>
<tr>
<td>3.2.3</td>
<td>Waste and environment</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
<td>86%</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td>3.2.5</td>
<td>Security management</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
<td>90%</td>
<td>7%</td>
<td>0%</td>
</tr>
</tbody>
</table>

(*Developmental criterion)
Figure 24: EQuIP 4 AC60 outcomes by State / Territory (surveys completed and/or finalised 1 January 2011 – 30 June 2011, n=116)

Figure 25: EQuIP 4 AC60 outcomes by health sector (surveys completed and/or finalised 1 January 2011 – 30 June 2011, n=116)

Figure 26: Number of EQuIP 4 criteria assessed at AC60 per organisation receiving any AC60 outcome during survey (surveys completed and/or finalised 1 January 2011 – 30 June 2011, n=26)
Figure 27: Number of AC60 outcomes per EQuIP 4 criterion (surveys completed and/or finalised 1 January 2011 – 30 June 2011, n=116; italicised text indicates a mandatory criterion; shaded text indicates the four criteria most frequently associated with an AC60 outcome)

<table>
<thead>
<tr>
<th>Criterion No.</th>
<th>Related to</th>
<th>Function</th>
<th>No. AC60 outcomes</th>
<th>No. HPRs*</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.4</td>
<td>Emergency and disaster management</td>
<td>Corporate</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>1.5.2</td>
<td>Infection control</td>
<td>Clinical</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>3.2.1</td>
<td>Workplace Health and Safety (including dangerous goods, hazardous substances and radiation, manual handling)</td>
<td>Corporate</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>3.1.5</td>
<td>Corporate and clinical policies</td>
<td>Corporate</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>1.1.2</td>
<td>Planned and delivered in partnership with consumer / patient</td>
<td>Clinical</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>2.1.1</td>
<td>Continuous quality improvement</td>
<td>Support</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>2.1.2</td>
<td>Risk management; corporate and clinical</td>
<td>Support</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>2.2.4</td>
<td>Learning and development system</td>
<td>Support</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>1.1.8</td>
<td>Health record</td>
<td>Clinical</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>1.5.1</td>
<td>Medication safety</td>
<td>Clinical</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2.3.1</td>
<td>Records management</td>
<td>Support</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3.2.2</td>
<td>Buildings, plant, equipment, supplies, utilities and consumables</td>
<td>Corporate</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3.2.5</td>
<td>Security management</td>
<td>Corporate</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>39</td>
<td>37</td>
</tr>
</tbody>
</table>

(*HPRs = High Priority Recommendations)

Figure 28: OA ratings awarded against EQuIP 4 criteria (surveys completed and/or finalised 1 January 2011 – 30 June 2011, n=116; italicised text indicates a mandatory criterion)

<table>
<thead>
<tr>
<th>Criterion No.</th>
<th>Related to</th>
<th>OA ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.4</td>
<td>Care evaluation</td>
<td>1</td>
</tr>
<tr>
<td>1.1.7</td>
<td>Decision making at end of life</td>
<td>1</td>
</tr>
<tr>
<td>1.1.8</td>
<td>Health record</td>
<td>1</td>
</tr>
<tr>
<td>1.3.1</td>
<td>Right care and services are provided in the right setting</td>
<td>1</td>
</tr>
<tr>
<td>1.4.1</td>
<td>Care and services are best evidence based and processes are effective</td>
<td>1</td>
</tr>
<tr>
<td>2.1.1</td>
<td>Continuous quality improvement</td>
<td>1</td>
</tr>
<tr>
<td>2.4.1</td>
<td>Health promotion, health protection and surveillance</td>
<td>1</td>
</tr>
<tr>
<td>2.5.1</td>
<td>Encouraging and governing research</td>
<td>2</td>
</tr>
<tr>
<td>3.2.1</td>
<td>Workplace health and safety (including dangerous goods, hazardous substances and radiation, manual handling)</td>
<td>1</td>
</tr>
<tr>
<td>3.2.3</td>
<td>Waste and environment</td>
<td>11</td>
</tr>
</tbody>
</table>
ACHS accreditation programs are reviewed at least every four years to ensure their ongoing relevance to the Australian healthcare system and their applicability to all types of health services.

The review of EQuIP 4 was conducted during 2009, and involved extensive consultation with working, reference and advisory groups, and other stakeholders. The draft program was subjected to field review and piloting across organisations varying in size, location and health sector, before the finalised content was approved by the ACHS Board. The revised EQuIP5 program was implemented 1 July 2011.

As a result of the review of EQuIP 4, the content of a number of criteria was separated, combined or broadened in scope, as appropriate. The other key changes to be found in EQuIP5 are:

- the inclusion of the developmental criterion 1.3.1 (appropriate care and services) as a full criterion
- the designation of criterion 1.5.1 (medication management) as mandatory
- the addition of non-mandatory criterion 1.5.7 (nutrition management)

Furthermore, a decision was taken to designate the evaluation rating level ‘Marked Achievement’ (MA) in EQuIP5, rather than ‘Moderate Achievement’, as better reflecting the level of performance by organisations. The awarding of an Outstanding Achievement (OA) rating under EQuIP5 is now determined by the ACHS survey team only; organisations are not required to self assess. The EQuIP5 accreditation program consists of 3 functions, 13 standards and 47 criteria; 15 of the 47 criteria are mandatory.

Structure of standards

The EQuIP standards have a hierarchical structure consisting of functions, standards, criteria and elements. The three functions – Clinical, Support and Corporate – group standards and criteria with common themes; the elements are the specific requirements within each criterion against which organisations are assessed during survey.

The structure of the standards, criteria and elements of the ACHS EQuIP accreditation program is specifically designed to guide organisations through increasing levels of performance over time. The elements reflect suggested areas in which the organisation can demonstrate performance at each level of achievement, and provide direction for achieving better practice. Organisations are not limited to the stated elements and are encouraged to demonstrate innovation that shows either equivalent or higher levels of achievement to the stated elements.
Function 1 - Clinical
Standard 1.1 Consumers / patients are provided with high quality care throughout the care delivery process.

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Little Achievement (LA)</th>
<th>Some Achievement (SA)</th>
<th>Moderate Achievement (MA)</th>
<th>Extensive Achievement (EA)</th>
<th>Outstanding Achievement (OA)</th>
<th>Leadership</th>
</tr>
</thead>
</table>
| 1.1.1     | Assessment ensures current and ongoing needs of the consumer / patient are identified. This is a mandatory criterion | a) Guidelines are made available to assist staff to assess physical, spiritual, cultural, psychological and social needs, including the identification of 'at risk' consumers / patients. b) Guidelines are available on the specific needs of self identified Aboriginal and Torres Strait Islander consumers / patients. c) There is policy / guidelines to assess a consumer / patient’s need for health promotion. d) Referral systems to other relevant service providers exist. a) Assessment guidelines based on current professional standards and evidence-based practice are implemented b) Assessments are conducted in a timely manner. c) The needs of 'at risk' consumers / patients are identified and managed. d) A support person / carer is involved in the assessment system where appropriate. e) Information is provided to the consumer / patient on their health status. f) Planning for discharge / transfer of care commences at assessment, is multidisciplinary where appropriate, and coordinated. a) The assessment process is evaluated and improved as required. b) Processes for assessing and managing 'at risk' consumers / patients are evaluated and improved as required. c) Planning for discharge / transfer of care is evaluated to ensure: (i) consistently occurs (ii) is multidisciplinary where appropriate (iii) meets consumer / patient and carer needs. d) Referral systems are evaluated and improved, as required. a) Assessment and discharge / transfer of care planning practices are compared with internal and external systems and improvements are made to ensure better practice. and/or b) The organisation undertakes research on assessment and discharge / transfer of care practices and improvements are made to ensure better practice. a) The organisation demonstrates it is a leader in consumer / patient assessment and separation planning.
Mandatory criteria

Mandatory criteria are selected by the ACHS Standards Committee and ratified by the Board. They address those areas of the accreditation program in which a stated level of performance must be demonstrated, with the aim of creating and maintaining a safe environment for the delivery of safe, quality care, and/or because they are fundamental to consumer rights.

The EQuiP5 program contains 47 criteria, of which 15 are mandatory. In order to achieve ACHS accreditation, an organisation must be awarded at least an MA rating (Marked Achievement; see ‘Levels of achievement’, below) in all mandatory criteria.

Levels of achievement

Organisations and surveyors use the elements in each criterion as a guide to rate the level of an organisation’s achievement. The elements describe practices that contribute to achievement at each level. Organisations carry out self assessments against the elements, and surveyors use the evidence provided to inform their subsequent onsite surveys. While the manner in which the elements are implemented may differ between organisations, it is important that the organisation’s staff members demonstrate that their practices address the intent of the element.

The cycle of events in which healthcare organisations submit at least one activity every year of their four-year EQuiP membership period is shown in Figure 31.

---

**Figure 30: Levels of achievement within the EQuiP5 standards**

<table>
<thead>
<tr>
<th>Awareness</th>
<th>Implementation</th>
<th>Evaluation</th>
<th>Excellence</th>
<th>Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic requirements met. Policy and legislative compliance is in place</td>
<td>Systems have been developed and implemented</td>
<td>Data are collected; evaluation of the system occurs to ensure the system works effectively. Improvement efforts support better results</td>
<td>Benchmarking and/or research and/or advanced implementation strategies and/or excellent outcomes are achieved</td>
<td>The organisation is a peer leader in systems and outcomes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LA</th>
<th>SA</th>
<th>MA</th>
<th>EA</th>
<th>OA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little Achievement</td>
<td>Some Achievement</td>
<td>Marked Achievement</td>
<td>Extensive Achievement</td>
<td>Outstanding Achievement</td>
</tr>
<tr>
<td>LA elements</td>
<td>LA elements plus the SA elements</td>
<td>LA, SA elements plus the MA elements</td>
<td>LA, SA, MA elements plus any ONE of the EA elements</td>
<td>All elements in LA, SA, MA, EA and OA</td>
</tr>
</tbody>
</table>
Phase 1
Self assessment
- New members provide a self assessment against all criteria.
- Existing members provide a self assessment of progress against the recommendations from the Periodic Review.
- Members update and submit their register of key organisational risks (risk register).

Phase 2
Organisation-Wide Survey (OWS)
- Approximately 6 weeks prior to OWS, members provide ACHS with a self assessment against all criteria and progress against recommendations. An updated risk register is provided to the surveyors at survey.
- **All criteria** are surveyed and progress on recommendations from the Periodic Review is reviewed.

Phase 3
Self assessment
- Members provide a self assessment of progress against the recommendations from the Organisation-Wide Survey.
- Members update and submit their register of key organisational risks (risk register).

Phase 4
Periodic Review (PR)
- Approximately 6 weeks prior to OWS, members provide ACHS with a self assessment against all **mandatory criteria** and progress against recommendations. An updated risk register is provided to the surveyors at survey.
- **Mandatory criteria** are surveyed and progress on recommendations from the Organisation-Wide Survey is reviewed.

Figure 31: The EQuIP5 accreditation cycle
APPENDIX B
BACKGROUND ON ACHS AND EQUIP5

Accreditation awards
An organisation’s achievements are reviewed against the EQUIP5 standards and the survey team provides an objective account of their findings, including a recommendation for the organisation’s accreditation status. The accreditation decision is based on the content of the survey report and pre-determined rules.

Figure 32: Accreditation awards following ACHS surveys

**Full Accreditation (4 years)**
- A Marked Achievement (MA) rating level or higher in all EQUIP mandatory criteria
- All previous recommendations are addressed
- Receive no High Priority Recommendation (HPRs)
- Have no significant risks

**Conditional Accreditation (1 year)**
- A Some Achievement (SA) rating level in six or more non-mandatory criteria irrespective of risk level
- High risk in any non-mandatory criteria
- Moderate risk recommendations from previous survey not addressed
- High Priority Recommendations (HPRs) in up to any two criteria that are not able to be resolved within 60 days

**Non-Accreditation**
- A Some Achievement (SA) rating level in one or more mandatory criteria that are not able to be satisfactorily resolved within 60 days
- High risk recommendations from previous survey not addressed
- High Priority Recommendations (HPRs) in more than any two criteria that are not able to be resolved within 60 days

Advanced Completion survey
If the survey team considers that a healthcare organisation does not meet the required Marked Achievement (MA) level in a mandatory criterion, if the organisation receives a High Priority Recommendation (HPR) for any criterion, or if it is assessed that there is high risk in a non-mandatory area, accreditation cannot be achieved or continued. If this situation arises, the organisation may be offered an Advanced Completion in 60 Days survey (AC60).

In these cases, the outcome of the original survey is not finalised until a review of the action to address the AC60 occurs. ACHS surveyors return to the organisation within 60 days following the initial survey and if the organisation is considered to have addressed the identified issues that led to the AC60, then accreditation can be awarded, being either confirmed as full, four-year accreditation or continued for one year only (i.e. conditional accreditation). In cases where the surveyors assess that the AC60 has not been addressed within the appropriate time frame, the organisation is not accredited.

ACHS membership
Between 1 January 2011 – 31 December 2012, ACHS membership numbers remained steady, increasing from 1450 to 1462. These figures include associate members, who share a single grouped membership within which each member organisation is individually assessed during a single survey. Each associate member must achieve a positive survey outcome for accreditation to be awarded. The number of associate members reflects the centralisation of health service delivery.

At 31 December 2012, of the total ACHS membership 928 (63%) members were in the public sector, and 534 (37%) members were in the private sector. This ratio remained constant over the transition from EQUIP 4 to EQUIP5.

By State / Territory, the composition of ACHS membership remained essentially constant between the survey periods 2009 – 2010 and 2011 – 2012, the most significant changes being a 6% drop in membership in NSW and a 5% increase in membership in Queensland. These were accompanied by slight increases in South Australia and Tasmania and a slight drop in Victoria, while in Western Australia, the Northern Territory and the ACT membership numbers remained steady. During the 2011 – 2012 period, ACHS welcomed a new member from Norfolk Island.
Figure 33: ACHS membership by sector (31 December 2012, n=1462)

Figure 34: ACHS membership by State / Territory (31 December 2012, n=1462)

Figure 35: ACHS membership by organisation type
(31 December 2012, n=1462)

(* “Other services” includes Divisions of General Practice, correctional health, agencies – health professional, corporate healthcare)
ACHS surveyors

The strength of ACHS and its accreditation programs is built upon the assessment of healthcare organisations by a team of surveyors who are independent, experienced, and currently or recently employed within the healthcare industry, and who have been involved in preparing an organisation for accreditation. The selection and recruitment processes used ensure that ACHS is able to compose survey teams with appropriate backgrounds and adequate numbers of the different specialties required. Categories of surveyors include medical clinicians, who are clinical specialists, visiting medical specialists or staff specialists; allied health specialists, who are responsible for administering clinical health care across a number of disciplines; health service managers with recent broad experience in health care; quality managers responsible for a number of service areas, with at least two years’ experience; and consumers with contemporary understanding of quality principles, who have been recently active in healthcare facilities and have knowledge of the accreditation process.

While the majority of the ACHS’ team of 356 surveyors are drawn from the areas of administration, nursing and medicine, a focused recruitment of allied health practitioners and consumer representatives has been undertaken to broaden the expertise of the surveying team and more appropriately match surveyors to the organisations they assess.

ACHS surveyors are required to participate in a minimum number of surveying and training days each year, to ensure that their skills remain current. Most surveyors volunteer their own time and many are supported by their employers who generously make them available to ACHS. Surveyors who are not employed receive a per diem honorarium payment from ACHS.

From 1 January 2011 – 31 December 2012, a total of 618 surveys were conducted, comprising an aggregated 6254 surveyor days. These figures include all categories of ACHS survey, that is, all surveys under the various sets of EQuiP standards as well as related surveys including AC60s, conditional reviews, alignment surveys and certifications; surveys under other programs including ACHS Quality for Divisions Network; surveys and assessments against external standards including the National Standards for Mental Health Services, Department of Human Services Standards, the Common Community Care Standards and, during 2012, gap analyses against the draft National Safety and Quality Health Service (NSQHS) Standards.
Figure 37: ACHS surveyor workforce by type (31 December 2012, n=356)

- Nursing: 38.5%
- Administrator: 30%
- Medical / dental: 24.5%
- Allied Health: 3%
- Consumer: 4%

Figure 38: ACHS surveyors by type and classification (31 December 2012, n=356)

- Nursing: 56%
- Administrator: 44%
- Medical / dental: 68%
- Allied Health: 32%
- Consumer: 70%
- Honorarium: 14%
- Volunteer: 10%

Figure 39: Surveyor days by surveyor type (EQuIP 4 and EQuIP5 surveys, 2011 – 2012, n=618)

- Nursing: 3044
- Administrator: 1203
- Medical / dental: 197
- Allied Health: 109

Figure 40: Surveyor days by surveyor type per year (2011 – 2012, n=618)

The following are summaries of the surveyors' comments with respect to the awarding of an OA rating against the ACHS accreditation criteria during survey between 1 January 2011 – 31 December 2012, arranged by program and criterion.

Member organisations were surveyed against the EQuIP 4, EQuIP5, EQuIP5 Corporate Health Services and ACHS Quality for Divisions Network accreditation standards. For individual organisational performance in this area, see Figures 41, 42 and 43.

### OA ratings against EQuIP 4

Figure 41: Organisations that achieved OA ratings in EQuIP 4 surveys conducted and/or finalised between 1 January 2011 – 30 June 2011 (n=116, italicised text indicates a mandatory criterion)

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Criteria with OA rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barwon Health, Geelong, Vic</td>
<td>3.2.1</td>
</tr>
<tr>
<td>Calvary Health Care ACT, Bruce, ACT</td>
<td>2.1.1</td>
</tr>
<tr>
<td>Eastern Palliative Care Association Inc., Nunawading, Vic</td>
<td>1.1.8</td>
</tr>
<tr>
<td>The Royal Children’s Hospital, Parkville, Vic</td>
<td>2.5.1</td>
</tr>
<tr>
<td>The Royal Women’s Hospital, Parkville, Vic</td>
<td>1.1.7, 1.3.1*, 1.4.1, 2.4.1, 2.5.1</td>
</tr>
<tr>
<td>St John of God Murdoch Hospital, Murdoch, WA</td>
<td>3.2.3</td>
</tr>
<tr>
<td>Toowong Private Hospital, Toowong, Qld</td>
<td>1.1.4</td>
</tr>
</tbody>
</table>

(*Developmental criterion)

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### Mandatory criterion 1.1.4

**Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.**

- **Toowong Private Hospital Toowong, Qld**
  - The evaluation of care is constant, comprehensive, efficient and multidisciplinary. The range of data and information collected is extensive in quantity and high in quality.
  - The utilisation of accurate patient / clinical data facilitates the staff / patient therapeutic relationship, which results in the capture of high quality and accurate data for analysis, which in turn funnels into care plans and use by the treating medical officers.
  - The refined data are available in comprehensive and well-summarised reports for staff and patients and contribute to a range of national databases. The Health of the Nation Outcomes Scales (HoNOS) data are benchmarked with between 46 - 50 other hospitals and the results of these comparisons demonstrate that the organisation is functioning at a high level.
  - The scope of evaluation of the many and varied day programs is regular and consistent, and includes considerable follow-up evaluations.

### Criterion 1.1.7

**Systems exist to ensure that the care of dying and deceased consumers / patients is managed with dignity and comfort.**

- **The Royal Women’s Hospital Parkville, Vic**
  - RWH is a tertiary care provider of services to women and babies. As part of the service, it provides tertiary-level care to women who experience reproductive loss or who are terminal due to a women’s health-related cancer.
  - There are extensive systems in place to support women and their families. This was demonstrated to the survey team through the effective Bereavement Response System.
The role of the Reproductive Loss Coordinator is unique in Australia.

Experts in Anatomical Pathology assist in the provision of training and education to staff, as well as evaluation of the loss. Multi-faith guidelines and the Sacred Space contribute to the comprehensive service.

RWH offers a non-religious funeral service for families who have a pregnancy loss before 20 weeks’ gestation.

Each year RWH invites women and their families to an annual memorial service. Staff who have been involved in their care are also invited.

As part of its participation in the Western and Central Melbourne Integrated Cancer Service (WCMICS), RWH has reviewed and implemented changes in practice associated with the death and dying of women with cancer, including updated palliative care guidelines and processes.

An excellent new initiative “My Kite Will Fly” has been introduced for the families of women dying from a terminal illness. This program has been developed for patients and their young families affected by cancer. The program uses photographs, art and drawings to provide children with an expressive medium to deal with their mother’s terminal illness.

From a staff perspective, RWH provides exceptional support through debriefing processes as well as the Employee Assistance Program.

Peer healthcare providers and tertiary education facilities across Australia seek information, assistance with guideline development, education and training from RWH, who are identified nationally as leaders in mortality management and end-of-life care for women and babies.

RWH demonstrated to the survey team that it is one of the best and that it has taken a leadership stance in the area of dignity in death.

**Mandatory criterion 1.1.8**

The health record ensures comprehensive and accurate information is recorded and used in care delivery.

**Eastern Palliative Care Association Inc.**  
Nunawading, Vic

- A health records policy and process map supports the management, storage, archiving and disposal of the PalCare IT medical record, which is appropriately referenced to legislation.
- A single patient identification number is allocated by the intake officer at first contact.
- All staff used the PalCare software program, which is a paperless health record designed by EPC in conjunction with a software provider.
- Staff receive training in the PalCare program on commencement of employment.
- Since its development, it has been evaluated on a number of occasions and many changes have been made.
- The program now allows all documents to be scanned into the individual patient record. Event data are entered following each visit and the program then collates the Palliative Care Outcomes Collaboration (PCOC) statistical data.

Entries in the health record are now completed in the client’s home and were seen to be both timely and accurate.

Access to the medical electronic record is password protected. Old paper-based health records are kept in a locked compactus in a locked area of the building. Access to records is audited, and the effectiveness of scanning is evaluated for error rates.

The PalCare program is now used across nine palliative care services in New Zealand and five in Australia. It will be presented at the Palliative Care Conference in Hong Kong later in the year.

**Criterion 1.3.1**

Health care and services are appropriate and delivered in the most appropriate setting.

