

# Health Quality and Complaints Commission

## Submission:

In response to:

*Discussion Paper – National Safety and Quality Accreditation Standards* (November 2006)

Australian Commission on Safety and Quality in Healthcare

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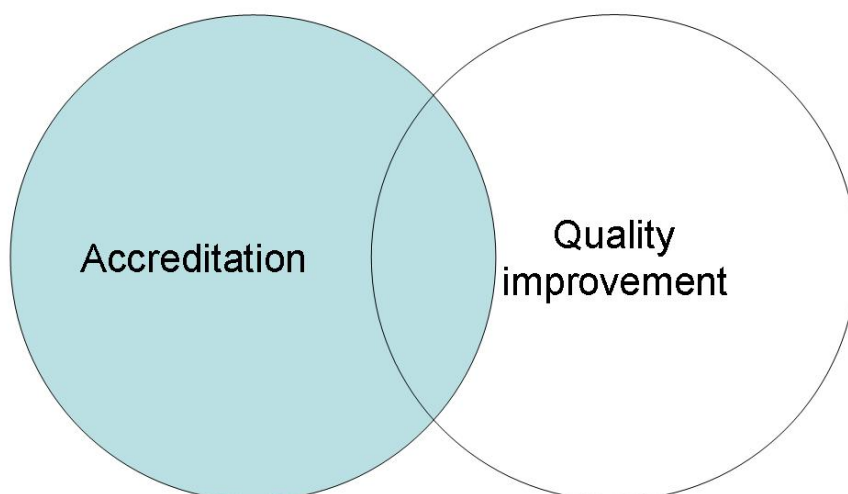
### **PREFACING COMMENTS**

The Australian Commission on Safety and Quality in Healthcare (ACSQH) discussion paper raises for debate, a range of operational issues relating to stakeholder roles and responsibilities for safety and quality in health care settings.

The ACSQH Discussion paper prefaces its introduction on the assumption that "*Accreditation in Australia is widely recognised for substantially improving safety and quality over recent decades.*" This assumption does not in fact, represent the complete picture of accreditation. Neither does the paper document a proven causal relationship between accreditation and quality improvement, or the influence of other factors.

Clearly the role of accreditation, as noted in the paper, is broader. Accreditation is required with a different focus for licensing and funding arrangements. Further, in many jurisdictions, legislation overrides or directs accreditation requirements.

Further, the paper does not consider the governance roles of all stakeholders within both accreditation and quality improvement arenas. It is possible that these stakeholders, objectives and outcomes, in some cases, are mutually exclusive. See Figure 1 below.



In order to better inform this debate, the Health Quality and Complaints Commission (HQCC) recommend that a framework be provided which outlines the underpinning principles. The HQCC suggests the National Strategic Framework for Safety and Quality in Australian Healthcare. This framework should be underpinned by guiding principles that reflect the commission's vision for the accreditation industry regulating the Australian healthcare system to ensure a common understanding of the purpose of the reforms, the intended outcomes, and strategic alignment. What is the problem we are trying to fix?

The issues with the current system of accreditation when considering quality improvement include:

- Defining acceptable performance

- Credible processes for assessing performance
- Availability of timely relevant information
- Value adding
- Determining the overall status of the quality of health services.

The ASCQH's Discussion Paper, *The Governance of Health Safety and Quality*, (Braithwaite, Healy & Dwan 2005) discusses effective regulatory mechanisms for improving the safety and quality of health care. This paper considers regulatory strategies and policy instruments available for governance that includes: command and control; meta-regulation; economic instruments; and self-regulation and voluntarism.

The discussion paper groups accreditation into "self-regulation". Further consideration is required as to the role of accreditation in governance, including determining its role in market forces (eg accreditation as a requirement for funding), and the role of regulation (mandated quality improvement).

The introduction notes that "*Accreditation was considered as part of the Review of Future Governance Arrangements for Safety and Quality in Health Care*<sup>1</sup>, (the Patterson Report), that was submitted to Health Ministers in July 2005. The Report recognised accreditation as an important driver for safety and quality improvement and noted Australia's health accreditation processes are highly regarded internationally."

Further it states that

*"However, the Patterson Report also noted stakeholders were concerned about duplication where facilities are required to be assessed by multiple accreditation bodies or meet the additional requirements of regulators or funders. The Patterson Review team suggested that Ministers reduce the burden for health services meeting accreditation requirements by identifying alternative models and options for streamlining.*

*A number of the Patterson Report's recommendations were incorporated into the AHMC paper including:*

- *The review of existing standards that apply to the health sector, to determine opportunities for streamlining and reducing duplication;*
- *The need for a best practice model to translate nationally agreed safety and quality improvement policy and standards into accreditation standards as a mechanism for implementation;*
- *The requirement for methods to address the rigour and robustness of survey processes; and*
- *Development of mechanisms to ensure appropriate action is taken in the event that an unacceptable threat to the safety and quality of care is identified by an accreditation agency."*

The document states that "*It [the Patterson Report] aims to generate discussion about the proposed model and on the need for, and contents of, a set of core safety and quality standards broadly applicable across the health sector.*" In providing this limit on the discussion of accreditation, without recognising the additional roles of accreditation (as outlined in Section 3 – Definitions, of the ACSQH's Discussion Paper), the intention of the paper becomes mixed and the goals of the Patterson report unattainable.