**The Royal Women’s Hospital**  
Parkville, Vic

- Excellent outcomes have been achieved through RWH’s commitment to appropriate care. Care is delivered in very modern and well-maintained buildings with state-of-the-art equipment.
- There is a formal credentialling system for medical, nursing and allied health staff and regular reviews of the appropriateness of care through a number of forums, and an extensive suite of clinical indicators is collected, reported and compared against peers.
The care that is delivered at RWH is of a high quality, clinically appropriate, and aligned with the hospital's Statement of Priorities, Strategic Plan and Clinical Services Plan 2010 – 2013. The Quality of Care Report also contains numerous examples of excellence.

The Sexual Assault Prevention Program for Secondary Schools (SAPPSS) managed by CASA House is an outstanding program, which received due recognition through being the worthy recipient of the 2010 Victoria Public Healthcare Award.

Simultaneously, the introduction of the Prosima device in pelvic floor surgery to prevent recurrence of prolapse and incontinence has been very successful.

The Chronic Pelvic Pain Clinic is based on an innovative multidisciplinary approach to managing women’s chronic pain.

Evaluation of this program has shown pleasing results for 50% of the women who have accessed this service.

Furthermore, the newborn model of care has seen sustained improvements in families’ and staff satisfaction rates.

The strategic vision that has resulted in the establishment of the five research centres is commendable.

There is evidence that RWH's research informs practice, not only at RWH but at a state, national and international level. There is recognition that RWH is a highly regarded leader in the areas of women's health and neonatal care.

The Royal Women's Hospital Parkville, Vic

There is a significant amount of evidence-based resources, underpinning care delivery and available on the RWH intranet site, and there are frequent requests for access to the Clinical Practice Guidelines.

The Centre for Women's Mental Health is the first gender-based mental health research centre in Australia.

RWH was awarded two highly competitive and prestigious grants from the National Health and Medical Research Council (NHMRC) of Australia to undertake seminal research work in Newborn Medicine and Infectious Diseases.

At the same time, RWH has had a major role in the evaluation and clinical introduction of treatments such as vaccines against Human Papillomavirus (HPV) in young women and caffeine in very preterm babies.

The research team has been a leader in the development and application of molecular testing for the detection of sexually transmitted infection (STI) of marginalised, remote populations.

The methods established have been utilised both nationally and internationally in a number of projects, including STI prevalence in various populations such as antenatal patients in Vanuatu, Samoa, Thailand, China and Mongolia.

The number of research publications continues to increase and more importantly, the rest of the world is reading and quoting work that has been undertaken by RWH researchers.

Participation in the Health Roundtable data reviews and meetings indicates that RWH effectively interrogates its clinical indicators in order to evaluate the use of evidence-based care.

The surveys noted that RWH received the 2008 Victorian Public Hospitals Premier’s Award for Excellence for improving cancer care by combining breast services with the Royal Melbourne Hospital. This is an outstanding achievement.

The maternity clinical information system has replaced all paper records for labour and birth care, enabling improved data quality and more timely access to outcome data.

The COSMOS trial, the first such trial in Australia, is being undertaken to determine if caseload midwifery influences caesarean section rates.

The Project Primip has already demonstrated that research can positively influence clinical practice. Simultaneously, the work that has been carried out with HIV discordant couples is commendable, as is the work with ambulatory hysteroscopy.

Furthermore, the STEPS program has resulted in a reduction in long waits and an increase in gynaecological surgery throughput.

The review and restructure of the Access Centre have improved the referral turnaround time by having a single point of electronic entry for all referrals.
Calvary Health Care ACT Bruce, ACT

The surveyors saw many examples of an integrated and ‘mature’ continuous quality improvement system.

Quality is supported and reflected from the top down within all areas / departments of the organisation. Staff take great pride in their work. Quality is embedded in the day to day activities of all staff. Medical staff are working alongside their nursing and allied health colleagues to continually strive for improvements in patient care.

Medical staff are active participants in governance and quality committees.

Some particular examples of quality in the organisation include the following:
- The designation of clinical champions on each ward in the areas of pressure ulcers, falls, medication safety, blood safety and infection control. Each one wears a colour-coded name badge identifying them as a ‘champion’ for the particular area. Unsurprisingly, blood safety is red!
- There is a long list of research and publications attributed to CHC ACT staff for 2010.
- The dietitian has been instrumental in contributing to the development of the new ACHS standard on nutrition. She will be formally recognised by her professional organisation for her contribution to this work.

The Royal Women’s Hospital Parkville, Vic

- RWH demonstrates a strong commitment to health promotion, disease prevention and public health, and the surveyors validated the eight key improvements that have been implemented.
- The introduction of a smoke-free environment has been well received by staff, patients and visitors.

The patient and staff vaccination programs which enable access to the H1N1 flu vaccine, cervical cancer vaccine, varicella and pertussis (whooping cough) boosters are all excellent initiatives.

Simultaneously, leading the implementation of the state and national health promotion programs targeting Violence against Women is commended.

The program delivered by the CASA House in relation to sexual assault prevention in secondary schools is an excellent example of addressing identified issues in the community and meeting the needs of individual groups and is the recipient of the 2010 Victorian Public Healthcare Award.

The role that RWH undertakes in the advocacy of women’s contemporary health issues has been recognised by the Australian Government, because of the leadership role that RWH has undertaken in relation to informing the general public and health sector about the importance of decriminalising abortion.

The appointment of a Strategic Advisor to provide relevant advice on policy and law reform in order to support government submissions is another example of RWH’s commitment to women’s public health issues.

There was a significant amount of evidence which showed that RWH consistently engages in extensive benchmarking at state-wide, national and international levels.

The production of evidence-based clinical practice guidelines as a resource available through the RWH intranet for staff and other health professionals was also noted.

The women’s health research that is currently being conducted within the five research centres that RWH has set up is most

Mandatory criterion 2.1.1
The organisation’s continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.

ACHS National Report on Health Services Accreditation Performance 2011 - 2012
impressive and this work is internationally recognised, published and utilised as a resource by the WHO.

- The seminal work with HIV discordant couples is commendable.

- Other work that was well supported with evidence was the Pregnancy Advisory Service and the Women with Individual Needs program.

- The new program which targets young women and promotes health and wellbeing via social networking is a further example of targeting specific needs groups with appropriate services and high levels of community consultation.

**Criterion 2.5.1**
The organisation’s research program promotes the development of knowledge and its application in the health care setting, protects consumers/patients and manages organisational risks associated with research.

**The Royal Children’s Hospital Parkville, Vic**

- The Campus Research Committee, reporting to the Campus Council, is appropriately established and ensures coordinated and comprehensive research between campus partners the RCH, the Murdoch Children’s Research Institute, and the University of Melbourne Department of Paediatrics. The committee has overall accountability for promoting research, overseeing ethical research, monitoring performance requirements of the committee, and research office support for education. The committee oversees the annual Research Report publication.

- The appointment of a campus Director of Clinical Research and the establishment of “theme” directors of research, which include all clinical disciplines, will enhance the already high research profile. A Campus Research Week complements the promotion of research strategy, as do the weekly Grand Rounds and quarterly Theme Newsletters.

- The implementation of a risk-based review process, stratifying low-to-high risk projects, provides increasing efficiency of process. Additionally, a peer review process prior to submission to ethics review involves each head of service and peers in the governance of quality of product and ensures valid process.

- A monitoring and auditing program ensures researchers meet standards, monitors project progress or outcomes including adverse events, and maintains standards of security of records, approvals and discontinuation compliance, and annual reports. Research is encouraged in all clinical areas and disciplines.

- The research program aligns with the hospital’s strategic direction, quality and improvement culture, commitment to high standards of care, and the attraction and retention of highly qualified and experienced staff.

- Contributions to the research portfolio include medical, nursing and allied health projects. Staff performance review will include reference to research achievement as an element of accountability.

- A 2010 NHMRC audit of research governance and practice demonstrated a very high level of achievement in meeting required standards. Of note by NHMRC was the pre-submission peer review process, the robust monitoring program and the improvement ethos of the governing body, enabling the hospital’s aspirations to implementation of Harmonisation of Multi-centre Ethical Review (HoMER) principles as a single ethical and scientific review site for multi-centre research.

- Demonstrating excellence in the translation of research to clinical and public health outcomes is an integral part of the performance assessment of the research themes.

- These are a number of examples of research programs or projects undertaken on campus, which have impacted clinical outcomes and changes to clinical practice at local and state levels, and some at national and international levels (more information is available in the Campus Research Report 2009):
  - Safety and efficacy of procedural sedation in the Emergency Department
  - Development of rotavirus vaccines
  - Impact of infant sleep intervention on infant sleep and maternal wellbeing
  - Victorian Infant Hearing Screening Program (ViHSP)
  - Neurocognition and psychological outcomes of Type 1 diabetes
  - Improving repeatability, validity and clinical utility of gait analysis measurements to support orthopaedic surgery in Cerebral Palsy.

- Clinical research is also driven by the hospital’s quality assurance program; for example, a randomised control trial comparing two intravenous fluids was designed to answer questions raised through the hospital’s own quality assurance program.

- RCH demonstrates extensive contribution to knowledge and a broad-based multidisciplinary research competency, adheres to best-practice standards of governance, and actively fosters education and support by
scholarship to aspiring and existing contributors to research. It is for these reasons that an OA rating is appropriate.

The Royal Women’s Hospital Parkville, Vic

- The strategic vision, commitment to the development of partnerships, and dedication to research have enabled staff to achieve excellent outcomes for women and newborn babies, not only in Australia but in other countries around the world.
- The research that is carried out by the five research centres (Pregnancy, Neonatal, Gynaecology, Infectious Diseases and Mental Health) directly informs and supports the diverse range of health services that are available at RWH for women and neonates.
- It is noted that each Research Centre has Professorial leadership, there are joint appointments with the University of Melbourne, and the research has received due recognition at state, national and international levels.
- There are sound clinical governance processes in place to support the work of researchers.
- External evaluation has been carried out in relation to the Neonatal Research Program and the Pregnancy Research Centre.
- The five NHMRC grants held by the Centre for Infectious Diseases and the five clinical trials being undertaken through the Centre for Women’s Cancer Research will support scientists to undertake meaningful work in the areas of mother to baby infections and women-specific cancers.
- The excellent translational research that has informed the caffeine treatment that is given to premature babies in order to manage apnoea, the administration of magnesium sulphate to pregnant women to prevent cerebral palsy, and the use of air rather than oxygen in premature babies, is recognised as best practice and these treatment modalities are being used worldwide.
- It is pleasing to note the increase in research publications by 13% and the 350 peer reviewed publications that have been published since 2008.
- The Research Department has presented research data at 59 scientific and clinical meetings in 2008/09 of which 20 were national and 40 were international meetings.
- The support provided to seven PhD candidates is outstanding. Hopefully, the availability of research scholarships will increase over time.
- To conclude, the visit to the Research Precinct was very interesting and informative. The commitment of the scientists was palpable and very impressive.

Barwon Health Geelong, Vic

- There is an excellent safety Framework in place at Barwon Health supported by documented policies aimed at ensuring a safe work environment. These include, but are not limited to, OHS, return to work and identification and control of hazardous goods. Staff expressed confidence in their ability to identify risk and make organisational changes with the use of the RiskMan system of incident reporting.
- The Occupational Health and Safety Committees are responsive to organisational change, and work has been undertaken to ensure delegates are more actively involved and engaged in the work of these committees, particularly through the use of information technology via SharePoint.
- A number of activities are evidence of Barwon Health’s safety management system. These include investment in mobile hoists, additional training in manual handling through the “Smart Move – Smart Lift” program and the work of Barwon Medical Imaging (BMI) with the use of the MED RAD INTEGRA system. The survey team noted that BMI had recently been awarded the Victorian Government’s Enterprise Award which is a significant achievement.
- Barwon Health demonstrates outstanding leadership across all elements of this criterion, including development and dissemination of the Management of Violence and Aggression International Training (MOVAIT) aggression management training both within and outside of health.
- The normalising approach of the return to work program – i.e. staff injured outside of work receive the same program as those injured at work – has resulted in superior performance in comparison to peers (42.9% v 35.4%) and been identified as good practice worthy of dissemination by WorkSafe. It is evident that Barwon Health is regarded as a leader and is used as a state and national reference site.
APPENDIX C
OA SUMMARIES BY CRITERION

Criterion 3.2.3
Waste and environmental management supports safe practice and a safe environment.

St John of God Health Care – Murdoch Murdoch, WA

- The survey team received a comprehensive presentation on broad-ranging initiatives and projects which demonstrated SJOGM’s achievement in this criterion.
- The environmental sustainability program strategy and the action to reduce energy use includes the installation of large-scale solar panels to reduce gas consumption for heating of the hospital’s domestic hot water system, which has been operational since mid-January, 2011.
- USBs are provided to graduate nurses as a means of reducing the need to copy numerous documents for training and development purposes.
- The divisional management committee members use iPads in place of hardcopy for all committees.
- An environmental sustainability workshop was conducted by SJOGM for major local organisations in the precinct with a view to fostering relationships and to determine sustainability priorities for the precinct. In addition to information provided at orientation, all caregivers now have access to an online environmental training package.
- There is excellent awareness and action relating to recycling overall.
- The energy management policy details the process for monitoring energy consumption and tracking, monitoring and reporting systems that allow target setting and evaluation and there is also a water efficiency policy.
- The SJOGM hospital has been proactive in partnering with the department of transport to implement the "green travel plan" as a means of reducing caregiver and visitor reliance on single occupancy transport.
- The SJOGM hospital is able to demonstrate leadership at the local level, namely the immediate Murdoch precinct, leadership within the SJOG hospital group through a vast array of strategies, and leadership within the WA health industry through the solar water system.
- In addition the Manager, Environmental Sustainability, participated in the WA Health Department working group to develop an operational directive on the management and disposal of clinical and related waste and the WA Health Department and several hospitals use the SJOGM waste education posters.
- Leadership at a national level has also been demonstrated at conferences and through several publications.
**OA ratings against EQuIP5**

Figure 42: Organisations that achieved OA ratings in surveys against EQuIP5 conducted between 1 January 2011 – 31 December 2012 (n=341; italicised text indicates a mandatory criterion)

<table>
<thead>
<tr>
<th>Organisations</th>
<th>Criteria with OA rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT Health, Canberra, ACT</td>
<td>1.5.3</td>
</tr>
<tr>
<td>Cabrini Health, Malvern, Vic</td>
<td>2.3.4</td>
</tr>
<tr>
<td>The Children's Hospital at Westmead, Westmead, NSW</td>
<td>1.1.7, 1.1.8, 1.2.1, 1.6.1, 2.1.1, 2.3.3, 2.4.1</td>
</tr>
<tr>
<td>Country Health SA - Port Augusta Hospital, Hawker, Roxby Downs, Woomera, Leigh Creek &amp; Quorn Health Services – Port Augusta, SA</td>
<td>1.6.3</td>
</tr>
<tr>
<td>Country Health SA - Upper South East Cluster – Bordertown Kingston &amp; Naracoorte – Bordertown, SA</td>
<td>1.4.1</td>
</tr>
<tr>
<td>Currumbin Clinic, Currumbin, Qld</td>
<td>1.5.7</td>
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<tr>
<td>Donvale Rehabilitation Hospital, Donvale, Vic</td>
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<tr>
<td>Hepburn Health Service, Daylesford, Vic</td>
<td>3.2.3</td>
</tr>
<tr>
<td>Hunter New England LHD - Armidale Rural Referral Hospital, Armidale, NSW</td>
<td>1.5.3</td>
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<td>Hunter New England LHD – Greater Newcastle Cluster, Wallsend, NSW</td>
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<td>Kooweerup Regional Health Service, Kooweerup, Vic</td>
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<td>Maitland Private Hospital, Green Hills, NSW</td>
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<td>Melbourne Health, Parkville, Vic</td>
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<td>Mercy Health &amp; Aged Care Central Queensland, Rockhampton, Qld</td>
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<td>Metro North Hospital and Health Service (MNHHS) – Royal Brisbane and Women’s Hospital and MNHHS Oral Health Services, Herston, Qld</td>
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<td>Metro South Clinical Tuberculosis Service, Wooloongabba, Qld</td>
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<td>The National Capital Private Hospital, Garran, ACT</td>
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<td>St John of God – Subiaco Hospital, Subiaco, WA</td>
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<td>St Luke’s Care, Potts Point, NSW</td>
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<td>St Vincent’s Health, Fitzroy, Vic</td>
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<td>St Vincent’s Private Hospital Melbourne Limited, Fitzroy, Vic</td>
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<td>The Surgery Centre Hurstville, Hurstville, NSW</td>
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<td>Swan Kalamunda Health Service, Midland, WA</td>
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<tr>
<td>Very Special Kids, Malvern, Vic</td>
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<tr>
<td>War Memorial Hospital Waverley, Waverley, NSW</td>
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<tr>
<td>Watershed Drug &amp; Alcohol Recovery &amp; Education Centre Inc., Berkeley, NSW</td>
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<tr>
<td>West Gippsland Healthcare Group, Warragul, Vic</td>
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**Mandatory criterion 1.1.1**

*The assessment system ensures current and ongoing needs of the consumer / patient are identified.*

**Karitane, Villawood, NSW**

- Karitane's leadership in the area of early parenting assessment is evident through the development and implementation of the Karitane Parenting Confidence Scale. This is an evidence-based assessment tool which has been published in a peer-reviewed journal. It demonstrates parents' increased confidence following interventions and guidance by clinicians.

- The tool is being used internationally including in Turkey, Singapore, the UK, the USA, Switzerland, Romania and China.

- The Toddler Clinic coordinator was supported to attend training in the USA, hence developing networks and contacts with other providers and trainers of this program to inform further development and implementation by Karitane, including assessment practices for Toddler Clinic clients.

- Toddler Clinic assessment forms were developed based on an international evidence-based program.

- The Toddler Clinic Clinical Nurse Consultant (CNC) is a mentor and the Karitane Parent Child Interaction Therapy Clinic was used as a best-practice site. The international workshop was held June 2011 in Australia. The Toddler Clinic CNC / Manager is now providing supervision and leading advanced practitioner workshops.

- Karitane's leadership is also demonstrated in conference presentations and papers publishing research and clinical practice. Staff continue to be recognised for their initiatives and are requested to present at various conferences on these initiatives.

**Royal Victorian Eye and Ear Hospital, East Melbourne, Vic**

- Internal and external benchmarking has resulted in improvements to patient assessment. The improvements have evolved over time as continuous evaluation occurs.

- There has been an increase in the number of permanently employed medical officers and senior medical officers to oversee the junior medical officers, the creation of a Hospital Medical Officer position to provide services after hours, and placement of an emergency department registrar and ophthalmology registrar in the emergency department after hours.

- The emergency department has been redesigned to improve flows, reduce waiting times and support timely and relevant assessment and reconfiguration of departments to provide a multidisciplinary presence.

- An increase in the availability of equipment ensures that timely diagnosis and assessment takes place, and equipment replacement ensures the latest diagnostic equipment is available.

- Aboriginal Liaison Officers assess the needs of the indigenous population and ensure planning is collaborative in order to maximise attendance and compliance.

- There is assistance and support to geographically isolated areas through teleconferencing and to referring services, e.g. General Practices, as well as planning for advancement in information technology in order to be able to directly assess patients who live in isolated areas.

- New assessment clinics address areas of identified need not currently covered, e.g. a “balance assessment clinic”, the introduction of nurse-initiated pain assessment for waiting patients and enhancements in existing clinics in order to address unplanned appointments and reduce waiting lists.

- Research, the publication of articles, presentations to conferences, and the development and distribution of assessment guidelines for external service providers all contribute to demonstrating the organisation’s leadership in patient assessment.

**Mandatory criterion 1.1.2**

*Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.*

**Karitane, Villawood, NSW**

- Karitane's leadership in care planning and delivery is demonstrated through the multidisciplinary teamwork evident in the delivery of education, care planning and delivery practices to other service providers throughout NSW.

- Karitane continues to receive requests for Karitane policies, forms and resources from national and international organisations.
Following the implementation of revised Karitane Sleep and Settling Clinical Practice Guidelines there have been multiple requests to provide education on ‘Responsive Settling’ to rural and metro services, the State CNC network, the State Parenting Educators Network, and College of Nursing students, and interstate services have requested permission to utilise the documents in the development of their clinical practice guidelines.

Karitane is a key provider of Family Partnership Training, with the Sydney South West Area Health Service (SSWAHS) Family Partnership Coordinator position being held at Karitane to provide coordination support and, importantly, consultation and leadership in the area of working in partnership with families.

Karitane is currently listed as a partner investigator on a research proposal being submitted to ARC exploring the adaptation and strategies to support sustainability of the Family Partnership Model in practice. In addition, Karitane has been chosen as the site of an ethnographic study of the Family Partnership Model in practice, being recognised as a leader in the implementation of the model to support the planning and delivery of care in partnership with families.

Karitane was commended by the Clinical Excellence Commission auditors during a Quality Systems Assessment audit regarding the tool developed for documentation of clinical handover, which specifically supports the planning and review of care in partnership with clients, with documentation and signing by the clients required to confirm their participation and agreement with the ongoing plan of care on a daily basis.

In partnership with the University of Western Sydney Karitane has developed the Masters Degree in Child and Family Health Nursing. Karitane staff have written the learning module content, and also mark assessment papers. This course is the first in Australia to include Family Partnership Training (FPT) and promote practice readiness of graduates to provide health care in partnership with consumers.

The model is also integrated into all modules of the course which have been written and revised by Karitane staff. Karitane have developed perinatal psychology education programs to up-skill allied health professionals in supporting families coping with perinatal mental health difficulties, including a specific program for psychologists in response to identified need. The Karitane Toddler Clinic is also seen as a leader in the delivery of toddler behaviour interventions, working specifically to build upon the strengths of families and being inclusive in all stages of the program.

Very Special Kids Malvern, Vic

Very Special Kids is providing a very flexible and family-centred approach to care which is totally unique with respect to anything the survey team had ever seen before.

Very Special Kids House (the Hospice) provides both planned and emergency respite care and is sometimes used to provide transitional care between the acute sector and home. End-of-life care is also offered with children transferred from the acute sector or the community.

A Family Support Team (FST) worker is allocated to each family and will conduct an initial family assessment, to identify the needs of the family and link them into internal services and programs such as respite care at VSK House, sibling programs, counselling.

Parents are required to complete a “Daily Care Routine” chart which describes to the Hospice staff what the parents normally do at home with the child so that continuity of routine is maintained.

Parents can stay in accommodation close to the Hospice (onsite) where they can sleep and be called in should the need arise. This process allows the child and family to slowly build confidence in staff providing care to the children. Once the first visit has been conducted, subsequent bookings are made and parents are entitled to three weeks of respite days per year. These visits are often booked as a week at a time to give the parents a well-deserved break or time away with other family members.

The survey team feels that due to the uniqueness and flexibility of the service provided by VSK, along with their dedication to the children and families involved, a rating of OA should be awarded on this occasion.

Wimmera Health Care Group Horsham, Vic

Collaborative care is a demonstrated area of strength for WHCG. It is seen as a leader in collaboration with the consumer, having been recognised at the 2010 Victorian Public Healthcare Award with the “Improving Quality Performance Award” for outstanding clinical achievement and providing sustainable long-term outcomes, with results able to be demonstrated over the past 10 years.

Care pathways have been developed and refined for the patient, with this approach being supportive to care and assisting...
with the sustainability of the high-level performance demonstrated at survey.

The system for the management of deteriorating patients is well-established and includes an Emergency Medical Review (EMR) team, retrieval processes for transfer of patients to Melbourne tertiary hospitals and monitoring of outcomes.

As a rural site in Victoria, WHCG has been recognised locally, across the state and nationally for its approach to care. Papers have been presented and published and many sites have actively sought to follow the lead of this healthcare provider.

In 2009, WHCG published “Enhancing Patient Care – A practical guide to improving quality and safety in hospitals.” As a result of the local initiatives there has been improved confidence and patient experience.

There is substantial evidence of participation in external benchmarking, submission of data to national databases, review of performance and improvements made as a result of these activities.

It is evident that other sites look to WHCG and recognise its work as a rural health leader.

**Mandatory criterion 1.1.3**

**Consumers / patients are informed of the consent process, and they understand and provide consent for their health care.**

**The National Capital Private Hospital Garran, ACT**

- NCPH has a comprehensive and current consent policy in place. Consent is obtained prior to any surgical procedure being undertaken. The process that has been implemented to ensure that patients do not leave the surgical ward without a written consent has been very successful. The clinical team should be commended for their efforts and the achievement of this goal.

- Audits have been conducted on a range of consent issues, including consent for blood transfusion, bone marrow and lumbar puncture, medical consent and financial consent. NCPH has demonstrated very positive results for these audits.

- It was evident to the survey team that, for the services NCPH provides, it is a leader in the area of obtaining informed consent from clients. There was illustration that the team at NCPH are leading the way from a Healthscope point of view, in that they are informing the processes undertaken at other hospitals within their group. The ability to benchmark and provide best-practice advice to others has led to a number of the NCPH initiatives being taken up at a national level.

- NCPH was considered by the surveyors to be a leader in this area, and should be very proud of their achievements to date.

**Mandatory criterion 1.1.4**

**Outcomes of clinical care are evaluated by healthcare providers and where appropriate are communicated to the consumer / patient and carer.**

**Donvale Rehabilitation Hospital Donvale, Vic**

- DRH is being recognised as a leader in the implementation and analysis of clinical outcome measurement and senior staff are increasingly being invited to advise other organisations. The survey team encountered many examples of changes and improvements made to care systems, guidelines and tools as a result of evaluation.

- Patient outcomes are assessed daily and scrutinised at weekly case conference meetings and unexpected changes are analysed and modifications made to the rehabilitation plan as required.

- Clinical outcome measures are routinely used, such as the functional independence measure (FIM) and specific therapy outcome measures.

- There is a general expectation across all disciplines that any changes made to clinical guidelines and tools, or the introduction of new interventions, must be thoroughly reviewed
and evidence-based. This is reinforced by the Clinical Risk and Quality Committee, Medical Advisory Committee and Senior Management Committee, which approve any recommended changes.

- It was evident to the survey team that DRH has a strong academic and systematic approach to outcomes measurement, and research is expanding with two staff undertaking PhD studies.

- The suite of outcome measures that drives internal evaluation and supports external benchmarking is well-established. Data reports are analysed and reported to the governance committees.

- ACHS and AROC benchmarking reports demonstrate that DRH results are very favourable across all data sets compared with peer organisations across Australia, including in timeliness of assessment, discharge outcomes, medication errors, staff needlestick exposure, falls, pressure injuries.

- Reports show that DRH has a shorter Length of Stay (LOS) relative to patients of similar complexity in the benchmark group, while at the same time the mean FIM changes improved.

- Discipline-specific outcome measurement results have been presented at professional medical, nursing and allied health conferences, with the result that DRH is continually approached by other health organisations, and is contributing to knowledge about clinical outcome measurement practices in the broader health sector.

- In-depth case analysis is undertaken by medical staff for 100% of unplanned transfers.

- A recent study conducted at DRH based on a 350 patient cohort demonstrated that the Lower Extremity Function Scale is a more appropriate outcome measure tool than the AROC Lawton’s Scale for the outpatient population. AROC is now considering the results of this study.

- The survey team considered that DRH’s focus on improving outcomes, embedding outcome measurement within practice, and sharing this information with the broader health and scientific community was exemplary.

Karitane
Villawood, NSW

Karitane has extensive evidence of evaluation of processes and client outcomes as demonstrated by evaluation research studies which have been published and reported at conferences on a local, national and international level.

- A report from the Karitane Research Officer on completed and current projects, and articles published in peer-reviewed journals and conference presentations, are available.

- Research examples include: “Evaluation of child and maternal outcomes, following admission to Karitane Residential Unit”, presented at international and national conferences, article accepted for publication in the Australian and New Zealand Journal of Psychiatry. The outcomes of this evaluation have been reported at national and international conferences.

- The development and validation of the Karitane Parenting Confidence Scale (KPCS) occurred following identification that there was no available tool to adequately and appropriately measure parenting confidence in child and family health services.

- In response, a manual has been developed and made available to services and clinicians nationally and internationally in order to measure outcomes in terms of parenting confidence. This tool has been published in peer-reviewed journals and presented at conferences.

- A register of services utilising the KPCS across Australia and internationally provides evidence of leadership and utilisation. A manual and sample data collection spreadsheet have been developed to facilitate use of the scale in the evaluation of outcomes for families.

The National Capital Private Hospital
Garran, ACT

- There are clear systems in place such as a daily clinical review, medical review and multidisciplinary review that serve to evaluate care and aim to meet the needs of patients.

- There are multifaceted audits and follow up with individuals to measure progress and evaluate care. Evaluation of clinical risks has led to the implementation of robust risk management systems. The falls risk assessment and management system is an illustration of this. Regular Patient Satisfaction surveys, analysis of incidents and complaints as well as the audit and clinical indicator processes all serve to provide ongoing evaluation of care.

- Other clinical systems are also regularly reviewed. There is evidence of extensive benchmarking of performance indicators including a wide range of care outcomes. This process is facilitated through Healthscope at a corporate level.

- The provision of clinical indicator results on the public website is to be commended. NCPH consistently performs very well in comparisons with other Healthscope services and in many instances is consistently the best performer.
NCPH contributes to the ACHS clinical indicator suite. Actions are taken to address results which fall outside the expected parameters; these have led to service level changes, such as the review of appropriate booking of day cases by Visiting Medical Officers.

Patient feedback is accepted as a means of identifying opportunities for improvement and is evaluated on that basis.

NCPH is providing excellent levels of individualised care to patients and is recognised as a leader within Healthscope nationally as well as by non-Healthscope health services.

NCPH staff regularly present papers / posters at state and national conferences and clinical policies authored by NCPH have also been adopted across Healthscope.

There is a strong focus on effective discharge care for each patient. Carers and family members are closely involved in the planning for discharge, and end-of-life care is managed extremely well. The level of engagement between the staff and patients and their significant others is to be commended.

The strong focus on delivering DVA patients with supportive and evidenced-based care was noted. The team involved should be very proud of the care they provide. Feedback was provided by patients and their carers that they were also very impressed by the care.

In the other areas across the hospital, there was also a strong focus on delivering excellent levels of care and communication to patients and carers. It was clear that the team at NCPH is providing leadership in the area of care evaluation.

Wimmera Health Care Group
Horsham, Vic

WHCG is actively engaged in the process of monitoring clinical outcomes and the provision of improving quality and safety in care. Care outcomes are measured and benchmarked internally and externally. Improvements are implemented in response to identified gaps or opportunities for improvement. This approach to measurement of effective outcomes has been in place for the past 20 years, with 10 years of data presented to the survey team.

Data demonstrate continued long-term, sustainable improvement across a number of clinical areas including stroke management, anterior myocardial infarction, large bowel resection, and care of the dying patient, as well as a range of obstetric and gynaecological indicators, orthopaedics and medical indicators, and appropriate use of clinical pathways.

There has been extensive work in care maps that have been put in place for the complex, frequently occurring admissions and patients are provided with “non-health language” pathways to support patient information and compliance.

Clinical pathways have been developed to support consistent care and this is measured with the organisation’s adoption of “all or none” compliance expectation. This approach has set a high standard that has assisted with the delivery of sustained improvement in the standard of care.

WHCG is recognised as a leader in Clinical Governance and actively participates in the presentation of results in papers and conferences, and has now published a book outlining its approach to evaluation of care.

Wimmera Health Care Group
Horsham, Vic

WHCG is to be commended for its focus on the client and its achievement of sustainable, measured results demonstrating improvement.

Mandatory Criterion 1.1.5
Processes for clinical handover, transfer of care and discharge address the needs of the consumer / patient for ongoing care.

Swan Kalamunda Health Service
Midland, WA

SKHS commitment to the transfer and handover of care is culturally embedded right the way through the organisation and has continued to build upon the very good position they were in for the Organisation-Wide Survey.

The patients presenting, their carers and, where appropriate, the partnering health professions are apprised through a variety of communication media including patient handbooks, verbal communication and the obvious staff commitment to this process.

The clinical redesign project that is badged as the ‘Four Hour Rule’ has had commendable results across SKHS in patient care, clinical systems improvements and flow-on corporate effects.

The achievements attached to this project are embraced by the whole of the service. This has been underpinned by formal change management processes, with good engagement of executive, management and a cross section of staff in every department and change champions embracing their roles.
Despite the increasing number of emergency department attendances between October 2009 and October 2011 (~22%), the percentage of ED attendances with LOS less than four hours has improved from 67.5% to 85.5% and the percentage of ED departures to the ward with LOS less than four hours has improved from 77.3% to 92.3%.

Flow-on effects of the whole-of-health-service change-management approach have included the Medical Unit ALOS decreasing from 5.3 days to 2.9 days. Quality health service continues to be provided during this change as evidenced by unplanned ED readmissions within 72 hours remaining relatively consistent at ~2%.

There is a comprehensive approach to people who present frequently to the Emergency Department and multidisciplinary, cross-service and cross-agency care plans are drafted and implemented to ensure that everyone has the same care map to provide services from and that transfer of care is relatively seamless.

A number of recently developed assessment forms have elements of discharge integrated into them and it is evident that discharge planning begins at the booking stage for planned admissions and at the point of entry into the health service for unplanned admissions.

There are innovative Risk Screen stickers that address a range of high-risk health issues, which are completed on all persons over 65 years of age, and outcomes against these have been evaluated.

Therapy services and allied health services are going through a significant growth period. These services are both complementary and integral to the transfer of care for the community SKHS serves.

ISOBAR has more recently been introduced and the survey team noted that this is being well embraced and is evident in 2pm whiteboard handovers.

Discharge planning is very much tailored to the patient. On discharge every patient gets a discharge summary, a medication care plan and a generic care plan.

SKHS is being held up as a star performer in WA Health and has presented its program to WA Health. In addition, it has been assisting NSW Health with improving transfer and discharge processes.

The SKHS improvements around transfer of care and discharge are being benchmarked against peer services in WA Health.

Results of SKHS indicate it is performing above benchmark target and in advance of peer facilities across a range of transfer and discharge criteria.

Furthermore there is evidence to substantiate improvement in the patients’ understanding of pain management.

There is good evidence of extensive clinical benchmarking both internally and externally.

The work done to develop best practice through the Neuro Orthopaedic Institute (NOI), and appointment of the NERC senior physiotherapist as an instructor with development of a new course for the NOI, is impressive.

In effect NERC now has an international profile in pain management rehabilitation.

It is expected that this profile will continue to expand and the organisation is to be congratulated on clinical leadership in this area.

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Criterion 1.1.6
Systems for ongoing care of the consumer / patient are coordinated and effective.

North Eastern Rehabilitation Centre
Ivanhoe, Vic

The surveyors were impressed with the system to ensure ongoing care and to coordinate inpatient and outpatient clinical programs where the same allied health carers remain continuous as far as practicable.

Considerable effort has been placed into developing and offering best-practice education regarding pain management to the multidisciplinary team.

The “Allow a Natural Death by Limiting the use of Life-Sustaining Treatment” (locally referred to as AND) policy and procedure are well known to staff. Documentation is referenced and provides links to NSW guidelines for end-of-life care.

A comprehensive “Death of a Child” procedure is supported at local ward level by a purple folder to guide the care of deceased children and their families in culturally appropriate ways, and prompts various legislative and reporting
Local improvement strategies were instigated to improve consistency in end-of-life discussions between clinicians (multidisciplinary representation) and families, resulting in the development of relevant policy and procedural documents and forms to be included in the medical record.

Follow-up audits have demonstrated compliance with the processes, reflecting improved consistency of information discussed with parents and documentation of ongoing management plans.

Electronic alerts ensure appropriate supportive care is provided upon presentation to ED to avoid inappropriate resuscitation or excessive life-preserving therapies. This work was extended to the state-wide ambulance service to ensure that ambulance officers avoid inappropriate intensive therapies where a child is receiving palliation services at home.

This has led to state-wide policy, procedural and supportive documentation tools and NSW Ambulance Services have extended this approach to adults as well, through a trial to avoid inappropriate intensive therapies at end-of-life.

Working parties under CHW stewardship have developed Fact Sheets, Information Sheets and common brochures to ensure consistency in approach across NSW.

A successful volunteer program to support families during end-of-life care was developed with financial support from a Cancer Institute grant. A volunteer management policy, education program and recruitment strategy were developed and implemented. A survey to ascertain effectiveness of the program demonstrated that volunteers and families benefitted from the program.

An Arabic-speaking women’s group was established to encourage ongoing support networks.

CHW is an international leader in paediatric palliative care, training overseas medical fellows who return to their country of origin to implement palliative care services.

Fellows are encouraged and supported to participate in research programs. CHW palliative care staff are widely published in relevant journals, contribute to book chapters and have representation on the World Health Organization Committee producing global guidelines for the management of persisting pain in children.

There is a large Palliative Care team including physiotherapy and occupational therapy, social work, pharmacy, case manager, pastoral care, and access to consultation liaison psychiatry service. The Palliative Care physicians and dedicated nursing staff (including a nurse practitioner candidate) are actively engaged within the hospital such that palliative care is now well-accepted and often introduced to patients and families at a distance from the end-of-life care episode, usually for symptom relief advice.

Pastoral care is an important component of the care offered and this team is actively involved not only in the clinical care but also in the research program. There is an active ongoing clinical and death audit (the usual mortality review as well as a “good death review” audit) supplemented by active and ongoing involvement in education and research programs.

Medical, nursing and other staff are involved and actively contribute at state and national level. This group was actively engaged with and influential in the recent review of the Pastoral Care standards. Senior staff are pursuing research into the art of hard / difficult / confronting conversation so relevant to this area of practice.

This clinical service presented at survey as a multidisciplinary, coherent and respectful clinical team actively working to the Mission of the SJJHC Group, focused not only on the provision of care within the hospital but also on influencing the development of palliative care and bereavement support services at state, national and international level and succeeding in gaining a voice at each of these levels.

Their models are being actively used to explore and set standards. They clearly demonstrated their leadership in end-of-life care.

**St John of God Subiaco Hospital Subiaco, WA**

Whilst the Palliative Care Service has its roots within the cancer care service, it has become a hospital-wide service using a consultancy model and links seamlessly with community service providers such that patients are able to be cared for within the appropriate clinical setting as determined by the stage of their disease and their preferences.

There are five dedicated palliative care rooms situated within the cancer care ward with facilities for family members to remain 24 hours per day. The service however is not limited to these dedicated inpatient facilities as the multidisciplinary team is actively engaged throughout the hospital and community.
Women’s and Children’s Health Network
North Adelaide, SA

The WCHN Palliative Care team have contributed to a model that is arguably the leader in its field. End-of-life policies and procedures are in place with staff awareness promoted through education at orientation and induction and through regular in-service.

There are a number of key documents available to assist patients, families and staff to deal with issues surrounding the dying patient, and a range of educational programs is provided to staff not only within WCHN but externally.

The Paediatric Palliative Care Service (PPCS) Nurse Practitioner is a recognised leader and contributes prolifically to the profession for improvement of palliative care.

The chaplaincy service is highly regarded by staff and families and provides spiritual support for all.

There is a range of actions taken to assist parents coping with death and dying and these include assistance with gathering mementos on the death of a neonate, allowing appropriate access to enable participation in cultural rituals, e.g. lighting of candles or burning of incense, and in being responsive and compassionate to specific requests from parents or children.

Clinical reviews of all deaths are undertaken through case review, morbidity and mortality meetings and other relevant clinical governance processes. Where indicated, improvements are made to practice and/or education is provided.

The viewing room which comprises a ‘bedroom’ and side lounge for grieving families has been beautifully refurbished and provides a place where grieving can occur privately.

The movement of the deceased throughout WCHN is managed discretely through concealed trolleys or carry cots.

Where relevant, paediatric patients are referred to the PPCS which is a 24/7 service provided by an enthusiastic, caring team. This service is provided state-wide across homes, hospitals and hospices to patients during the antenatal period and through to 18 years of age.

There have been 2 publications led and/or developed by WCHN. The first edition of “Journeys”, which was released in the ACT in August 2011, was led by the PPCS Nurse Practitioner. The “Home Care Companion” developed by WCHN and used within the service by families and carers is another excellent resource.

In addition, participation in the National Standards Assessment Program, publication of a number of scholarly works, contribution to research and assisting other clinicians to develop their knowledge and skills all contribute to the excellent reputation of the service.

As Advance Health Directives are unable to be used for people under 18 years of age, the PPCS is actively advocating for this age to be lowered to 16 to enable adolescents to document their own specific wishes should their condition deteriorate.

Clinical reviews of all deaths are undertaken through case review, morbidity and mortality meetings and other relevant clinical governance processes. Where indicated, improvements are made to practice and/or education is provided.

The Children’s Hospital at Westmead
Westmead, NSW

The management of the health record by the organisation demonstrates a strong commitment to ensuring comprehensive information is recorded, and readily available to clinicians.

The Health Care Record Forms Business group has been established to govern the overall development of paper, electronic and state forms.

Patient health records are comprehensive, supported by appropriate policies and adherence to legislation.

PowerChart is used for results. Trending of data indicates good compliance. There was extensive work around scanning of paper records immediately following discharge to allow records to be available on PowerChart and minimising satellite records.

State-required paediatric forms were being developed in an electronic format.

CHW is a pilot site for a number of state initiatives including the NSW Health GWS PCEHR (Patient Controlled Electronic Health Record) project.

CHW is a leader in developing the Client Registration Review, which has enabled the upload of a number of different media types into the EMR.
The organisation has developed a pro forma template, now copied by the NSW State Forms Committee, as was the electronic “Keep Them Safe” pro forma letter.

CHW has presented its work at numerous forums both locally and internationally and provides an excellent role model for other organisations.

**Criterion 1.2.1**
The community has information on health services appropriate to its needs.

The Children’s Hospital at Westmead
Westmead, NSW

- CHW has a unique reputation and there is a 90% recognition of the CHW brand which is extremely high.
- The Management Support and Analysis Unit supplies population and disease data for use in planning and informing the appropriate geographical areas to cover with information roll out.
- The Planning and Performance Department ensures consultation around the information available to families and its accessibility.
- There are extensive Fact Sheets covering important medical topics as well as other areas of interest for parents.
- There have been a number of excellent initiatives including development and promotion of the “Kids Don’t Fly”, “Kids Quit” and the RESUS4KIDS promotion and prevention projects which have been utilised by the Ministry of Health.

Karitane
Villawood, NSW

- Karitane’s leadership in providing information on health services appropriate to the community’s needs is demonstrated through a number of methods including: Karitane website; Connecting Carers NSW (CCNSW) website; Talking Realities website; development of various brochures and training packages specific to the services provided.
- The Karitane Connecting Carers service is delivered to foster, kinship and relative carers who are the most valuable resources and major stakeholders in the Child Protection System. This service has provided support, information, education and training to help improve and strengthen foster and kinship care roles.
- The foster, kinship and relative carers report that they are stronger and better able to attend to their parenting and family roles as a direct result of the support received from the Karitane CCNSW Program.
- An Annual Training Calendar is available to all carers in NSW through a number of outlets including a specific website, Community Service Centres, group meetings, conferences and camps. Strong partnerships have been developed for the successful achievement of project outcomes that include government, non-government and indigenous organisations.
- Karitane provides help services such as a Parent ‘Careline’ and 24 hour (1300 number) CCNSW Support and Crisis Line for CCNSW (both services manned by Karitane staff).
- Karitane CCNSW in partnership with the Department of Family and Community Services (FaCS) and non-government agencies is committed to working collaboratively to achieve out-of-home care (OOHC) reform. To date, three consultative groups have been established under the Child Protection Advisory Group to work through and provide advice on a number of issues. Information is available on the FaCS website and in an evidence folder.
- The Minister and Chief Executive Officer, FaCS, call on Karitane CCNSW manager and staff to comment and support the department with policy and legislative changes and reforms.
- The Minister and FaCS see CCNSW as a leader in the advocacy and support of foster, kinship and relative carers and CCNSW plays an important role in supporting the Minister and the department with resolving issues, building capabilities for carers and preparing for the future of the OOHC system.
The Referral and Information Centre (RIC) is a point of access for all referrals to primary and community network services and for information about managing client and/or carer needs. This service is managed by experienced clinicians who have the required skills and knowledge about community services, and staff are able to prioritise client needs and refer them to the appropriate service in a very timely manner.