Neither ACSQH's principles nor vision of have been incorporated into the discussion presented. This omission presents difficulties for stakeholders who are being asked to respond strategically to an alternative model of accreditation for health services in Australia without awareness of the strategic intent of the ACSQH.

The introduction states that "*The need for a new model is not because of fundamental failures with the current accreditation system.*" Whilst there are clear examples of safety and quality failures in accredited facilities, it would appear that the reforms are striving to support a strengthened association between quality and accreditation, while continuing to address safety in healthcare. Stakeholder response to the discussion paper must be developed with this principle in mind.

Industry stakeholders have divergent perspectives as a factor of their function, and their response to proposed reforms will be shaped by this perspective. As the ACSQH was newly formed in 2006, articulating strategic direction is seen by the HQCC as an important starting point to consultation regarding and implementation of the proposed accreditation and standards reform package.

## **COMMENTS RELATING TO THE HEALTH QUALITY AND COMPLAINTS COMMISSION**

As discussed in the prefacing comments, there are a number of regulatory strategies and policy instruments available to improve the safety and quality of health services. Accreditation is but one. The Health Quality and Complaints Commission (HQCC) has a range of regulatory and legislative powers determining its role in safety and quality in health care.

### **Legislative Requirements of the HQCC that underpin the Submission:**

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The HQCC is an independent body dedicated to improving the quality and safety of health services in Queensland. Its scope, functions and powers are governed by legislation<sup>1</sup> and include the ability to set and monitor compliance with standards and accreditation relating to quality of health services.

Accreditation processes are central to the business of the HQCC and its Act is reliant on these processes as they pertain to health services and providers. Changes to the industry may have a bearing on the HQCC. Similarly, elements of the HQCC's functions, such as its ability to undertake investigations and develop standards, and its independent nature may impact upon the health care accreditation industry.

**Therefore, the HQCC requests that the ACSQH review process consider:**

- **the overall governance of health safety and quality;**
- **the role of bodies with overlapping governance functions; and**
- **legislated responsibilities of other relevant bodies.**

In its function as a standard setting body, the HQCC will independently prioritise and set standards that are in the best interest of the user of a health service, or adopt accreditation standards if appropriate. While it supports the introduction of best practice models, the HQCC's independent nature demands that it not be beholden to any limitations made upon the standard setting process that may compromise its legislated functions. In order to clarify roles and responsibilities in a new accreditation environment, a model such as a Memorandum of Understanding may need to be established between the HQCC and the accreditation and standard registering authority.

In its function as a quality monitoring body, the Commission will assess the quality of health services against standards and/or accreditation as well as the provider's duty to continuous quality improvement. The HQCC is concerned that in the current environment, quality of health service outcomes is not an automatic assurance of accreditation. Significant change to accreditation processes must be initiated for the association between the two to be strengthened. While the proposed reforms may progress this development, the industry's position is not yet broadcast and therefore the level of commitment to the proposal is unknown. For this reason, it is essential for the HQCC to retain independence of any processes that may constrain its ability to carry out quality monitoring and to make its findings known to the public.

**Therefore, the HQCC requests that the ACSQH review process consider the role of accreditation in the provision of quality assurance for health service outcomes.**

The HQCC supports the principles of proposed accreditation reforms, namely to engender a patient focus, systematise continuous safety and quality improvement, detect and respond to systems failures, develop best practice models, harmonise standards development and establish a nationally recognised accreditation process.

**Given its jurisdictions as a standard setting body, the HQCC would request involvement in the development processes that are a product of this consultation.**

Comments regarding the HQCC's position on the proposed reforms are detailed below. They address Future Systems and Processes (Accreditation and Standards Reform Strategies, Mutual Recognition of Standards and Accreditation Processes) described in Section 8 of the ACSQH Discussion Paper<sup>2</sup>.

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<sup>1</sup> *Health Quality and Complaints Commission Act, 2006 (Act)*

<sup>2</sup> Discussion Paper – National Safety and Quality Accreditation Standards (November 2006)

## **PROPOSED ACCREDITATION REFORM STRATEGIES**

The following response addresses the specific reform proposals outlined in the Discussion Paper - National Safety And Quality Accreditation Standards (November 2006). The responses provided are numbered in accordance with the numbering of initiatives as outlined in section 8 of the Discussion Paper. Responses are provided with the understanding that they are to be considered in conjunction with preceding comments.

Additional responses were provided at the Consultation Forum on 21 March, held in Brisbane, and attended by staff members of the HQCC

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### **1: Register of accrediting bodies:**

*ACSQH proposes that a register of accrediting bodies that is easily accessed and affordable for accreditation agencies be established as well as a nationally agreed set of accreditation data on safety and quality. The purpose is to increase coordination within the industry and provide a single point of reference to funders, service providers and consumers.*

#### **Questions:**

***What needs to be in place to make this approach feasible?***

***Which organisation is best placed to manage the registration of accreditation bodies?***

To make registration of accrediting bodies feasible *and effective*, all accrediting agencies would need to subscribe to the approach as registration will impact on the independence of agencies.