The work of RIC is recognised across NSW as the leading model for community access. Additionally, the Care Placement Team at the Short Term Residential Accommodation Service (STRAS) Unit receives information from the local private hospitals about resident placement in aged care settings and the aged care facilities also provide vacancy updates daily to assist access to aged care beds.

Staff attend meetings with referrers to ensure clear understanding of entry, assessment and screening.

The Referral and Information Services team liaises daily with referrers to provide ongoing promotion of entry criteria for aged care and chronic disease. The team discusses each step of the entry and assessment processes with the patient and the family members.

Karitane continues to ensure that care is appropriately delivered through its intake policies and procedures across the spectrum of Karitane services including residential, Family Care Centres (FCCs), Perinatal Mood Disorders Day Unit, Toddler Clinic, and volunteer programs.

Karitane has conducted a number of clinical practice improvement projects which provide evidence of leadership in ensuring services are appropriate and delivered in the most appropriate setting.

Karitane has led the benchmarking of secondary level FCCs across NSW. This state-wide survey included details of referral criteria, intake processes and the modes of clinical care delivery (i.e. centre-based, home-based and group interventions).

Karitane has subsequently implemented revised processes and policies, including the introduction of the multidisciplinary intake meeting at FCCs to ensure appropriateness of care in an appropriate setting.

Karitane has also led a review of service networks in response to the implementation of the Supporting Families Early NSW Health policy directive which outlines the directions for child and family health services in NSW, with particular focus on addressing the complex needs of vulnerable families.

The continual evaluation of the residential, Perinatal Mood Disorders Day Unit, volunteer programs (including appropriate services for culturally diverse families), Toddler Clinic, FCCs and the NSW Connecting Carers Program specific to foster and kinship carers also provides valuable information to inform service planning and to ensure appropriateness of care and service delivery.

Karitane leadership in this area is demonstrated through conference presentations and abstracts of evaluation studies, including the Toddler Clinic, FCCs, Perinatal Mood Disorder Day Unit and the NSW Connecting Carers Program. Articles have been published in peer-reviewed journals.

Karitane has developed a new service at Camden Hospital which commenced operation in November 2010.

This multifaceted service includes residential admissions, day stay and a perinatal mental health service. The model was informed by evidence and adapted for the context and environment from other Karitane services with proven effectiveness.

Benchmarking of intake processes occurs with member organisations of the Australian Association of Parenting and Child Health Inc.
Very Special Kids
Malvern, Vic

The survey team was most impressed with not only the uniqueness of the service but with the flexibility of the model of care which can be and is constantly adapted to meet the changing needs of the families it services.

One of the referring Palliative Care Specialists interviewed provided at least four examples of children who had been referred to VSK. In each case, the circumstances of the child required immediate action from the VSK team to quickly assess and admit the child for care and treatment.

One child actually stayed at VSK for almost three months until they died which goes outside the normal limits of stay at the Hospice. However, the Palliative Care Specialist reiterated that all of these four children would have had much poorer outcomes had VSK not intervened and taken care of the children.

VSK is a unique service – there is nothing else like it in Australia. The team at VSK is constantly asked to talk about their service at both national and international conferences.

Western Australia has asked VSK to come over in the next few months to assist them to set up a similar service in Perth.

Criterion 1.4.1
Care and services are planned, developed and delivered based on the best available evidence and in the most effective way.

CHSA – Upper South East Cluster – Bordertown, Kingston & Naracoorte
Bordertown, SA

(Please note: following amalgamation this organisation is now part of CHSALHN – South East Rural Region)

Naracoorte was the state trial site for the web-based cardiac electronic medical record, accessible to the on-call cardiologist via a secure website and is a virtual cardiac unit for Flinders Medical Centre. It was the first SA hospital to offer stress testing by GP over-read by a cardiac specialist at Naracoorte.

Project outcomes demonstrate improved clinical outcomes, including reduced length of stay for acute coronary syndrome (ACS), reduced time to angiography in line with current guideline recommendations, 40% reduction in cardiac arrests, and 50% decrease in in-hospital ACS deaths, reducing the discrepancy that previously existed between country and metropolitan hospitals.

Awards include the inaugural SA Health Award for Building and Strengthening Partnerships, South Australian Government in 2009, and the SA Health Award for Enhancing Primary Care in 2010.

Research outputs have been reported at national and international conferences, in journals and a recent book chapter, Point of Care Testing (PoCT).

Naracoorte participates in both internal and external quality control programs which meet the recommendations established by the Australasian Association of Clinical Biochemists (ACCB) PoCT Committee. This has been well-implemented with increasing staff skills to ensure a sustainable service for PoCT onsite.

Papers have been presented at national and international conferences, demonstrating the effectiveness of nurses managing PoCT in rural sites. The Naracoorte Clinical Nurse has become a national speaker on PoCT, presenting at both ACCB PoCT meetings and Practice Nurse education meetings.

The program On-line Web based Links (OWL) has been developed in the Upper South East Cluster to facilitate clinician access to evidence-based resources available on the intranet to support care. Naracoorte developed the tool as a pilot site and it was then rolled out to other sites within the Cluster.

Naracoorte has developed the capacity to manage the Wiki site at a local level allowing for prompt inclusion of new links. The listing is very extensive and well understood by Cluster staff. The tool continues to be developed in response to CHSA rural and remote requests.

The Mental State Examination (MSE) was developed as a research project between Naracoorte CHSA Mental Health Directorate and the University of South Australia. The program ran over a six-month period using Naracoorte nurses to develop a workable MSE tool for use for all mental health presentations. The tool has been rolled out for use across the whole of rural South Australia.

In addition to the above projects, other initiatives include linkages created with Queen Elizabeth Hospital in Adelaide enabling...
expeditious transfer of those with strokes to a specialised unit, work conducted on high-risk medications via a benchmarked exercise as part of a Victorian project, and the asthma education project in Bordertown schools.

Surveyors were confident that the community served by this Cluster is the recipient of effective evidence-based care, in ways not immediately available to most residents of similar country communities.

Karitane Villawood, NSW

Karitane has demonstrated the capacity and commitment to develop and deliver evidence-based services tailored to the needs of target groups in various communities across NSW. All services and programs are developed and reviewed to ensure service delivery is based on best available evidence. Examples include the introduction of the Karitane Toddler Clinic which is based on the Parent-Child Interaction Therapy (PCIT) model developed in the USA.

This program has a strong evidence base for effectiveness, however Karitane has taken this further and conducted research in collaboration with the University of Sydney to demonstrate the effectiveness of the program within an Australian context.

Following this, the program has also been adapted for use with a younger age range and a research evaluation project conducted to assess and demonstrate efficacy of the adaptation. The Toddler Clinic continues to benchmark with other services delivering PCIT in the USA.

Karitane has been able to draw upon models of service delivery with proven effectiveness and adapt them to different settings, as demonstrated by the development of the Karitane@Camden service.

Karitane has been approached by Local Health Districts to explore opportunities for service developments based on identified needs.

Karitane is consulted nationally and internationally regarding the development of effective and appropriate services to provide best outcomes for families. Examples include representation on the NSW Health Children and Young People’s Health Priority Taskforce, Chair of the NSW Child and Family Health State-Wide Services Committee, the NSW Child and Family Health Clinical Nurse Consultant Network, the Parent-Child Interaction Therapy International Advisory Committee and a request from the National Director of Child Health (China) to provide consultative support for the development of clinical practice guidelines.

Karitane receives regular requests from member organisations of the Australian Association of Parenting and Child Health to observe practice and discuss service development systems for benchmarking and to inform services throughout Australia and New Zealand.

Karitane has been funded by NSW Family and Community Services to develop and deliver the highly successful Connecting Carers NSW program. This program and the staff are now sought after by government and community agencies to consult on the development of initiatives to address the needs of children in out-of-home care and their carers.

Medication management at SJOGSH is managed proactively and it was clear to the surveyors that the pharmaceutical service is a leader in the field. Surveyors were impressed with the ergonomic design of the pharmacy service and obvious adherence to infection control and occupational health and safety.

Clinical governance is the responsibility of the multidisciplinary Drug and Therapeutics Committee, which reports to the Divisional Management Committee (DMC) via the QPC&RM Committee. The Drug and Therapeutics Committee routinely reviews all medication incidents, adverse drug reactions, policies, education, new drugs, and distribution of Safer Practice Notices from the Department of Health Western Australia.

All newly appointed doctors receive a comprehensive orientation that includes medication charts, abbreviations, financial management, and the PBS. There is a tracking system for all high-cost drugs and procedures are in place to negotiate with health funds as required.

There is a comprehensive range of current policies that are referenced to national and state legislation and guidelines. Implementation is supported by Professional Development Activities.

Mandatory criterion 1.5.1

Medications are managed to ensure safe and effective consumer / patient outcomes.

St John of God Subiaco Hospital
Subiaco, WA

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The predominant trend presenting from incident reporting is omissions of drug therapy. In response to this, nurses who are specifically allocated to drug rounds wear a bib so that they are not interrupted, and another nurse is allocated to deal with arising issues on the ward during the drug round. The system was piloted, and despite initial resistance is now widely accepted. Furthermore it was identified that the anticoagulant medication chart was a primary source of omissions and this has now been evaluated and improved. It should be noted that this new tool has been adopted state-wide in public hospitals.

At SJOGSH the incidence of drug omission has improved markedly since the implementation of these initiatives. Furthermore there is a relatively new medication chart for insulin.

Stickers are used to alert for insulin and anticoagulant therapies respectively. The Medication Reconciliation Form (MRF) is another impressive initiative that is usually completed by trained nurses at pre-admission.

The ‘Motion’ medication chart tracker is an electronic initiative that has been instrumental in not removing the medical record from the ward. The ‘Motion’ has links to pathology results, IBA PAS and eMIMS. Ward caregivers have access to eMIMS, pharmacy drug bulletins and therapeutic guidelines.

Medication management at SJOGSH has attracted national and international attention as is shown by the number of conference presentations by senior clinicians as speakers and key note speakers.

St Vincent’s Hospital Darlinghurst, NSW

The medication management system is very well developed and is underpinned by documented medication management policies and guidelines and auditing procedures to facilitate compliance with Australian Pharmaceutical Advisory Council (APAC) guidelines and State legislation.

Robust processes for safe prescribing, dispensing, supply, administration and storage of medications, and monitoring of the effects of medication, are in place.

The electronic medication management system (MedChart), which incorporates a modified version of the National Medication Chart, computerised physician order entry, a computerised decision support system and medication administration and pharmacy review components, is in use in every ward of the hospital, including the high dependency and intensive care units, day-stay unit, and the operating theatres.

The system has the capacity to link with medication policies, therapeutic guidelines and MIMS, with hyperlinks to NSW Health Safety Notices, and for provision of real-time messages for medical, nursing and pharmacy staff.

Evidence provided to the survey team showed that in November 2011 92.45% admissions were reviewed by a clinical pharmacist (excluding ED patients). Implementation of electronic discharge summaries with compulsory fields for documenting medication changes has improved communication with GPs related to patient medications.

There is substantial evidence that the medication management system is subject to ongoing auditing and monitoring of compliance with required standards and regulations. Regular audits of drug registers and other aspects of the medication system are undertaken by nursing staff and pharmacists. Audits of inpatient medication charts are routinely undertaken by clinical pharmacists.

Results of a Medication Safety Self Assessment for Australian Hospitals (MSSA) completed in August 2010 showed that when compared with all hospitals that submitted data to the CEC for the MSSA, SVH performed better than like hospitals on 6 out of 10 Key Elements (i.e. the mean aggregate score for SVH was better than that of the peers).

Benchmarking of performance occurs within the SVHA group and through submission of Adverse Drug Reactions data to ACHS. Considerable evidence was provided which demonstrated that the SVH Pharmacy Department provides leadership on Medication Safety and Quality Use of Medicines within SVH and wider networks.

Extensive research related to medication safety with publication of results has been undertaken or is in progress. Results of research undertaken by the service are used to inform clinical practices and development of SVH services and in other organisations.

The organisation is recognised widely for its contribution to advancing clinical change and in expanding the body of industry knowledge related to medication safety and management. Of particular note is the leadership role in the development of the electronic medication system which has been associated with a substantial reduction in prescribing errors, and the multiple publications and presentations about the SVH experience related to the use of the system.
Other healthcare organisations that have followed SVH’s leadership in implementation of the MedChart system include Northern Territory hospitals and two private hospitals.

Maitland Private Hospital
East Maitland, NSW

MPH has been recognised and has demonstrated that it is a leader in infection control systems through a number of initiatives, and is a Gold Standard auditor with Hand Hygiene Australia.

MPH was the pilot site for the National Program and workshop for Hand Hygiene Australia (first private hospital in Australia to conduct workshops), which included ongoing product review and trial of hand hygiene products in consultation with National Procurement Officers (across three local sites).

MPH chairs the Healthe Care National Infection Control Committee and provides ongoing 24/7 advice for other sites across Healthe Care beyond its contractual obligations.

Door signs have been developed for patient protection, ‘hand-coloured’ for specific precautions, and frames are now supplied for all patient doors to attach ‘hand’ signs as required.

Other Infection Control Coordinators attend MPH to review practices and procedures (information sharing) and consultation with other Infection Control Coordinators at various Healthe Care sites occurs as needed.

It is also noted that the four-theatre operating suite is superbly managed with a dedicated nursing supervisor and team who ensure the infection control system throughout the operating theatres, and the CSSD is strictly observed and functions according to ACORN standards at all times. Hand hygiene auditing is reported nationally with high compliance ratings.

The surveyors commend the staff on infection control across MPH.

Melbourne Health
Parkville, Vic

Infection Prevention (IP) policies are well-structured, current and relevant, and reflect best practice, providing a good foundation for the IP program across the breadth of the service.

The Infection Prevention and Surveillance Service (IPSS) team coordinates the program and provides specialist advice; there is direct access to Infectious Diseases and Microbiology advice through senior members of the IPSS.

Appropriate resources are allocated across the organisation. Staff skill and expertise is overall of a very high standard. Staff have 24/7 access to specialist knowledge (via pager / on-call system after hours). There is a clearly defined governance and reporting structure with the Infection Prevention and Surveillance Committee (IPSC) providing oversight and guidance through the Infection Prevention Management Policy (IPMP).

The IPMP is comprehensive and risk-focused. Priorities include the surveillance program, staff education and outbreak management. A schedule of reporting for IP-related preventive maintenance and audits was noted during the survey visit.

Surveillance activities are targeted to those patients at highest risk of healthcare-associated infections and include multi-resistant organisms, bloodstream infections and notifiable diseases.

The survey team noted improvements including decreased infection rates in some specific areas including hip and knee surgery, central line-associated bloodstream infections in ICUs and hospital-acquired Staphaureus bacteraemia.

There was discussion of the follow-up to outbreak management. The examples demonstrated the practical application of guidelines for look-back procedures.

The VicNISSS service monitors healthcare-associated infection and is managed by Melbourne Health (MH). The service collects and analyses data on state Department of Health mandatory elements from all acute public hospitals in Victoria and 11 private hospitals enabling accurate and reliable benchmarks against which hospitals and health services can assess their performance. The Victorian Infectious Diseases Reference Laboratory (VIDRL) is also managed by MH.

VIDRL’s core work is in virology and mycobacteriology, and staff expertise is accessible across MH and beyond, making significant state, national and international contributions in infectious disease knowledge and management. Also, there is ongoing collection of data and reporting to the IPSS on surveillance of flu-like symptoms across MH, enabling early identification of the onset, duration and relative severity of flu seasons and early recognition of new viruses.
The survey team noted that there was no evidence of any transmission of influenza at MH during the recent influenza pandemic. Given the age and design of much of the inpatient accommodation, and the small number of single rooms, this was a significant achievement.

Food services are very well managed. Regular auditing of the environment is undertaken and there is evidence of compliance with legislation and industry standards.

Environmental cleaning standards are monitored on a regular and ongoing basis, of high standard and fed back to unit/service managers.

There is a well-functioning linen service with improvements noted in processes and communication with end users.

Reprocessing of instruments and invasive devices is very well managed, including those items reprocessed outside of the Sterile Processing Service. The survey team looked closely at the management and tracking of loan equipment, noting also the instrument tracking system.

The IPSS education and training program is comprehensive, providing orientation and ongoing support for staff. There is good use of staff expertise within and across MH. Many staff provide education to external organisations.

The staff immunisation program is well scoped and includes base-line testing and follow up. All new staff undertake an immunisation assessment.

Hand hygiene is being continuously addressed with a steering committee overseeing strategies. The survey team noted the consumer input in that group and its positive impact.

Antibiotic use is monitored and data submitted to the National Antimicrobial Utilisation Surveillance Program (NAUSP). The Guidance program is an excellent initiative to improve the prescribing and administration of antibiotics across MH and has been taken up outside of MH.

A range of improvement activities underpinned by KPIs and benchmarking were noted. These include but are not limited to: the revised procedure for the use and management of invasive IV devices, the improved infection rates since the introduction of the nurse-led peripherally inserted central catheter (PICC) service, the increased uptake of the staff immunisation program, the antibiotic stewardship in ICU, the ICNet surveillance and reporting system and use of alerts/flags.

Also of note were the breadth and depth of awards, publications, presentations and research projects across MH in relation to IP.

Overall the IP program at MH is well-structured and governed and effective in preventing and managing infection risks. The activities relating to benchmarking of audits and surveillance trends are well-developed. There are many examples of significant contribution at state, national and international level.

Also of note were the breadth and depth of awards, publications, presentations and research projects across MH in relation to IP.

The executive is commended for providing the investment for support of best practice in skin integrity management including the supply of appropriate beds and wheelchairs, chairs, high standards of pressure relieving mattresses, and support for research, education and point prevalence studies.

A recent highlight is accreditation of the nursing service by the International Council of Nurses (ICN) for commitment to improvements and leading the way in pressure injury.

### Criterion 1.5.3

The incidence and impact of breaks in skin integrity, pressure ulcers and other non-surgical wounds are minimised through wound prevention and management programs.

ACT Health Canberra, ACT

Remarkable achievements are evident across all services in the maintenance of good skin integrity and prevention of pressure injury according to relevant current policy, procedures and national guidelines.

Skin integrity management is under the guidance of the Research Centre for Nursing and Midwifery Practice with a well-established committee and reference groups to monitor incidents and continuously improve practice through evaluation and research.

There is evidence of high levels of compliance with patient assessment for risk by the use of the Waterlow Risk Screening Tool on admission, during hospitalisation or change of condition, at discharge and also post-discharge follow-up for neonates, paediatrics and adult patients.

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management and change of definition from pressure “ulcer” to pressure “injury”, which has been adopted worldwide.

The most recent pressure injury prevalence survey for the first time included assessment of pressure injury according to national standards across the continuum of care, which demonstrates a strong commitment to prevention of pressure injury to the overall community of Canberra.

The establishment of the Tissue Viability Unit has brought wound management practice across the directorate to a level of best practice. This includes involvement in research studies and also presentations at international and national conferences on the ongoing improvements to wound management.

Post-discharge care is patient-focused with ongoing support for wound management and evidence that this service prevents re-admission to hospital. A Wound Diary for patients has been developed which each patient receives to assist with self-management and awareness of their wound, and also for information to general practitioners.

There is close collaboration between occupational therapy and nursing services, including the work undertaken in pressure mapping technology resulting in improvements to cushions for wheelchairs.

Results are within benchmarked results for ACHS indicators, and as members of the Health Round Table, the Canberra Hospital is the second-best performing hospital out of 31 for wound dehiscence.

In 2011 the CNC for wound management was the recipient of the research excellence award during the ACT International Nurse and Midwives week.

The research project “Creating a level of knowledge and confidence in wound management and infection prevention and control for graduate nurses” resulted in a tool which is being used by a researcher in New York.

The Centre for Newborn Care identified that there was a need for a skin assessment tool for neonates and through research a tool was piloted and the Canberra Neonatal Skin Risk Assessment Scale (CNSRAS) was developed. This has been presented at international conferences.

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management. A DVD has also been produced to assist in education of carers and patients.

Impressive work has been undertaken in improving wound management. This includes the development and implementation of the Greater Newcastle Cluster (GNC) evidence-based best practice Wound Management Model in GNC community nursing teams, which incorporates evidence-based clinical guidelines, a wound assessment tool, digital wound imaging and care algorithms, and use of standardised wound-related aids and products, weekly clinical reviews, education programs and robust systems for monitoring of wound healing outcomes.

The model has been acknowledged by the HNE Quality and Safety and NSW Health Baxter Awards and is being recognised internationally.

Wound survey data are benchmarked internally and externally. The Director of the Wound Healing Research Centre in Cardiff, Wales, visited the GNC and undertook a critical appraisal of the Wound Management Model, reviewing the trending data of healing outcomes. These data were recognised by the Director to be a valuable inclusion with the Australian initiative of the 1st Wound Cooperative Research Centres (CRC).

Improvements in risk assessment and pressure-relieving devices have resulted in a substantial reduction in the prevalence and severity of pressure ulcers across the Cluster. This project has won Quality and Safety Awards at the HNE Health Awards and the Clinical Excellence Commission Award for Improvement in Patient Safety at the NSW Health Awards.

There is a high level of participation in conference presentations and advisory committees, particularly by the Nurse Practitioner. The work is progressively being published and practices are being adopted by other health organisations.

During the survey the Nurse Practitioner Wound Management was acknowledged as the HNELHD 2011 Clinician of the Year.

Criterion 1.5.4
The incidence of falls and fall injuries is minimised through a falls management program.

Hunter New England LHD – Greater Newcastle Cluster Wallsend, NSW

The system and processes for prevention and management of fall injuries in inpatient and community settings are very well developed and underpinned by a comprehensive range of evidenced-based policies and guidelines and multidisciplinary practices.

Risk assessments are completed using the Modified Ontario Stratify Sydney Scoring assessment tools on admission to inpatient settings; the Ongoing Needs Identification (ONI) risk assessment tool is used for community nursing and HACC clients, and is subject to ongoing review during the episode of care.

Care plans incorporate falls prevention strategies and are subject to ongoing review and auditing. Evidence showed that the fall rate has been reduced substantially in the Short Term Residential Accommodation Service (STRAS) Unit, with no occurrences of SAC 1 and 2 fall events at Rankin Park since 2009, and a decreasing falls trend across the Cluster.

Comprehensive falls prevention education programs are available for staff and include the use of e-learning education modules, and verbal and written education materials are provided to patients and carers regarding fall injury prevention and management.

The program guides clinicians in the best-practice measures to reduce falls, and appropriate preventive measures for at-risk residents / clients.

An impressive range of falls prevention programs are conducted in the Cluster. The Cardio Rehabilitation Units located at 5 sites conduct a ‘Stepping On’ program, targeted at people 65yrs and over living at home, and Otago Home-Based programs target those over 50yrs and Aboriginal and/or Torres Strait Islanders 45yrs and over.

Day centres and the Rankin Park Centre Day Hospital incorporate falls prevention in their programs. Falls Clinics are conducted at Rankin Park Centre Day Hospital and the Westlakes Community Centre.

Evidence provided showed substantial improvements in strength, flexibility and reaction times of clients attending the Stepping Up and Otago programs.

GNC has developed and implemented a robust system for the follow-up of non-admitted patients with a history of falls presenting to emergency departments of acute hospitals in the Greater Newcastle Sector.

GNC staff conduct triaging of referrals using predetermined criteria, undertake follow-up telephone risk assessment of patients, and provide falls information and coaching of patients in prevention strategies. They also undertake referral of patients to the falls clinic if required and to the GNC falls prevention programs and Active Over 50 and Heartmoves programs conducted by other agencies in the community.
This program is to be extended to other rural areas in the near future.

E-learning packages and a DVD have been developed by GNC and implementation has commenced in HNELHD.

GNC has completed a fall injury prevention research project in eighty-eight residential aged care facilities, which resulted in increased use of hip protectors and uptake of vitamin D and calcium supplements. Results of this study have been published in two journals.

Extensive work has been undertaken by GNC Aged Care Education (Community Services) in improving falls prevention strategies in HNE Multi-Purpose Services and residential aged care facilities and other residential aged care facilities managed by private providers.

GNC clinical and managerial staff undertake leadership roles in the HNELHD Falls Injury Prevention programs. A Service Manager is a member of the Clinical Excellence Commission NSW Falls Prevention Network Advisory Group.

Criterion 1.5.5
The system to manage sample collection, blood, blood components / blood products and patient blood management ensures safe and appropriate practice.

Women’s and Children’s Health Network
North Adelaide, SA

The systems to manage collection and transfusions of blood, blood components and blood products are extremely well-managed within WCHN, ensuring safe and appropriate practices.

There was ample evidence, both written and verbal, of a keen, dedicated team well aware of the potential dangers related to transfusion and the necessity for continuous awareness and education of the hospital staff members with particular emphasis on the careful orientation of new staff members.

Education programs are numerous and innovative. Examples include the e-learning program, Blood Safe, the basic idea of which was formed at WCHN. The “Flippin Blood” book is also a product of this unit. Such ideas are now being used nationally.

The capabilities of the staff are well recognised within WCHN, the state and nationally. Rigorous frequent audits are carried out as are external audits and benchmarking. Programs for the management of massive blood loss and transfusion are in place and a committee reviews all incidents.

Criterion 1.5.7
The organisation ensures that the nutritional needs of consumers / patients are met.

Currumbin Clinic
Tugun, Qld

Attention to meeting the nutritional needs of its consumer group is a standout criterion for this service. Through the efforts of the organisation’s clinical staff, catering manager, catering staff and dietitians the organisation has achieved national recognition through publication and a Baxter Award in 2010 for its “Perfect Meals for Patients” program.

This has been a whole-of-service strategy to ensure consumers can access appropriate nutrition based on their individual needs and preferences. Of particular note is that the program has been tailored for mental health consumers within an inpatient setting but can be readily translated to post-discharge needs.

A range of guidelines and educational activities are provided to staff in addressing the nutritional needs of consumers.

Whilst led by the dietetics staff, the development and provision of the healthy eating options for consumers involves catering staff and clinicians.

Consumers are assessed for nutritional state and preferences on admission and dietitian assessment is available upon request by the medical staff. Ongoing monitoring of weight and BMI occurs throughout the admission and individualised nutrition plans as part of the treatment plan are developed where required.

Consumers are formally educated regarding nutrition via the therapy program, and posters and other material remind consumers about the importance of healthy eating. Consumers are able to utilise specific dietary tools such as the ‘Food, Mood and Exercise Diary’.

The “Perfect Meals for Patients” program has been evaluated with consumer surveys demonstrating high levels of satisfaction.

Feedback regarding nutrition and meals is routinely considered by the catering manager and clinical team and refinements effected.

The organisation’s nutrition system has been published in industry journals and the organisation has commenced research into nutrition within mental health settings.
Through its Baxter Award and media attention the service has demonstrated it is an industry leader in nutrition.

Osborne Park Hospital Program Stirling, WA

The dietitians, cooks, and dietetic and clinical staff work collaboratively to determine ways to offer their patients excellent, nutrition-based, healthy meal choices.

A comprehensive Nutrition Care Policy and Dietetics Manual are in place and regularly updated.

All patients are screened for malnutrition on admission with dietitians’ referral and menu selection assessment. Nutrition and diet therapy is recorded in the patients’ medical records.

The Multidisciplinary Food Service Committee is very active in reviewing and improving patient food options; patient satisfaction surveys are undertaken to guide practice changes.

The purée meal satisfaction survey and the snack satisfaction survey are good examples of the depth of review and improvement.

Patients are encouraged to provide feedback regarding their meal through a section on the standard menu and the catering menu card comments and rating system.

Education on nutrition for patients, healthy food choices and malnutrition is regularly conducted for nursing, allied health, medical and catering staff.

Regular Catering Liaison meetings occur where staff are encouraged to raise issues and work towards patient-focused solutions – outcomes are no packaged biscuits only fresh baked cake, muffins or biscuits as snacks, and a pictorial guide of main meals with serving sizes (small, medium and large) is in place to guide staff.

Nutrition of patients is a focus from a risk management perspective in patient falls and pressure management screening, plus aged care and rehabilitation patient management.

The kitchen is a fresh-cook environment where the cooks and dietitians work together to develop recipes, vary the menu offered and are innovative in the manner in which they address special meals.

All purée meals are presented in an imaginative manner using moulds so that the meals are visually appealing; for example, purée peaches are prepared in the mould of an actual peach and minced steak with beans and carrots is served in the shape of a piece of steak and like so the vegetables.

Costing of all meal options occurs with comparison to other facilities as part of a Quality Improvement Project.

Wastage audits were undertaken to evaluate the value of soup on the menu from a nutritional perspective resulting in deletion of soup from the main meals with improved intake of the main meal. Weighing pre- and post-serving has been used to evaluate wastage of purée meals.

The service has presented nationally, providing information on “Menu Modification to Improve Nutritional Intake in the Hospital Setting” and the “Purée Meal Fortified Recipe Development Initiative”. This information has been sought and provided nationally and implemented in a number of aged care facilities.

The service benchmarks with other hospitals and the service lead-dietitian has been actively involved with WA Health developing the state-wide Nutritional Standards.

St Vincent’s Private Hospital Darlinghurst, NSW

Nutritional care for patients at SVPH is very well-addressed and is supported by a Nutrition Governance Management Committee, Campus Nutrition Committee, Menu Review Committee and a documented nutrition policy.

A team-based, multidisciplinary, patient-centred and integrated approach to nutritional care is evident with very good working relationships between catering services, dietitians, nutrition assistants and other clinical staff.

Catering staff are trained in safe food practices and qualified nutrition assistants provide support for the dietitians.

Education programs have been provided by the dietitians to nutrition assistants and nursing staff on malnutrition and nutrition management. Food services distribution staff are trained in customer service.

Well-developed processes are in place for nutrition risk assessment of patients, and incorporate the use of a validated risk assessment tool. All patients identified ‘at risk’ are referred to a dietitian for consultation and are flagged in the CBORD Food and Nutrition system and in the electronic patient information system.

Nutritional care plans are documented in the patient medical record and patients requiring meal assistance are flagged in the electronic information systems. Assistance with opening of meal packaging is undertaken by food distribution staff.

Dietitians oversee menu planning and recipe development, nutritional analysis and management of special diets.

The NSW Health Nutrition standards have been incorporated into the current
menu and are being integrated in the development of a new menu. It is noted that the SVPH dietitians are represented on the NSW Health Agency for Clinical Innovation Nutrition in Hospital Working Party.

每月进行质量保证活动，包括就提供的膳食与所要求的膳食、补充剂摄入及浪费进行比较。

The introduction of a spoken bedside menu service where a nutrition assistant visits a patient and uses a laptop and wireless technology at the patient’s bedside has been associated with increased interaction with patients and provision of opportunities for them to flag any meal service issues identified for timely resolution.

自动化数据收集已经改善了饮食订单的管理、减少了浪费，并提高了营养助理与患者之间的互动，从而提高了膳食的准确性。

The Children’s Hospital at Westmead Westmead, NSW

The organisation is able to demonstrate a strong commitment to consumer participation through a long-established Family Advisory Council and a philosophy of Family-Centred Care.

The Medical and Dental Advisory Committee (MDAC) is chaired by the Community representative and there is good consumer input to facility planning such as the recent upgrade to the Emergency Department.

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The active participation of the health services and Executive in NAIDOC celebrations is noted and the Aboriginal Reconciliation and Acknowledgement of Commitment posters were noted in all health units.
The Aboriginal Cultural Awareness Program is a visible articulation of the Executive’s commitment to Aboriginal health. With more than 50% of Cluster staff having attended the training it is facilitating a change in the provision of services within the health units of the Cluster.

The Renal Unit has participated in state-wide benchmarking of its clinical outcomes and these are noted to be similar to or better than centres where there is little Aboriginal population accessing the renal unit.

Aboriginal cultural needs are being met across the Cluster, with commitment to supporting linkages to country, spiritual healing and Sorry Time acknowledged as supporting and encouraging the Aboriginal community to access services.

The Anangu Bibi Aboriginal Birthing Project is a leader nationally and internationally in indigenous birthing and has been presented at a number of conferences and meetings. Indigenous service providers from Canada, New Zealand, Vanuatu, Tonga and Solomon Islands are visiting to view the program.

The clinical outcomes achieved by this program include increased birth weights and increased number of ante-natal and post-natal visits by Aboriginal mothers. It is also noted that the program is now widely receiving referrals from within the Aboriginal community itself.

The program established the Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care, which is now a nationally recognised certificate, and has been featured in a number of books including Midwifery Continuity of Care (2008, Churchill, Livingstone and Elsevier) and a number of journals including The Aboriginal and Islander Health Worker Journal Nov/Dec 2010 Vol 34:6.

The Aboriginal Birthing Project Team has presented at a number of national and international conferences and the project will also present at the international conference on Building Capacity of National Women’s Machineries for Gender Sensitive Governance in September 2011.

People from other cultural backgrounds are managed in a positive and appropriate environment when they access health services.

At the multicultural town of Roxby Downs the cultural needs of the community have been identified and a number of programs established to address the needs of young mothers in the community. A multicultural group which includes members from 16 different cultural backgrounds focuses on sharing and understanding other cultures and customs.

Karitane Villawood, NSW

Karitane demonstrates its leadership for consumers / patients from culturally and linguistically diverse (CALD) backgrounds and with special needs through the continued collaborative partnerships with communities.

There are specific programs which address the needs of consumers from CALD backgrounds and with special needs.

The Linking Families program and Connecting Carers NSW are being used as the model for future services by the Department of Human Services. Karitane’s leadership in the development of programs and resources for families from CALD backgrounds has led to funding to support the translation of ‘Love, Talk, Sing, Read, Play’ resources in a number of languages to be accompanied by training workshops.

Karitane’s ‘Deadly Tots - No Gammon’ project is a communication strategy for key parenting messages for indigenous families. This is recognition of Karitane’s ability to provide culturally sensitive and appropriate programs which successfully engage and address the needs of families across a diverse range of cultural backgrounds.

Karitane has also been asked to consult on the development of education modules for Aboriginal Health Education Officers as part of the Aboriginal Maternal and Infant Health Strategy.

In addition, Karitane’s Connecting Carers NSW has demonstrated its capacity and capability to develop, offer and deliver flexible and customised training to Aboriginal and Torres Strait Islander communities and to clients from CALD backgrounds.

The organisation understands that a ‘one size fits all’ approach will not work and it tailors its ways of working and communicating to meet the needs of the individuals and communities concerned. CCNSW does this by operating in a respectful manner and by developing strong partnerships with indigenous organisations, such as the Aboriginal Child, Family and Community Care State Secretariat (NSW), AbSEC, which is recognised as the peak NSW Aboriginal body providing child protection and out-of-home care (OOhC), and the KARI Aboriginal Resources Incorporated (KARI) not-for-profit community organisation based at Liverpool in Sydney’s South West.

The CCNSW service has a history of successful training delivery and completion for Aboriginal and Torres Strait Islander people and communities, for example, the Aboriginal Co-Facilitators Training Package and specific successful partnerships in rural and remote areas include Safe Families in Lightning Ridge and Wilcannia.
Western Health Service
Footscray, Vic

- It is clear from the moment of entering the facilities that the health service operates in a very culturally diverse environment and there is some pride amongst staff that it operates in the fastest growing corridor of Melbourne and indeed Australia, with a large diversity of migrants settling in identifiable waves.
- A Community Concord Agreement signed by the CEO and that of the Victorian Multicultural Commission is displayed in the foyer.
- The Victorian Patient Charter is displayed in the lifts and on noticeboards, and on the intranet and internet.
- There are a number of patient information stands in foyers which contain important patient information in key languages.
- Information sessions on accessing health services have been held with the local Turkish and Macedonian communities and community feedback sought.
- Cultural diversity is also recognised at Board level, with a sub-committee of the Board being the Cultural Diversity and Community Advisory Committee, which is chaired by a Board member and has one other Board member. Local residents from the CALD community make up the remaining membership.
- The committee approved the health service’s Cultural Responsiveness Plan, which was highly commended by the Department of Health, and monitors progress against the plan.
- Separate plans include a Community Participation Plan, which addresses other elements of diversity, including gender, age and disability, and one to meet indigenous health needs and build partnerships.
- Demographic data have been evaluated and drive strategic planning. The Western Health strategic plan has an objective (3.3) of understanding and responding to the specific needs of their CALD community, with measures related to increasing staff cultural competency, evolving language services to meet the needs of newly arrived communities, and improving health services and supports for the local indigenous community. The health service is commended for this.
- Due to its experience with a migrant population, the health service manages the Victorian Migrant Health Unit. This Unit cares for migrants with tropical diseases, injuries and tuberculosis.
- Western Health also participates in the Western Collaborative for Obstetrics which includes Djerriwarrh Health. They are also involved in a joint project with two other health services to address the health needs of Aboriginal and Torres Strait Islander patients, particularly in discharge planning.
- Staff can access on-line education modules on culturally appropriate care, including for Aboriginal and Torres Strait Islander, Sudanese and Vietnamese patients.
- A QI initiative, “Respecting Privacy and Dignity”, has reduced gender co-mixing in wards and introduced red pegs on curtains to prevent unwanted intrusions.
- The Language Service handles >20,000 requests for interpreters each year and has a large number of in-house interpreters, all of whom have NAATI 3 accreditation.
- An electronic booking system through i-PM has been developed, which allows staff to book interpreters directly (100 per day). This innovation was the first in Melbourne.
- A scorecard is kept for unmet needs, and is currently running at 2-5%pa. This shortfall is being addressed through the strategic plan.
- A culturally appropriate survey template has been developed, which allows thematic analysis using Survey Monkey, which in turn informs QI projects.
- A DVD outlining child language development has been produced in Vietnamese. Useful visual products have been developed to support menu choices for low literacy and allow dysphagia assessment in CALD patients.
- One product won silver in the Victorian Healthcare Awards and will be submitted to the Victorian Multicultural Awards. The products are now being sold to other area health services and will be marketed across Australia.
- Western Health aims to become a centre of excellence for culturally appropriate care and they are well on their way.

Mandatory criterion 2.1.1
The organisation’s continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.

The Children’s Hospital at Westmead
Westmead, NSW

- The organisation has striven to become a leader in continuous quality improvement in recent years. This aim is progressed with both top-down (from the governing body) and bottom-up strategies, with the Clinical Governance Unit (CGU) being a key part of the organisation’s quality and safety program.
The CGU is well-resourced to manage or coordinate the full range of components that make up a continuous quality improvement system, including positions for facilitating consumer participation, patient safety management, clinical risk management, improvement coordination, carer support, project management, accreditation coordination, policy and procedure coordination, medication safety management, and IMS data management.

The organisation’s quality improvement activities that are registered with the CGU have increased significantly with the introduction of CHARLI, which is an Improvement Database used for the submission, review and approval process.

The CGU undertakes ongoing development and maintenance of CHARLI, supports staff undertaking improvement activities, manages hospital-wide improvement projects, raises awareness through Improvement and Safety Week, and collects, analyses and disseminates information to enable evaluation and opportunities for improvement via posting on the Improvement and Safety Intranet page and Dashboard.

A unique service offered by the CGU, and supported within CHARLI, is that all staff who wish to have their quality improvement project ethically reviewed are offered advice on their improvement activity methodology.

There are twice-weekly Improvement Project Review Meetings which far exceeded anything that the surveyors had seen before. Indeed it exceeded the recent draft requirements in the NHMRC document, “Using the National Statement: Ethical Review of Quality Improvement Activities in Health Services”.

‘Implementation of the process of ethical review of improvement activities at the Children’s Hospital at Westmead’ has been published in the BMJ Quality & Safety Online First, on 12 January 2011.

The organisation has an impressive set of quality outcomes, such as improvements in hand hygiene, reducing surgical site infections, the Clean Hearts project, the Deteriorating Child, Rights of the Child and Consumer Participation.

‘Improving hand hygiene in a paediatric hospital: a multi-model quality improvement approach’ has been published in the BMJ Quality & Safety Online First, on 2 January 2012, and showed an increase in compliance from 23% in 2006 to 87% in 2011.

The organisation compares itself with other similar organisations, such as via the benchmarking process for the Children’s Hospital Australia, the national comparison of PICU and NICU data, the performance in relation to complaints and incident management compared to other NSW LHDs, and participation in the QSA via the Clinical Excellence Commission (CEC).

A further recent improvement is that the organisation has joined the Paediatric International Patient Safety and Quality Committee (PiPSQC), which is a collaboration of members who want to work together to hasten the delivery of safe health care to children.

Karitane Villawood, NSW

A culture of continuous quality improvement was demonstrated with commitment from every aspect of the organisation, from the Board through every department and staff member with whom the survey team interacted.

External and internal audits, plus surveys (staff, volunteer and consumer), were completed, collated, analysed and utilised to improve service delivery. Innovation and responsiveness to changing needs were evident. Success and accolades for quality projects were evident and research and education were embedded throughout the organisation to support practice, and contribute to the wider community and the body of knowledge.

Although Karitane is a secondary and tertiary service it also demonstrated a commitment to improving health outcomes through its primary health focus.

Karitane excels at its core business and is seen as a leader in delivery, research, education and policy in relation to creating safe, healthy, nurtured and confident families and communities.

The National Capital Private Hospital
Garran, ACT

NCPH has an annual Safety and Quality Plan, which is aligned to the Healthscope corporate Quality and Safety Plan, with a well-documented action plan to guide implementation.

A large number of quality KPIs are monitored quarterly and benchmarking of performance, across all services as well as within peer groups, is undertaken.

A range of relevant ACHS clinical indicator data is collected and submitted, including Hospital-Wide, Infection Control and Anaesthetic Outcomes. Any outliers in the clinical indicator results are responded to with specific follow-up improvement actions. Healthscope has established National Clusters to facilitate a coordinated approach to improving quality and safety in relation to various clinical practices.
NCPH is actively involved in the development of national Healthscope policies and has authored a significant number in recent years.

NCPH representatives have also been invited to participate in ACSQHC working groups in the development of the National Standards.

Commitment to quality improvement is evident in all areas of the organisation, in clinical services as well as in administration and support services.

Promotion of safe clinical and work practices and evaluation of performance were noted in many ways.

Participation in the Safety Map / Advanced Safety Map desktop auditing processes and the subsequent external Practical Inspections all serve to demonstrate consistent and effective safe workplace practices.

A wide range of audits is undertaken and used to identify opportunities for improvement.

Any identified deficits are addressed through improvement projects across all departments / units. The surveyors were particularly impressed with evidence of willingness to trial solutions or ideas that have been suggested by staff, but also an acceptance that some ideas do not work and that it is quite acceptable to change direction and trial something else.

There is a committee structure to support clinical and non-clinical review processes and support action to achieve improvements across the organisation.

There is evidence of strong links between quality improvement and risk management, with improvement initiatives being developed to address identified risks.

Across Healthscope services, the findings from investigation of any sentinel events are disseminated through a program of “Shared Learning”, which enables all services to benefit from the findings of other organisations which are relevant to their own service role.

The introduction of learning and assessment packages related to “Correct Side Surgery” and “Counting of Accountable Items in the OR” are examples of improvement initiatives of this nature.

Healthscope has established a website as a public medium to display quality of care outcomes, and individual health services, such as NCPH, can therefore ensure that customers / patients are able to access information about the services and the standard of performance which can be expected at the hospital.

Staff are made aware of the organisation’s commitment to quality improvement from the time of the pre-employment interviews and consideration of position descriptions, to subsequent annual performance appraisals at which time staff are asked to discuss their involvement in quality and safety improvement initiatives.

The Clinical Team Leaders on each unit are expected to complete a quality improvement project each year as part of the leadership role. NCPH was a finalist in the ACT Quality Awards in 2010 for improvements in medication management safety.

The approach developed by NCPH has since been adopted across all Healthscope hospitals as well as being presented at state and national conferences.

St Luke’s Care Potts Point, NSW

St Luke’s Quality and Risk framework is impressive. The software IONMY is used and integrates reporting, monitoring and recording of information in one location.

Automatic links are provided between Governance, Risk Management, Suggestions and Complaints, Quality Improvement, Workforce Planning, Credentialling, Education, Performance Review and Staff Health. The functionality of the system ensures that the automatic cross-links for any entry are maximised.

The software is the central repository for managing data and ensuring the appropriate flow of information to relevant committees, the Executive and the Board.

A culture of continuous improvement is embedded throughout the organisation and is fundamental in decision making at all levels.

Using a continuous calendar of audits and improvement activities provides a plethora of external benchmarking opportunities.

External organisations have recognised St Luke’s Care as a leader in continuous quality improvement. Staff have been sought to present at conferences, been invited to facilitate learning sessions and have hosted many organisations to learn how they have achieved the risk and safety culture that is integral to the way St Luke’s operates.
A framework for integrating clinical and corporate quality and safety systems is in place with oversight by two key governance committees that include consumer members.

Quality improvement is a well-structured and continuous process linked to strategic and business planning, risk management and budget-setting processes from top management to unit level, and quality, risk and safety policies and priorities are in line with state and national priorities and the strategic directions of the organisation.

Key enablers of this successful linkage are the development and implementation of a Management and Planning System (MAPs), which serves to integrate the organisation’s strategic and business planning processes and support clinical and corporate teams to achieve them, and the presence of a single Quality and Risk Unit being responsible for clinical governance, quality coordination and management, risk management, incident management and complaints management.

The performance measurement framework is in line with the Australian Commission on Safety and Quality in Health Care’s key performance indicators (KPIs).

The organisation uses data effectively and feeds back KPIs to individual units.

Quality, Safety and Risk Scorecards are discussed and monitored monthly at all levels of the organisation to document performance against targets and the resulting quality improvement projects, while quarterly reporting is made to the key governance committees.

Significant projects being undertaken include Department of Health-funded redesign projects to improve discharge planning in the Medical Department, and to streamline the patient journey in the Orthopaedic and Emergency Departments.

It is clear that there is a strong culture of collaboration and multidisciplinary approach to improving care and performance, and the Survey Team is impressed by the commitment and initiatives of medical and nursing staff to continuous quality improvement and clinical excellence, and evidence of clinical leadership and accountability at all levels.

The organisation also demonstrates that it is a leader in continuous quality improvement through leading the state in redesign projects and guidelines in palliative care, the country in clinical advances such as hand transplantation, and the world in innovations in epilepsy management and its Antibiotic Stewardship Program (through a world’s first electronic antimicrobial approval system).

The organisation trains clinicians and clinician managers from overseas and holds dialogue with the National Health Service of the UK in issues related to service improvement activities, to achieve healthcare quality and safety.

There was a major quality activity in conjunction with Research Week. During that time major presentations were made highlighting the achievements of all departments in research and quality. Guests attending were from major health services and clinics from all over the world.

The surveyors were impressed by an almost tangible culture of quality improvement across the organisation.

There was ample evidence of quality improvement initiatives across the hospital both in clinical and non-clinical areas.

There was evidence of identification / awareness / insight of issues and challenges, confirmation and then review of the literature, benchmarking, trending and an analysis, auditing, monitoring and maintenance, development of implementation plans followed by evaluation, and very importantly effective operationalisation.

The CARE First initiative has been one of the main reasons for awarding an OA against this criterion.

All elements of a continuous quality improvement program were demonstrated and evidenced. Importantly at interviews and site locations the program was seen to be effective by the users of the program and staff had integrated quality improvement into core business practices.

The leadership and coordination of integrating the program into core business and operationalisation so effectively is commended.

At survey one of the surveyors commented that there is ongoing discussion on how to effectively enhance clinical governance and corporate governance integration. Throughout his career the surveyor had been looking for examples where an executive from a finance background particularly may jointly lead in clinical governance with clinically trained executives. It was pleasing to see that he had now found one.
Quality improvement data are collected from a range of services and reflect the strength of the multidisciplinary team.

Quality projects are numerous reflecting a culture of continuous quality improvement and there is evidence of staff participation at all levels of the organisation.

There is evidence of staff participation in research projects resulting in publications in peer-reviewed journals. Outcomes are benchmarked both internally and with external institutions including the Australian Rehabilitation Outcomes Centre.

Data collected from the sub-acute non-acute phase of service delivery (SNAP) for 2010 - 2011 reflect that WMH has 0.5 day shorter length of stay and a higher Functional Independent Measure (FIM) score (.5) as compared to similar organisations. Results are further enhanced when taking into account that 75% of WMH patients are over 80 years of age and 75% of WMH patients return home.

The achievement of a rating of OA (outstanding achievement) is based on the organisation’s development of a “Geriatric Flying Squad”: an innovative multidisciplinary team of health professionals enriching lives of the struggling elderly through rapid sub-acute assessment and intervention underpinned by the guiding principles of inspired care” (Vision Statement for the Geriatric Flying Squad).

This highly successful and innovative program is a fast-response, multidisciplinary community assessment and case coordination service for community-dwelling elders who are suffering from a sub-acute physical and functional decline.

The project was initiated in May 2010. The program aims to keep elderly clients at home and prevent emergency department presentations and hospital admissions.

Methods of evaluation include measuring efficiency, customer, GP and community health provider satisfaction, and multidisciplinary follow-up clinics that are facilitated monthly to monitor the progress of clients 3 - 6 months after discharge from the service.

It is also worthy to note this initiative won the Innovation in Nursing category at the 2011 HESTA Australian Nursing Awards and won a $10,000 grant to further develop its service. Promotion of the Geriatric Flying Squad has taken on a national presence with presentations at conferences in NSW, Victoria and Queensland.

Due to the success of the service, two similar service types have been established within the Sydney area utilising the Geriatric Flying Squad title.

Watershed Drug & Alcohol Recovery & Education Centre Inc.
Berkeley, NSW

Watershed clearly has a strong culture of quality improvement. The quality program is underpinned by the senior management group and an enthusiastic Quality Coordinator.

The Board quality agenda focuses on client needs and service improvement. Research and increasing the levels of stakeholder engagement are also areas of focus.

The Quality Improvement Calendar is the year planner for the quality program.

There is a quality improvement report template. Along with reporting the activity and improvement, the template prompts comment about the effectiveness of the quality activity.

Quality activities are recorded in team meeting minutes. The minutes, and staff comments during the survey, show that quality activity is ongoing and broad-ranging across the work groups.

Audits and project initiatives are reported at the Quality Improvement Council meeting.

Evaluation of the quality program includes the review of follow up to quality study recommendations and findings, and the Board feedback on quality reports.

A number of special projects were noted. These included the review of the case management frameworks based on a survey of the case workers.

A number of activities demonstrated innovation and the effective use of benchmarking. The Share Point system for logging quality activities will simplify reporting requirements for audits, and provide automated reminders for audits.

A client management system has been developed; the database is used to record client questionnaires.

Further improvements are in progress including a function to enable management of waiting lists. Staff and clients participated in a Quality Program planning day.

Staff members are being trained in the use of an Outcome Rating Scale for the Drug and Alcohol clients.

Watershed has been awarded a partnership grant with the University of Wollongong to support a research-based approach to the provision of Employee Assistance Program services.
Watershed received a 2011 Mental Health Matters Award for improvements to programs to support people with drug and alcohol problems and mental illness.

Through the CEO, Watershed is an active member of NADA; through that group the organisation has contributed to the development of the MERIT Residential Treatment Guidelines.

The quality system has evaluation built into it. Annual reviews of the Strategic Plan by the Board include an evaluation of quality improvement using KPI trends. This in turn may generate further projects.

The surveyors noted both a commitment to and examples of quality improvement in every department they visited as well as overall organisation-wide projects to do with the redesign of the Healthcare Group.

Medical staff are involved in quality projects including the Redesign Project, as well through multidisciplinary committees such as the fortnightly INSPIRE (concerned with medication) and EXPIRE (discharge planning, palliative care and deaths) committees. They have also been involved in projects concerned with Caesarean Section, Stroke, Acute Coronary Syndrome and the redesign of the Emergency Department.

Projects are regularly submitted for state-wide prizes and Premier’s awards, and almost as regularly have been successful.

Consumer involvement comes from satisfaction questionnaires, complaints and membership of the Consumer Advisory Council, and in specific projects, such as the redesign of patient brochures and sign posting. There is a regular report to the community (and staff) on quality and safety in newspaper format, “Quality Care 201 – “.

Staff membership of a number of Victorian State bodies concerned with quality has enabled the organisation to review and improve its own systems, over and above improvement instigated through mechanisms such as Board planning days.

West Gippsland Healthcare Group Warragul, Vic

Quality improvement is embedded into the way “things are done” in the West Gippsland Healthcare Group. Multidisciplinary committees feed into the Clinical Quality Council which in turn reports to the Standards Committee of the Board. This committee receives reports on individual projects and monitors a comprehensive set of KPIs for clinical and non-clinical functions.

Quality improvements are instigated on both a top-down and bottom-up basis. Quality projects related to identified risks and strategic direction are included in the strategic plans and the reflected operational plans at all levels.

During the year, trends identified from incidents reported in the electronic risk management system, RiskMan, can generate remedial projects or training.

Individual staff members can suggest projects using the Quality Project Form and are assisted to carry out the projects with external training if necessary.

Quality improvement is included in staff orientation. First-line management training involves the identification, ‘work up’ and implementation of a quality improvement project. Visio, a project planning software system, is available on every PC.

St Luke’s has a comprehensive and mature risk management structure in place that encompasses all facets of health care. Safety is identified as a priority and is seen as being part of everyone’s role.

There is a high level of engagement by all staff and managers as well as external providers. Staff actively identify and assess risks and understand the opportunity that gives to the organisation to improve.

Incidents and the resulting improvements are discussed openly at all forums and disseminated widely through meeting minutes and newsletters.

There is considerable comparison with external systems and also regular review within the organisation of the risk management system.

Staff have presented at conferences and been actively involved in mentoring other organisations to help them develop effective risk management systems such as St Luke’s.
St Luke’s Care
Potts Point, NSW

- The management of healthcare incidents is impressive. Utilising the iONMy incident reporting system, analysis is systematic and timely. This involves all staff and other experts who may be able to contribute to the analysis.
- Improvement strategies are identified and actioned – with a process to ensure that these actions are evaluated further on and are effective.
- SLC has also developed a Root Cause Analysis tool which is comprehensive and intuitive to use.
- It appeared to be second nature for staff to report incidents (including near misses) and staff stated both formally and informally that they had confidence in the process of managing incidents.
- An open disclosure policy has been implemented – with staff training completed.
- The information from incident investigations and improvements arising from these experiences are shared with all staff who are encouraged to contribute.
- Information is provided externally to other organisations so they can also learn from these events.
- SLC has also reviewed research papers to compare their Incident Management System with other external systems in order to improve it. Presentations of such information are well documented and have been provided to Board members at a recent meeting.

St Vincent’s Private Hospital
Darlinghurst, NSW

- All relevant systems for ensuring ongoing employment are in place and operational.
- There are appropriate systems for volunteers as well as staff.
- There is a specific policy relating to making a complaint against a clinician as well as for managing complaints against other staff members. These policies have recently been evaluated and improved with flow charts simplified and better information provided so that concerns and complaints are better handled.
- Indicators are specified in the strategic plan and need to be met by managers.
- The performance review system was evaluated across the whole of St Vincent’s Health Australia and processes that needed improvement identified.
- As the previous system was not delivering the outcomes desired a new competency system was developed with the assistance of an external provider. This new system was trialled in 2010 and is in the process of roll out.
- A similar online tool has been developed for non-clinical staff. For food services staff, for instance, the questions include food safety information.
- The report is provided as a gap analysis so that specific training can be initiated to improve performance.
APPENDIX C
OA SUMMARIES BY CRITERION

Criterion 2.2.4
The learning and development system ensures the skill and competence of staff and volunteers.

Mercy Health & Aged Care
Central Queensland
Rockhampton, Qld

- The organisation demonstrated a clear commitment to the learning and development of its staff throughout all sites.
- The organisation is to be complimented on the amount of work that has been put into the learning and development system, which has a strong workforce planning focus.
- One key focus noted at the time of survey was “Our People”, which identifies the organisation’s employees as key resources and their ongoing development as fundamental to achieving its goals.
- KPis include areas such as: attendance at mandatory training and orientation, scheduled in-service sessions, undergraduate student orientation and total education expenditure.
- Annual staff development planners were evident at all sites and each unit / ward maintained a monthly calendar, listing additional specialised education for staff.
- The implementation of the focus on unit / ward-based mandatory training data has resulted in an improvement of 66% compliance from 33% in March 2012 to 99% in September 2012.
- Education of Medical Practitioners is comprehensive and includes an orientation program and provision of a detailed information guide.

St John of God Subiaco Hospital
Subiaco, WA

- The SJOGSH Operational Plan reflects the requirement to enhance clinical care and new service provisions by ensuring appropriate skill mix and the development of a workforce plan to address workforce issues including educational needs.
- The Strategic Plan 2011 - 2015 provides a framework for the yearly operational requirements and long-term requirements for workforce development.
- These requirements are achieved through the provision of a wide range of professional and technical training programs, leadership training and development programs and collaborative and integrated learning opportunities in partnership with internal and external providers inclusive of Registered Training Organisations, Universities and Institutions of Technology.
- SJOGSH participates in internal and external benchmarking focusing on five key indicators: the LOD system, the Undergraduate teaching and supervision, the graduate programs, the Leadership development program and Mandatory and essential training.
- Key achievements include the development of the Advanced Skill Enrolled Nurse (ASEN) pathway, the development of the postgraduate diploma in clinical nursing in collaboration with the University of Notre Dame Australia (UNDA) and another St John of God facility, and the development of a suite of non-clinical based training opportunities.
- Since 2011, SJOGSH internal training opportunities have attained 18715 training hours. External training opportunities were offered and attended by 155 caregivers.
SJOGSH has also worked collaboratively with universities and TAFEs to develop models of postgraduate courses for RNs including Graduate Certificate in Clinical Nursing embedded into the Graduate RN Program in collaboration with UNDA, and a Postgraduate Diploma in Clinical Nursing provided in collaboration with UNDA and another St John of God facility.

SJOGSH staff members demonstrated leadership through participating and delivering presentations at national and international conferences.

The surveyors were impressed by the performance of the hospital on this criterion. The hospital provides an excellent system of medical training to medical students, residents and nursing staff members. SJOGSH demonstrated leadership beyond the SJGHC group boundaries in training and education and for this the organisation has achieved an OA rating.

St Vincent’s Private Hospital Darlinghurst, NSW

It is clear that St Vincent’s Private sees learning and development for all staff as the key foundation of care and service delivery.

The survey team was impressed by how this permeated all of the organisation and the resources provided to support all staff and volunteers in improving their skills and competencies.

Volunteers need to have the ability to fulfil their positions descriptions so an education plan is developed for them each year which includes improving competencies and mandatory training.

There are a variety of organisations that St Vincent’s partners with for education. These include Hunter TAFE for certificates in hospitality and in qualifications for hotel services, business administration and supply management. Much of the training is carried out onsite with the TAFE educators coming to the hospital. An English as Second Language program has been run for 240 staff and a DVD prepared to assist with this.

The University of New England is the partner for postgraduate programs including MBA programs which are fully paid for by the hospital. The program includes case studies developed specific to the hospital. Where staff do not wish to complete the whole university program they can still attend modules.

Other available programs include certificate 4 in education, a graduate program in finance, a postgraduate program in ethics and a dignity-of-work program for both clinical and non-clinical staff. This latter program aimed at taking responsibility for one’s own actions is extended for managers.

An internally-led leadership pathway “Discovery” has been developed across the organisation and over 200 staff have attended. This program includes mentoring, coaching, and 360 degree assessment.

St Vincent’s Private also has relationships with four universities for nursing students and two universities for medical students. Facilitators throughout the hospital are used as education resource people. The experiences of students are evaluated online and improvements made where necessary. A work experience program for indigenous students is also being developed.

There is no doubt that the programs used to provide learning and development activities are not only innovative but are far in excess of those normally seen at health organisations in Australia. The large numbers of staff who have accessed these programs not only free of charge but in their work time and have gained qualifications in a wide variety of areas is testament to this.

Criterion 2.3.3

Data and information are collected, stored and used for strategic, operational and service improvement purposes.

The Children’s Hospital at Westmead Westmead, NSW

Information is disseminated through the Children’s Hospital Information Management Portal (CHIMP) to all department heads. Reports available include standard Business Objects reports & Corvu monthly performance reports, ad hoc reporting, dashboards and the balanced scorecard.

The Health Information Exchange (HIE) and EDWARD are data warehouses used across the state as is the reporting database (MSAURPT01).

The Power Performance Manager (PPM) has all the patient-related information, which creates a picture of a patient’s stay in hospital, and shows resource utilisation and costs. CorVu application assists in decision making on a daily basis including “real time” operational (CHIMP dashboard) and aggregate strategic information (scorecard).

Operational Data Store (ODS) and Area Executive Dashboard (AED) have been implemented to be in line with the NSW Health Information Business Information Strategy.
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- HIE is the main retrospective hospital reporting system, and all staff can request ad hoc data through application using the Management Support & Analysis Unit (MSAU) ad hoc report form. The report details will be assessed by MSAU to determine if further authorisation by the HRE or CGU is required.

- A monthly performance report is generated by the MSAU to Division Heads to facilitate management. This report includes financial, HR, revenue and activity analysis.

- CHW contributes to data collection by external bodies including the CHA, Cancer Council of Australia, Birth Defects Registry, National Hospital Cost Data Collection, ACHS clinical indicators.

- CHW communicates with external bodies and shares activity and cost information for collation into a benchmark report by DRG.

- It demonstrates and discusses systems in place to cost, store and report clinical costing information with other LHDs, the Paediatric consortium and NSW Health, and at conferences and workshops.

- CHW has been identified as an industry leader in Business Intelligence by Rocket Software for the Information Management strategy plan / reporting framework and implementation.

- Training is provided to staff on data collection, business requirements and use of systems. Clinical coder education and privacy training on data collection and use are also provided. Training is evaluated to ensure improved skills in information and data management.

- Data are available for clinical research and improvement activities via access to health records and HIE. Reference material is available from libraries and the Clinical Information and Access Program (CIAP).

- The library makes its catalogue available on the CHW intranet and internet. The catalogue is a joint service with the libraries of the Western Sydney LHD and Nepean Blue Mountains LHD. The HIE security and access policy has been updated to comply with ePolicy requirements.

- There is evidence that CHW is an industry leader in the collection, storage and usage of data for strategic, operational and service improvement purposes.

- Over 600 doctors now have direct access to their patient information using Wi-Fi access.

- In addition and in recognition of the advanced reliance on technology, the emergency generators have all been upgraded.

- CH is regarded as a leader in many fields and there have been a number of internal and external presentations to interested parties.

- All information is fully backed up and a Disaster Management Plan ensures that all contingencies can be catered for.

- Policies exist for the procurement of new ICT equipment resulting in an excellently executed needs-analysis system for the procurement of hardware and for ensuring that redundant equipment is disbursed effectively.

- Staff from all areas verbalised their appreciation of the help desk and their timeliness of intervention when called.

- Criterion 2.3.4
  The organisation has an integrated approach to the planning, use and management of information and communication technology (ICT).

Cabrini Health
Malvern, Vic

Cabrini Health has adopted a strategic approach to the management of its ICT infrastructure and is working hard to ensure that it is “future proofing” to meet current and future challenges.

A recent review by Deloittes in 2010 confirmed the robustness of the systems in place.

There is an integrated approach and comprehensive planning for improving access to electronic information systems across all sites with the implementation of the Clinical Viewer via iPads being an excellent example of innovation.

The Surgery Centre Hurstville
Hurstville, NSW

- The preventive maintenance and repair system for ICT is reported monthly through the MAC and executive.

- The management of the risks associated with the system is addressed very effectively including through continuous backup to the Central Banking Facility and provision of staff training on completing manual records and printing abilities in the event of loss of the system.

- Extensive research has been undertaken by the Board and management of SCH to enable the installation of the best available ICT system with capabilities to address Australian needs.
Future new developments of Surgical Centres Australia (SCA) will be decided based on the success of SCH in implementing the ICT successfully.

The planning, use and management of the full integration of information systems using the GE Centricity system has attracted extensive interest in Australia, New Zealand, Singapore and the USA.

The management team of SCH provides advice and information about the system to a number of organisations, and have hosted numerous tours of the facility for diverse groups including a delegation from Singapore who are building a new hospital.

The survey team believes that given the research and development during the two-year lead up to the opening of SCH, the subsequent requests for advice about implementation of the system into other hospitals and confirmation of implementation from a number of the hospitals that an OA rating is justified despite SCH’s short time of operation.

Criterion 2.4.1
Better health and wellbeing is promoted by the organisation for consumers / patients, staff, carers and the wider community.

The Children’s Hospital at Westmead
Westmead, NSW

Kids Health is the Health Promotion Unit for CHW. The Unit has been instrumental in a wide range of health promotion and advocacy projects.

The health promotion work undertaken is outstanding and leveraged from a small staffing profile through strategic partnerships with a range of organisations and supporters.

The health promotion resources provided are relevant and highly regarded with the Kids Health website receiving 2,500 hits per day.

The FACTS sheets are available for ongoing care of various conditions, with 800 registered users, many of whom are GPs, receiving regular updates.

A series of health promotion and injury prevention projects have received a high profile from the media including one addressing falls from buildings which resulted in changes to building codes for new homes.

Kids Health was instrumental in bringing the issue of injuries involving portable soccer goal posts to the Australian Safety Standards Product Safety Committee, leading to their subsequent banning across Australia.

Prevention of drowning in backyard inflatable pools is another area of focus with the summer months approaching.

Shaking baby and smoking cessation are ongoing projects.

The bookshop specialises in health-related materials that parents / carers and professionals would find difficult to obtain elsewhere.

Significant research and health promotion are taking place in a number of areas that demonstrate the organisation is a leader in health promotion, including childhood obesity and weight management, oncology, kidney research and cardiac surgery research.

The evidence indicates that the health service is a leader in the important area of health promotion.

Kooweerup Regional Health Service
Kooweerup, Vic

A strong commitment to and involvement in better health and wellbeing programs for the local community was evidenced. Information brochures related to falls prevention, effective hand-washing, nutrition and stroke prevention education are examples of information readily available to promote healthy lifestyles.

Open days and numerous forums on relevant subjects have been organised, especially in the HUB (Men’s Shed). These forums are further developed at focus groups. Outcomes have been documented, initiated and evaluated.

Current services such as walking groups, after-school programs for school children and driving tuition were primarily developed from focus groups.

Where possible, community education forums are presented without charge at the hospital and outside venues. These are hosted by staff and the practitioners of the hospital.

The development of the Men’s Shed and associated activities has been inspirational for both the hospital and community. This local initiative has now expanded to include 15 sheds in the region. The Men’s Shed provides an opportunity for social engagement and inclusion whilst also acting as a conduit for health education sessions.

The Men’s Shed project has been formally evaluated by the Australian Catholic University.

The coordinator has hosted numerous forums, spoken at conferences and submitted abstracts at the Gippsland Health Promotion Conference.

Another recent innovation which has been widely accepted in the region is the “Hairdressers
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as a resource in addressing family violence" (Talking Health) project, which involves hairdressers receiving training in basic counselling skills and information on how to refer at-risk clients to a social worker.

The project has attracted some sponsorship from within the community. An abstract on this program has been published in the Health Promotion Journal of Australia 2010;21 (3). So far more than 50 hairdressers within the Gippsland Region are participating. The hospital is planning to copyright the project.

The Men’s Shed and Talking Health programs are both innovative and lead the field in health promotion.

Criterion 2.5.1
The organisation’s research program develops the body of knowledge, protects staff and consumers / patients and has processes to appropriately manage the organisational risk associated with research.

Karitane
Villawood, NSW

Research is an area where Karitane demonstrated a strong commitment and engagement in projects with a significant number of academic institutions.

The degree and output of research was and is spectacular for an organisation the size of Karitane.

Ethics approval is in place through Sydney South West and the appropriate universities and the research interest group meet four times a year.

Evidence was supplied to confirm nine projects, a number of which are ARC funded, including two that are focused on various aspects relating to toddlers.

Two biological studies are current and other research into adult separation anxiety was exemplary.

One staff member is undertaking a PhD and one staff member has completed a PhD.

Six universities are engaged: University of Western Sydney, University of Technology Sydney, University of Sydney, Charles Sturt University, University of NSW, and new work with the University of Beijing.

There was evidence that Karitane is a leader in research in the areas of its influence and national and international requests for information, use of tools, and evaluation of research projects all contribute to this criterion.

Melbourne Health
Parkville, Vic

There is a large research program occurring at Melbourne Health with over 1,000 active research projects under way.

The Melbourne Health Office for Research is well-respected throughout the organisation. Apart from providing the formal governance structure for research for Melbourne Health, it also plays a large role in educating and supporting potential researchers regarding the processes that need to be followed to obtain the necessary ethics approvals.

Senior staff within the Melbourne Health Office for Research are actively leading the development of health research in Victoria by guiding the establishment of the Bio21 Hospital Research Director’s forum, the development of the VMIA Research Governance Toolkit and through the Victorian Consultative Council of Human Research Ethics, which led to a streamlining of the process for multi-site research in Victoria.

Traditionally North West Mental Health (NWMH) has had an independent process for the approval and governance of research. During the past few years there has been a gradual merger of the two research governance and approval processes resulting in a combined Ethics Committee and a single governance structure and processes for health research within Melbourne Health.

Research within NWMH is very active and vibrant. National and international interest is evident in the research conducted and papers produced by Orygen Youth Health, Melbourne Neuropsychiatry Centre, the Psychosocial Research Centre and other individual research activities in many mental health subspecialties.

In the past four years, since achieving an OA rating in research governance, MH has continued a clear leadership role in this area. The emphasis has shifted in research circles from an almost sole focus on ethical review to the realisation that ethically good research can only be achieved within a robust and comprehensive research governance framework which operates diligently to minimise risk – to research participants, to researchers, to institutions conducting research, and to organisations that sponsor research.

Audit of research projects, introduced earlier this year, is not only best practice, but safest practice. Issues relating to hospital research are championed by the Bio21 Hospital Research Directors Forum (HRDF). This group comprises the 7 Directors of Research from Victorian public and private hospitals.

MH has a pivotal place in the dynamic and innovative Parkville Precinct and in the wider community. The Parkville Precinct provides enormous
research opportunities and, as the leading provider of health services in the Precinct, MH has a major role to play.

Parkville is currently the site of major building developments, all designed to facilitate the collaboration of the health sector and academia, for the best possible patient care, led by world-class, well-governed research.

The newly opened Melbourne Brain Centre has a translational facility within the Royal Melbourne Hospital and The Peter Doherty Institute will include MH’s Victorian Infectious Diseases Reference Laboratory and Victorian Infectious Diseases Service. The biggest current healthcare project in Victoria is the $1 billion Victorian Comprehensive Cancer Centre (VCCC), MH is one of the major partners, and has an unique role in that there will be research and clinical care across the Precinct – in the existing Royal Melbourne Hospital, in the new VCCC building on the former dental hospital site, and within the facilities of MH’s Precinct partners.

The Director of Research Governance and Ethics (DRGE) and Manager of the HREC contributed to the writing of the Victorian Research Governance Toolkit (RGT) and Standard Operating Procedures for achieving Good Clinical Practice, and visited hospitals across Victoria to educate staff on the research governance and ethics components of the new RGT.

In October 2010, MH collaborated with the University of Melbourne to establish the Collaborative Centre for Clinical Epidemiology, Biostatistics, and Health Services Research (now named “EpiCentre”), whose roles include biostatistical support for research and support for translation of research into clinical practice.

Possibly the most compelling evidence of leadership is the fact that hospitals in Victoria and elsewhere have sought advice on issues of research and risk management, including the Peter MacCallum Cancer Centre, Western Health, Northern Health, Eastern Health, Royal Canberra Hospital and Auckland City Hospital (New Zealand).

MH is a leader in facilitating collaboration in Victoria and beyond – collaboration not only in high quality and translational research itself but in the development, delivery and implementation of best-practice research governance. MH research governance includes risk management actions, particularly the internal audit process where there is now a structured auditing process in which staff of the Office for Research have commenced a program of auditing research proposals. In this way, the Office for Research is able to review the entire process from initial application through to the current stage of a project.

There is a clear governance framework in place in which the research agenda is progressed with strong partnerships with tertiary institutions, both for the conduct of research and for the training of staff.

Acknowledging the criteria in place for the awarding of an OA rating, the survey team offers the following comments: QTBCC is a leader in the field of diagnosis, treatment and management of tuberculosis; as a state-wide service, QTBCC has established an impressive database of clinical information over its many years of operation; and evidence was provided at survey that QTBCC is regularly contacted by services across the world treating and supporting people with TB, seeking advice, treatment options and the results of research initiatives.

QTBCC is congratulated on its commitment to clinical research into the most effective treatments for TB.

Metro South Clinical Tuberculosis Service Woolloongabba, Qld

(Formerly the Queensland Tuberculosis Control Centre)

The service is renowned for the research it conducts into the treatment and management of TB, and provided the survey team with a significant collection of research papers, publications, conference papers and requests for information that demonstrate the strong commitment to research at the Centre.

The Director is regularly invited to contribute articles to peer-reviewed journals and is in demand to present the findings from research conducted at the Centre to national and international conferences and seminars.

St John of God Subiaco Hospital Subiaco, WA

SJOGSH has an outstanding reputation for its high standard in the area of research and ethics and the surveyors noted a very active research climate throughout the organisation.

The SJGHC Group Research Governance Framework provides the infrastructure to support the rigour required to manage research and the associated risks involved.

The hospital has appointed a Clinical Trials Manager to coordinate and manage the day-to-day running of the hospital’s clinical trials.

The clinical trials software Velos is currently being investigated as a means of providing for a paperless diary system and invoicing requirements.
This Clinical Trials Unit also provides support for another St John of God facility that has a new research appointment in place.

There is an overarching Group policy, ‘Research Involving Humans’, that provides guidelines in terms of disclosure and management of conflict of interest.

The Research Handbook produced at Subiaco is an outstanding document providing clear information to stakeholders and the public regarding research processes, procedures, terms of reference of relevant committees and resource information to assist in the design and submission of research proposals for ethics approval. It is freely accessible and can be downloaded from the hospital website, and is available on the intranet.

Significant rigour is applied to the approval of research with strong consideration being given to the patients and caregivers participating in the research.

The hospital provides a comprehensive research service to privately insured cancer patients, giving them a unique opportunity to participate in clinical trials. This is supported by the hospital Clinical Trials Committee set up in consultation with the Director of Medical Services and the hospital’s Medical Oncologists to review new trials and select and prioritise acceptance. These decisions are supported by the criteria set down for new studies in clinical trials in the Terms of Reference of the Clinical Trials Committee.

Crucial nursing education programs are in place for the nurses in relation to understanding the adherence to clinical trial protocols and subsequently applying appropriate care for these patients.

SJGHCH has been awarded certification of its multicentre ethical review processes by the National Health and Medical Research Council (NHMRC). This certification is very prestigious and gained by few organisations throughout Australia and allows the hospital to operate as a “Reviewing Health Research and Ethics Committee”, enabling it to review and approve research proposed for multiple sites outside of SJGHCH.

SJOGSH as the central component of the SJGHCH Group has many outstanding elements that contribute to it being a leader in the area of research and ethics and in the management of associated risks.

St Vincent’s Health Fitzroy, Vic

There is a rich vein of education, improvement and commitment to best practice in research and education throughout the organisation.

Presentations made to the team highlighted the availability of resources to those who wished to access them, whether information was required for self-development, formal studies or specific research; STV has the facilities and the staff to assist at any level.

The team was privileged to meet with a group of clinicians who outlined a range of research that was currently being undertaken across all disciplines.

Evidence was provided to demonstrate that the results of the research undertaken at STV were presented in papers and journals worldwide and new interventions were accepted by the wider medical community.

The surveyors noted that research risk management was a major focus of STV; this was evident through a number of key initiatives that were implemented in collaboration with the hospital insurer, VMIA.

This collaboration assisted with the interpretation of legislative and other risk management requirements.

In conjunction with VMIA, a “Research and Governance Toolkit” was devised and implemented. This toolkit contains operational policies, procedures and other helpful sources of information specific to research, to ensure readers can acquire familiarity with such requirements.

Further, an agreement is in place with VMIA to minimise the legal risks in relation to clinical trials by having guidelines which specify those clinical trials that must be subject to external legal review, including the application form, participant information sheet / consent form, and legal contracts.

This third-party review ensures all legal issues are identified and resolved prior to the approval of research. This is an excellent initiative that strengthens the governance and risk management process.

Preparations were under way for a week of presentations to highlight the research currently being undertaken as well as that which had been completed. These presentations attracted interest and attendance from clinicians within Australia as well as from overseas learning institutions.

The 2010 Annual Research Report was made available to the survey team; the report highlighted many outstanding achievements.

Staff working within the unit were undertaking PhDs and Masters degrees as well as a wide range of further educational activities which were actively supported by management.

The survey team saw evidence to demonstrate that STV actively participates in a seminar series which promotes the VMIA Research Governance Toolkit.
This seminar series provides an opportunity for staff and students to attend presentations by industry experts, which further assists with the interpretation of risk management requirements, and the implementation of strategies to minimise risk in daily operational practices.

Finally the survey team was informed that a Global Connections study was undertaken in April 2011, which has provided a baseline picture of STV's many international links including Canada, Germany, USA, Belgium, Holland, United Kingdom, Hong Kong, Japan, Korea and China.

St Vincent's Hospital Darlinghurst, NSW

SVH is situated in an extensive bio-research hub named the St Vincent's Research Precinct. The precinct is highly regarded nationally and internationally.

The research governance is the responsibility of the Research Office and the office also manages all activities relating to the Human Research Ethics Committee (HREC).

As noted the HREC is a lead under the NSW single ethical review model and is accredited by the NHMRC under the HoMER initiative and this ensures regular external evaluation.

There are currently 700 research projects across the precinct under the governance of the Research Office.

The organisation through the Research Office promotes the campus as a leading centre for research and encourages and assists all employees.

There is an increasing emphasis on translational research and this is noted in the development of the Kinghorn Centre.

The Research Office is also responsible for affiliated agencies such as The Garvan Institute and The Victor Chang Cardiac Research Institute, and over 40 external entities.

The Plunkett Centre for Ethics, which is a joint centre between the Australian Catholic University and St Vincent's & Mater Health Sydney, has a distinguished record in academic research on the ethical, social and religious challenges associated with healthcare provision.

The Nursing Research Institute, which is also a collaboration with the Australian Catholic University, is a lead organisation in nursing-led multidisciplinary research generating evidence useful for clinical practice.

Areas of particular interest which have resulted in awards, publications and grants include pressure ulcer prevention and acute stroke care.

West Wimmera Health Service

Nhill, Vic

For a small organisation research is well developed, particularly in allied health where there is strong leadership and pride in the work done so far.

The formal research undertaken has received Ballarat Human Research Ethics Committee approval. Speech pathology has been the lead profession in research and has been multidisciplinary in its scope.

The Dysphagia study is a randomised control study that finishes in 2015. This research has been embraced by the organisation and there has been international interest in protocols as a consequence of the research findings.

In addition to the very impressive swallowing management research project, there has been other recent research undertaken by the podiatrist and massage therapist.

The organisation is also involved in an Ethics Committee approved project looking at a virtual MET call system called TeleMET, a project of Adult Retrieval Victoria. This project aims to provide remote support for the deteriorating patient via videoconferencing.

Further research interests are being pursued including farmer health.

The organisation is to be congratulated on the presentation of research findings at numerous conferences overseas and the general and wide applicability of the findings in the health system. Research outcomes are implemented in the organisation and are used to demonstrate improvements in health care.

The organisation participates voluntarily in a regular external evaluation of research governance and has demonstrated that the research undertaken has significant human safety impacts. The organisation is to be congratulated on its achievements.

Women's and Children's Health Network

North Adelaide, SA

Research governance is supported by the Human Research Ethics Committee (HREC) and is underpinned by the National Health and Medical Research Council (NHMRC) guidelines.

The HREC and Animal Ethics Committee have Terms of Reference and both produce reports of research outputs.
A research policy informs WCHN’s processes. Guidelines to monitor research as well as a Code of Conduct for Research complement the exhaustive suite of documents.

A vast number of forms are in place to inform research approval / disapproval / tentative outcomes with robust processes to direct the research applicant accordingly. Provisions to declare conflicts of interest exist as do Expressions of Interest processes.

Research activities are continually monitored with processes in place to both modify a research proposal after approval or to modify a research proposal if results are not tracking as proposed.

The surveyors were provided with the NHMRC Certification of Institutional Processes Relating to the Ethical Review of Multi-Centre Human Research and the Women’s and Children’s Health Research Alliance Strategic Plan.

Alliances with the three South Australian universities are noted as is the long-standing alliance with the South Australian Health & Medical Research Institute (SAHMRI) and other major research partners both nationally and internationally.

Nursing research is encouraged and has been pivotal in informing best-practice standards for nursing across Australia, and WCHN has a well-established nursing research framework.

The surveyors were provided with examples of WCHN research published in peer-reviewed journals.

The surveyors noted some innovative research being carried out at Helen Mayo House including mother and baby attachment and assessing clients through to three months post-discharge.

A number of research activities led and undertaken at WCHN have translated to improvements in clinical care, and of note is the work of the Vaccinology and Immunology Research Trial Unit, The Cystic Fibrosis Gene Therapy Group, and The Mental Health Research Group. It was noted that NHMRC funding grants have exceeded $11 million.

The first of these relates to the establishment of a renal transplant service for existing patients and is to be a live donor service. The second, to commence next year, is a mental health service for adolescents and young adults based on the Orxygen program in Melbourne.

The hospital also identifies its risks, particularly the increasing costs of an ageing patient population and the need for succession planning for older, highly experienced and sought-after doctors who are due to retire in the next decade. Various strategies have been put in place to address these risks.

The most significant strategy undertaken and achieved is being awarded Magnet status for nursing care earlier in 2011. This involved two years of planning and an extensive submission covering the four pillars of transformational leadership, structural empowerment, exemplary professional practice and new knowledge, innovation and improvements. The process culminated in an assessment visit in February and the awarding of Magnet recognition in May.

St Vincent’s Private Hospital is the first private hospital in Australia to achieve Magnet recognition and only the third in Australia.

**Criterion 3.1.1**

The organisation provides quality, safe health care and services through strategic and operational planning and development.

St Vincent’s Private Hospital Darlington, NSW

- A number of significant improvements have been achieved through the implementation of an up-to-date strategic plan and these have made an impact on care and service delivery of St Vincent’s Private.

- A ‘balanced scorecard’ approach is used in all departments leading to a coordinated focus on staff, consumers and financial performance.

- Considerable effort is presently being expended on planning for a new facility to replace the present hospital which is 35 years old, and this process is well-advanced.

- A new set of by-laws was developed in 2010 and this clearly identifies the obligations of medical staff and is used to ensure that they meet these obligations.

- Consumer needs have been identified with stakeholder input and these have resulted in the development and planned development of two new services.
Melbourne Health
Parkville, Vic

The organisation has a robust approach to the management of external contractors.

Procurement procedure directions are contained within the Financial Management Policy and are consistent with the Victorian Government’s guidelines for contract management.

Melbourne Health is fortunate to have its own enthused contracts lawyer on staff, who has responsibility for overseeing the contract processes.

Processes defining the management of contracts have been reviewed and enhanced over the past 4 years and during survey the organisation was able to demonstrate improvement changes and refinements as a result of these evaluative processes. For example, the Contract Approvals template has been modified in the context of Board review of its delegations policy.

The Contract Approvals Template and Flowchart provide clear direction for staff who may need to become involved in the development of a contract.

Melbourne Health has worked with a software company to create the iPro Live computer program which is used by both Engineering and Biomedical Engineering Services to provide information to those departments, related to the status of relevant contractors.

Evidence of specific contracts noted during the time of survey contained relevant Key Performance Indicators and reporting requirements in respect of the contractor providing commercial on-campus services.

An audit review of the contracts system conducted in late 2009 comparing the Melbourne Health processes against those of a government-funded organisation, not in the area of health, and a university concluded that “MH adheres to best practice across all areas.” This comment was made in the context of acknowledging the large volume of contracts processed every year (over 1000) in a decentralised contract management structure and process which is supported by only a small staff and budget allocation.

Melbourne Health has been working with the Victorian Managed Insurance Authority (VMIA) since 2009 to run a contract management forum for all public health services and has been recognised as the organisation best placed to lead the health industry in better practices for contract and tender management systems.

This has translated into Melbourne Health working with the VMIA to develop templates and guidelines for the VMIA Research Governance Toolkit.

When VMIA is approached by healthcare services to identify better-practice organisations in contract and tender management, they refer the organisation to Melbourne Health’s Contract Management Team.

There was clear evidence that in terms of management of external service providers, Melbourne Health is recognised and accepts the role of being a leader.

The National Capital Private Hospital
Garran, ACT

There is a comprehensive range of policies which are referenced to relevant standards and legislation and promote effective risk management.

There are Standard Operating Procedures for all high-risk activities. NCPH has well-defined training programs including orientation and annual mandatory education processes.

Staff participation is monitored to ensure compliance with organisational requirements and to maintain necessary staff skills. The rate of staff participation in mandatory education is regularly reviewed as a performance indicator at the Leadership and Management meetings.

Orientation is comprehensive, conducted regularly and evaluated by all participants. If a person is required to commence employment prior to attending the orientation program, an induction is provided to the work area which covers safety issues and emergency response skills. This induction process is evaluated at the subsequent orientation program.

An annual WHS plan is documented and implementation of planned actions is monitored through the Workplace Health and Safety Committee which meets monthly.
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- NCPH regularly participates in the Safety Map / Advanced Safety Map desktop audit process as well as the follow-up external Practical Inspections, which are designed to verify the outcomes of the desktop audits.

- Monthly unit environmental inspections are performed and twice yearly the General Manager undertakes a formal “Safety Walk” which involves completion of an audit tool required by Healthscope, as well as conversation with individual staff to seek feedback and ideas about WHS issues.

- The outcomes and recommendations from these “walks” are acted upon and reported to Healthscope.

- There is a strong focus on injury prevention strategies as well as a supportive approach to any staff member who does sustain an injury. Early return-to-work is promoted and limited and/or alternative duties are offered to enable this to occur.

- Appropriate equipment appeared to be available throughout the organisation to support its manual handling risk management strategies.

- There is a register of all dangerous goods and hazardous substances used on the premises and ongoing review has resulted in a significant reduction in the range of such substances. Current MSDSs were noted to be available in all areas where chemicals are used.

- Staff who provide chemotherapy services have completed online education on the safe management of cytotoxic drugs. Spill kits are available as well as personal protective equipment.

- There is a Radiation Safety Policy which covers the use of radiation in the operating suite and the angiography unit. There is a Radiation Safety Plan and the interventional radiologist carries the responsibilities of the Radiation Safety Officer. The imaging service is appropriately accredited. Evaluation is comprehensive and ongoing with a wide range of WHS performance indicators being reported regularly within Healthscope and benchmarking being facilitated between peer services.

- NCPH consistently performs well in comparison with peer facilities and is congratulated for this achievement. NCPH was the winner of the state WHS awards in 2010 and a finalist in the national Safe Work Australia Awards in 2011.

- In particular, the surveyors commend the organisation for having achieved this recognition for overall safe systems and not for a specific safety project.

- NCPH has subsequently been invited to participate in state and national forums in recognition of its expertise and leadership in this area.

- The program aims to significantly reduce the incidence of the four major safety-related issues reported at SJOGSH, namely manual tasks, slips / trips / falls, occupational stress and adverse workplace behaviour.

- Brochures and posters about this program are widely distributed and prominently displayed throughout the facility.

- The surveyors in consulting with caregivers were impressed with the overt safety awareness culture permeating the organisation and this was reflected by the benchmark score achieved in the OHS Perception Survey conducted in 2011.

- External and internal benchmarking is undertaken in the aforementioned four key injury areas with the result that SJOGSH has achieved lower injury rates than established targets, representing significantly improved performance in the KPIs of average lost-time injury frequency and incident rates.

- The hospital has now developed and implemented a best-practice model of injury management that promotes early intervention injury management services to assist caregivers with injuries.

- On the basis of its extraordinary safety management program and its uptake both by the SJGHC network and another prominent external hospital, the surveyors consider that the organisation satisfactorily meets criteria to be awarded an OA rating on this criterion.

St John of God Subiaco Hospital
Subiaco, WA

- SJOGSH has an exceptional safety management framework in place that is progressively being consolidated and enhanced.

- The surveyors noted that the organisation was audited against the National Self Insurance Tool in 2008 scoring 68% and that a subsequent internal re-audit in May 2011 achieved a score of 96%.

- A full external audit is planned for November 2012 and the organisation is confident of achieving a near-perfect score.

- SJOGSH has committed itself to a major promotion of safety awareness throughout the organisation with the progressive development of the “Safety in our Hands” program. This had a gestation period of 15 months before it was adopted by the SJGHC Group to be rolled out across the Australia-wide SJGHC network.

- The program aims to significantly reduce the incidence of the four major safety-related issues reported at SJOGSH, namely manual tasks, slips / trips / falls, occupational stress and adverse workplace behaviour.

- Brochures and posters about this program are widely distributed and prominently displayed throughout the facility.

- The surveyors in consulting with caregivers were impressed with the overt safety awareness culture permeating the organisation and this was reflected by the benchmark score achieved in the OHS Perception Survey conducted in 2011.

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St Vincent’s Private Hospital
Darlinghurst, NSW

- The safety management systems are robust and are underpinned by well-documented WHS policies that are linked to legislation and relevant Australian Standards.
- The WHS Committee meets regularly with wide representation from all areas of the organisation. Processes are in place to ensure all members are appropriately trained and that the minutes of the meetings of the Committee are made available for staff information and displayed on notice boards.
- WHS is a standing agenda item on all unit and executive meetings.
- All staff are responsible for assisting in completion of inspections to identify hazards and reporting potential and actual hazards to their WHS representative and their manager.
- A risk register which is subject to regular review is maintained and incorporates risks identified at functional sites and from incident reporting.
- There was evidence that staff, visitors and contractors are educated on WHS, and the introduction of the e-learning Workplace Safety & Culture Module has assisted in achievement of 90% compliance with the mandatory training requirements in 2010 – 2011.
- The introduction of a manual handling associates program, increased manual handling training, the purchase of manual handling equipment and new beds and a well-developed injury management program have been associated with a substantial reduction in costs and lost-time injuries associated with manual handling.
- The hydraulic lifter and packing tables installed in the sterilising services were designed by SVPH staff and other organisations have visited the facility with a view to adopting the design.
- Safe operating procedures are widely displayed at point of work throughout the hospital and storage and handling of hazardous substances and chemicals are managed in accordance with relevant standards and guidelines. ChemAlert is used.
- Material Safety Data Sheets are available and provide staff with current information in relation to product storage and handling.
- Radiation Safety is very well-managed and compliance with industry requirements is evident, including NATA and RANZCA accreditation.
- Nuclear medicine services were commenced during the week of the survey and there was evidence that substantial work had been undertaken to ensure staff and patient safety.
- Laser safety is also very well-managed and is overseen by a Laser Safety Committee.
- SVPH participates in external benchmarking of WHS performance and there is evidence of improvements made as a result of these activities.
- SVPH has received several awards in acknowledgement of its performance in workplace safety activities, including in 2010 two WorkCover NSW Safe Work awards and two awards from the National Safety Council of Australia.
- In October 2011 the organisation received a Mental Health Promoting Workplace award from the NSW Health and Mental Health Association NSW. Staff are congratulated on these achievements.

West Wimmera Health Service
Nhill, Vic

- The organisation is to be complimented on the presentation of all buildings within its organisation. They were clean and tidy and notably free of clutter.
- The natural light provided a lovely ambience; corridors were wide; floor surfaces were suitable; and the integrity of surfaces was well-maintained. All contributed to a safe environment for the frail and disabled.
- All buildings within the organisation, at all sites, have been designed and constructed in accordance with the Building Code of Australia (BCA) regulations and appropriately certified.
- There is evidence of consumer participation in the planning and design of the building and involvement of WHS and infection control where relevant.
- Safety measures are in place to accommodate patients presenting with the acute stages of mental unbalance. This takes the form of rooms separate from mainstream patients with entry and exit doors for staff.
- Areas for authorised access only were appropriately secured.
- Appropriate signage is in place to guide consumers through the buildings and highlights areas where authorised access only is permitted.

Criterion 3.2.2
Buildings, signage, plant, medical devices, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.
In accordance with BCA regulations vision-impaired signage is present for public amenities. Signage within the organisation is language-based.

An external signage review was conducted in 2012 and, as a result, new signage was installed throughout the Nhill site in accordance with the chosen “Way Finding Signage System”. The evaluation of this change has resulted in the system being implemented across the services.

Dangerous goods and hazardous chemicals are stored in accordance with relevant standards. Relevant signage is in place. Appropriately qualified external services are used to audit, check and test for consistent compliance. This includes testing and tagging of electronic equipment.

Log books are maintained for all generators. Staff are oriented to the use of engineering equipment before access is granted.

Biomedical equipment is maintained by biomedical engineers and the biomedical equipment register has been reviewed and updated.

Product evaluation is completed prior to the purchase of new equipment, which includes a record of consultation processes. A replacement plan is in place for equipment.

There are many examples of improvements throughout the service, including development of new facilities and renovation to existing, the purchase of medical and diagnostic equipment to accommodate new surgical and diagnostic procedures, the purchase of macerators (which has been rolled out across the services replacing pan flushers and resulting in a significant water saving, because the process does not require water and results in 80% energy saving), purchase of a telecommunication system for clinical and general conferencing, expansion of information technology, a tank farm being established to provide the organisation with an ample supply of water, new equipment and furnishings, and changes to air-conditioning and furnishings to accommodate fires and provide an increase in resistance.

The organisation has a fleet of vehicles and environmental and safety aspects are considered in the purchase and use of vehicles. Diesel-powered vehicles are utilised for fuel efficiency and reduction in greenhouse emissions.

Considerable improvements have taken place in the maintenance area. An extensive number of maintenance staff are employed by the organisation. Staff profile and skill mix is relevant to the needs of the organisation.

Other improvements include the development and implementation of a defined maintenance schedule. The grounds were well-maintained and aesthetically pleasing. Protective clothing was made available and used. The maintenance of grounds forms part of the maintenance service.

Consistent cleaning was evident. Staff interviewed had defined cleaning schedules and regular internal and external cleaning audits are performed to measure effectiveness.

The organisation demonstrates it is a leader in the management of buildings, signage, plant, medical devices, equipment, supplies, utilities and consumables, as evidenced by the Victorian Department of Health using the organisation as a benchmark for other healthcare organisations.

The organisation has been included in published papers presented at the Hospital Engineers Association, in published papers regarding the innovative use of LED lighting and papers have also been presented at national and international conferences.

The organisation has received visits from other organisations nationally to view the designs and usage of materials and equipment.

Workplace Safety stated that the organisation approached safety better than any other organisation they had visited.

The organisation is to be commended on its achievements.

Criterion 3.2.3

Waste and environmental management supports safe practice and a safe and sustainable environment.

Hepburn Health Service
Daylesford, Vic

The organisation is accountable for its waste from generation to its final disposal.

The organisation demonstrates both safe practice and a responsible environmental approach to waste management.

There is a long-standing commitment within the organisation to the efficient and sustainable use of energy and water.

In 2009 the organisation was the first Victorian health service and State Government agency to achieve Gold level certification as a “Waste Wise” organisation with Sustainability Victoria, which has now been replaced with a new initiative, “Resource Smart”.

ACHS National Report on Health Services Accreditation Performance 2011 - 2012
The organisation was selected as a pilot site for the new Resource Smart program. As a participant in the healthcare program, sustainable energy targets are considered in purchasing and maintenance processes.

Performance targets have been established and in state-wide results HHS has below-average carbon intensity compared with local hospital and whole-of-portfolio averages. Accommodation units currently under construction are being built to 6 star energy ratings.

Building renovations include environmental sustainability measures, e.g. solar hot water, toilets flushed by tank water.

VicHealth under the Resource Smart program has used the organisation’s policy, procedures and practice as a demonstration service to other healthcare organisations.

The organisation has also made multiple presentations at state-wide forums, accepted requests to speak to other services, and hosted visiting delegations.

Kooweerup Regional Health Service
Kooweerup, Vic

Excellence key improvements and a plan for improvement were evidenced.

Policies and procedures in place are in accordance with Australian Standards and guidelines.

Waste streams are for contaminated, general, cardboard and recycled waste. The WHS Committee, local Council and external contractors (contaminated waste) audit these streams.

Laundry for the hospital, nursing home and hostel is processed onsite.

Procedures are in place to ensure compliance with relevant infection-control barriers, especially for food and linen.

Contaminated waste is held in a secured room specifically provided for this purpose.

The kitchen is cook-fresh. Food scraps are used in the recently established worm farm.

Most lights within the new section are activated by movement detectors.

The Men’s Shed building is also utilised to host numerous community group activities. The recently appointed coordinator manages these projects and ensures nothing is wasted. Vegetables harvested and eggs collected are utilised by the cooking group and hospital or the surplus sold. This multidisciplinary unit is titled “The HUB”.

The water from the solar units being fed into the boilers is now regulated by an innovative system called the Building Management System (BMS). The large solar energy collectors allow significant savings in the cost of gas and electricity. These collectors are backed up by gas heating.

KRHS is considered an innovative leader in relation to environmental management and regularly hosts workshops and industry inspections in relation to the solar system, BMS, the HUB and the planned ECO house.

Metro North Hospital and Health Service (MNHHS) – Royal Brisbane and Women’s Hospital and MNHHS Oral Health Services
Herston, Qld

Comprehensive policies and procedures for the management of waste are available together with excellent recycling programs.

Waste disposal guidelines are in place for all categories of waste.

There is a strong sense of pride in the achievements in recycling and in significantly reducing the amount of waste sent to landfill, and results have been improved by benchmarking and by continually seeking avenues for the recycling of waste products.

The team leaders are proactive and dedicated to continually improving waste management. Significant savings have been generated by the compaction of waste.

Waste segregation is closely monitored and there has been a significant reduction in clinical waste and a bar-coding system has been developed to successfully track clinical waste.

The recycling area is well-organised, clean, safe, odour-free and with due attention to manual handling issues, and recycled water is used to clean the area.

Specially designed trolleys and equipment are used for waste management. Smaller bins are made available to smaller rooms to assist with waste segregation and recycling.

There is a training system in place for all waste staff. The survey team noted evidence of protective equipment and clothing used by waste staff.
St John of God Subiaco Hospital Subiaco, WA

- SJOGSH has a strong tradition of excellence in the areas of waste management and environmental stewardship.

- The surveyors noted the various awards the organisation has accrued since the last ACHS survey, the most recent being the Corporate Business Leading by Example Award at the WA Environmental Awards for the group’s innovative “Safeguarding Our Environment Program”, which is acknowledged as the best in the state and was developed and piloted at SJOGSH.

- The surveyors were also impressed with the consolidation of existing waste minimisation processes and the exceptional initiatives undertaken via the hospital’s Environmental Management Policy and associated Environmental Strategy.

- The most striking element of the latter is the Green Travel Plan and Program 2010 providing financial incentives to staff to utilise a range of options to significantly reduce single car travel to and from the hospital. Approximately 430 caregivers are now registered with this scheme, which is funded from the proceeds of the facility’s parking revenue. The organisation has been invited to present this Program to a WA Government Forum in August 2012.

- The hospital was the first health employer to implement and use the Energy Carbon Information System (ECIS) to electronically gather utility and waste data for performance management and National Greenhouse and Energy Reporting (NGER). Reports on carbon dioxide emissions/month and day are elicited for 17 cost centres and trended over time. The SJGHC Group benchmarks waste KPIs across its network.

Liverpool Hospital Liverpool, NSW

- Liverpool Hospital enjoys a prestigious and prominent position and reputation in emergency and disaster management.

- At the inception of the period of development, the hospital undertook to take a leading role in emergency and disaster management. Some years ago, two of the hospital’s doctors were instrumental in devising the MIMMS training method for medical disaster management. This method has gone on to become the standard, and is the method almost exclusively used for training in Australia.

- The hospital is exemplary in complying with best practice and in leading in disaster and emergency management. It attracts candidates for ED training and trauma management, and is a principal teaching centre for disaster and emergency management.

- The hospital is a principal receiving and coordination centre for responding to off-shore disaster, and is the provider for training in these areas for NSW ambulance and the ADF, with whom it has a special arrangement for providing services and training for disaster.

- Medical and nursing ADF personnel rotate through the ED, ICU and theatres in receiving emergency training.

Mandatory criterion 3.2.4
Emergency and disaster management supports safe practice and a safe environment.
The hospital provides the Definitive Surgical Trauma and Perioperative Nurses Trauma Courses for the ADF. The hospital even has special pad capacity for receiving heavy helicopters carrying multiple casualties.

Not only is the hospital compliant with state and national disaster plans, but its plans are also compliant with the WHO Disaster Plan, and it maintains annual compliance.

In 2012 it will host the 20th Anniversary of the SWAN Trauma & Emergency International Conference, with faculties attending from Europe, Asia, the Middle East, Africa, the Pacific and North America.

The hospital has numerous personnel trained for international disaster response, and has sent doctors, nurse practitioners and nurses to disasters such as the Pacific tsunami in Samoa and the Solomon Islands, and the earthquake in Christchurch received the services of a doctor trained in urban search and rescue (USAR).

Many staff are trained to teach internationally, and do so regularly in Cambodia, Singapore and Vietnam.

Several staff members are members of the World Association for Disaster and Medicine.

Locally, in addition to this emergency and trauma preparedness, the fire responses are exemplary, and used as a model within NSW and nationally.

The hospital has its own fire technicians, minimising delay due to travel and unfamiliarity, and the hospital retains ex-senior NSW Fire Brigade officers for training and disaster on-call.

The hospital maintains a disaster website and DVD, “Being Prepared”, now taken up by the Health Ministry.

Liverpool Hospital provided disaster readiness for the 2000 Sydney Olympics, and covers the massive public City to Surf every year.

Liverpool Hospital is an outstanding leader in emergency and disaster management, providing teaching, attracting trainees from around the country, and providing an exemplary model from which other NSW, Australian and international practitioners learn.

Princess Alexandra Hospital Woolloongabba, Qld

PA has a highly developed organisation-wide framework and policy for management of emergencies and disasters. This was particularly important for managing the recent emergencies associated with major flooding in Queensland, where emergency preparedness was tested.

A colour-code system is used to identify emergency responses. The codes are available in strategic locations throughout all sites. All code activation is responded to in a timely manner and reasons for activation are evaluated. Information is also available on the intranet and is easily accessible.

Drills and evacuation exercises have been conducted throughout PA and details are included in a register of training.

Mandatory training requirements were evidenced from an organisational and division perspective.

PA became the control centre and staff were deployed to evacuation centres when floods occurred in January 2011.

PA also assisted with the transfer of patients from Cairns Base Hospital during Tropical Cyclone Yasi. Innovative strategies, including setting up accommodation in hotels, were needed to ensure patients could continue to access care and treatment. No adverse outcomes were experienced and a detailed evaluation of these events has resulted in minimal changes to procedures being made.

Fire Reports were reviewed and all outstanding recommendations have been addressed and fire training meets requirements.

It was evident to the survey team that PA is recognised for its systems and processes and that these systems and processes were instrumental in meeting the challenges of the floods. PA is commended on this achievement.
APPENDIX C
OA SUMMARIES BY CRITERION

OA ratings against other criteria

Figure 43: Organisations that achieved OA ratings in surveys under other accreditation programs conducted between 1 January 2011 – 31 December 2012 (n=9; italicised text indicates a mandatory criterion)

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Program</th>
<th>Criteria with OA rating*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthscope Ltd, Melbourne, Vic</td>
<td>EQuiP5 Corporate Health Services</td>
<td>2.1.1</td>
</tr>
<tr>
<td>Medibank Health Solutions – Telephone and Online Services (Wollongong), Wollongong, NSW</td>
<td>EQuiP5 Corporate Health Services</td>
<td>2.4.1</td>
</tr>
<tr>
<td>Hunter Medicare Local, Newcastle, NSW</td>
<td>Quality for Divisions Network</td>
<td>1.3.1, 2.3.1, 4.2.1</td>
</tr>
</tbody>
</table>

(*The EQuiP5 Corporate Health Services criteria numbering follows that of EQuiP5; for the Quality for Divisions Network program, the relevant criteria are as follows: 1.3.1, Effective programs are implemented that support health outcomes and reduce health inequities; 1.4.1, Care is planned and delivered in partnership with the consumer / patient to achieve the best possible outcomes; 4.2.1, The organisation uses an integrated approach to plan, and appropriately use, information technology.)

### MANDATORY CRITERION 2.1.1

**The organisation’s continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.**

**Healthscope Ltd**

**Melbourne, Vic**

- It was evident that the management of Healthscope is committed to improving performance and ensuring the effective management of risk.

- An annual organisation-wide Safety and Quality Plan is used as a framework to monitor, review and improve clinical safety, risk management and quality initiatives, in addition to ensuring compliance with all external accreditation and certification requirements.

- The Plan is reviewed regularly, and includes a summary of prior year achievements, new initiatives for the coming year and performance indicators against areas of strategic focus that are reviewed and compared across the organisation to support continuous improvement.

### CRITERION 2.4.1

**Better health and wellbeing is promoted by the organisation for consumers / patients, staff, carers and the wider community.**

**Medibank Health Solutions – Telephone and Online Services (Wollongong)**

**Wollongong, NSW**

- The organisation is able to truly demonstrate that it is indeed a leader in its field, through the advancement of better health and wellbeing for its client population.

- There is ample evidence that the organisation is further developing and refining its programs based on its own extensive program evaluations and available clinical evidence to support service improvement.
**Criterion 1.3.1**

**Effective programs are implemented that support health outcomes and reduce health inequities.**

**Hunter Medicare Local Newcastle, NSW**

- Programs are largely determined in conjunction with the specific requirements of customers (for their specific client groups) and the organisation regularly works with its customers to tailor programs based on need and available clinical evidence.

- Based on the surveyors’ review and understanding of the organisation and using this a barometer for other organisations, the surveyors believe that the rating of this criterion should be OA to reflect the organisation’s position in its own market field and the recognition of it by many other organisations, in both the private and public sectors. It is also a reflection of the overall service provided.

- This collaborative and innovative Health Pathways project established an online portal which guides GPs and health professionals through referral lines or pathways for the treatment of chronic ailments. By helping GPs and primary care providers manage a condition and accurately refer a patient to local specialists and services, health outcomes are improved and waiting times reduced. Forty pathways have been developed with an additional 45 in development.

- HML is one of three national lead (eHealth Wave 1) sites. The eHealth Wave 1 sites have been chosen to progress elements of the PCEHR system in practical settings. This will allow the Australian Government to be confident that the different components of the system work as intended. To date the team has engaged 82% of local practices and 298 GPs in the project. Achievement in regard to KPIs has been on or above target.

- A survey was undertaken in conjunction with the Hunter Integrated Pain Service, to gather information about sharing pain research evidence through online media. Participants viewed a five minute YouTube video on pain management and were then asked a series of questions. A total of 149 participants completed the survey, with participants exhibiting a wide range of knowledge on pain management. Over 80,000 people have now viewed the YouTube video and it has been translated into a number of languages for foreign audiences. One outcome of the survey is the realisation that there is much scope for online sharing of information between health researchers and health consumers.

- The HML Connecting Care Team was established in September 2010 and was responsible for developing the clinical pathways, GP engagement strategy, and the WHS and clinical risk management documentation for use by HML and other Divisions of General Practice within the Hunter New England Local Health Networks boundaries. The service also supports GPs by providing targeted case management of their patients who have complex chronic disease issues.

- In October 2010 HML began participating in the Closing the Gap program, which aims to improve the health of indigenous patients. HML began working with practices to implement a range of strategies to combat the health inequities evident in the indigenous population. One strategy was to provide literature and other resources to practices, to ensure they were appropriately identifying patients as Aboriginal and/or Torres Strait Islander.

- A further strategy involved using the PEN Clinical Audit Tool to identify indigenous patients within a practice who had one or more chronic diseases, who were then contacted and invited to return to the practice for a health assessment.
Criterion 2.3.1
The organisation develops a continuous quality improvement system to demonstrate its commitment to improving performance in program and service delivery.

Hunter Medicare Local Newcastle, NSW

- HML has a clear commitment to continuous quality improvement, which underpins all its activities and makes it a leader in this field.
- Quality Improvement is embedded in the delivery of programs and services at all levels of the organisation.
- The monitoring of KPIs by Board Committees in the areas of clinical, corporate and financial governance together with the input of an Ethics Director ensures that the Board is fully apprised of performance within the organisation.
- The commitment of the Clinical Directors to clinical standards in the After Hours Service has resulted in outstanding performance in terms of patient care and efficient delivery of services.
- The Psychology service continues to get new GPs engaging each month, who have not used services before.
- Since July 2010, 416 (93%) GPs have referred from 168 (100%) practices. These numbers represent significant ongoing engagement with this service by GPs.
- Client Satisfaction Surveys are reported three times per year to the Clinical Governance Committee. 100% of the practices contacted by their assigned Practice Support officer and support activity demonstrates the success of this new model of practices for increasing services to members.
- The Practice Support team performed 886 practice visits during 2011/2012, an increase of 22% over the previous reporting period and 88 (59%) practices signed up for the Practice Incentives Program Indigenous Health Incentive, a 76% increase on the previous reporting period.
- Closing the Gap staff carried out 297 information and support visits to practices, a 111% increase on the previous year.
- There was an increase of 82% in the utilisation of ATSI Health assessment (item 715), taking the number of health assessments completed from 340 to 618 for the 12 months to March 2012.

Criterion 4.2.1
The organisation uses an integrated approach to plan, and appropriately use, information technology.

Hunter Medicare Local Newcastle, NSW

- HML continually addresses the user’s need for improved technology to facilitate the effective and efficient use of the organisation’s information, to provide quality programs and services and meet organisational goals.
- Despite the many challenges of the two-phase establishment of HML, the organisation has been able to maintain its position of being a leader in the effective and efficient use of information technology to support the providers of primary healthcare services.