Consideration is required of the current role of bodies responsible for accrediting accreditation agencies (eg ISQua and JAS-ANZ).

It is feasible that ACSQH may be well placed to establish and manage this register given its support by all health jurisdictions and perceived impartiality from commercial interest. While it is acknowledged that ACSQH's current Terms of Reference do not include long term implementation of projects, it may be possible to amend the Terms of Reference. However, consideration is also required of the potential for governmental influence in politicising the process (as noted in the Background paper when providing the example of CASA within Australia).

An Advisory Committee to the ACSQH may include representatives from 'not for-profit' and 'for profit' accrediting agencies, funders, public and private health service providers and consumer groups, to ensure balanced perspectives of the industry.

Registration would facilitate the establishment of a nationally agreed dataset for monitoring quality trends. As other jurisdictions such as the HQCC may have legislative requirement to access such information, the HQCC would request involvement in the development of guidelines detailing the management and access to the dataset. These guidelines would also identify:

- other uses of the data;
- how the information might be accessed by or disseminated to the public;
- privacy issues that impact upon data usage.

Currently accreditation data fails to provide an indication of how and where accreditation impacts upon clinical outcomes as a credible link between the two elements has not been established. The HQCC recommends that in association with accreditation reforms, the ACSQH facilitate the process to strengthen quality and patient focus within the accreditation process (further discussed, section 4, below).

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### **2: Standardise accreditation language and definitions:**

*ACSQH proposes that a language and definitions used within the industry be standardised.*

#### **Questions:**

***Who needs to be involved in the standardisation of language and definitions?***

The HQCC see this as fundamental to ensuring a cohesive approach to using standards and accreditation for quality improvement in health care and supports the recommendation for the ACSQH to lead this work. The HQCC would recommend consultation with a multidisciplinary working party that included clinical and consumer representation. Use of consistent terminology would enhance public access to accreditation information thereby facilitating consumer decision making and a more informed public. Revision of agency

standards should be conducted within a given timeframe and costs associated with revisions should be borne by respective agencies.

The HQCC would request to be consulted on this aspect of the reforms.

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### **3: Training and competency testing of surveyors:**

*ACSQH proposes that a review of surveyor qualification and training be undertaken.*

**Questions:**

***What are the essential skills, competencies and attributes that surveyors need?***

***What needs to be in place to train and assess surveyors effectively?***

***What must be done to ensure inter-surveyor reliability?***

***What strategies need to be put in place to ensure a sustainable supply of credible and competent surveyors is available?***

To ensure surveyors are adequately skilled, they should be required to undertake a periodic, core competency assessment program. This would include assessment of attitudes, values and skills to achieve increased inter-assessor reliability and a quality improvement focus for patient centred health outcomes. The competency assessment program would also inform a surveyor training needs analysis which might be conducted by the accreditation agency registering authority. Where specific competencies relevant to the accreditation domains of specific agencies were required, these would best be assessed separately, by the respective agency.

Minimum standards should be required for continued registration as a surveyor and the status of surveyor competency should be published through a readily accessible medium (ie electronically). Competency testing of surveyors would lead to credentialing and this function would be appropriately managed by the registering authority.

The discussion paper does not address the issues of management, monitoring and funding of this aspect of reforms.

Training and competency alone will not ensure objective and informative accreditation assessment; additionally, this requires appropriate recruitment and assignment of surveyors. If surveyors are seconded from the clinical arena but required to assess clinical setting outside their usual environment, the ability of the assessor to provide an objective assessment may be lessened, despite the presence of clinical credibility. Mechanisms that support assignment of impartial and appropriate surveyors in accreditation need to be established and managed. Possible models for further discussion include Peer Invitation or Peer Accreditation. These would incorporate quality improvement processes such as peer audit to increase reliability and reproducibility of results in competency assessment.

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### **4: Better use of data for evaluation of health service performance.**

*ACSQH proposes that the ACSQH explore opportunities to use data from a number of collections to provide a more comprehensive picture of health service output and to overcome current data fragmentation.*

**Questions:**

***What needs to be in place to allow accreditation data to be collected at national level?***

***What needs to be in place to allow accreditation data to be made available?***

***How can available data sets be used to inform accreditation processes***

Accreditation currently does not assure a benchmark for good clinical outcomes; there is controversy as to whether the two can be linked. However, for objective and meaningful evaluation of health service performance there is a need to advance a quality focus within the accreditation process. How "Quality", as an element of accreditation, might be addressed has not been explored in this discussion paper. The proposed reforms provide a good foundation for future development in this area.

The HQCC acknowledges that in evaluating health service performance, both health outputs *and health outcomes* must be reviewed and recommends that the proposal be expanded to reflect this perspective. Incorporation of the later enables patient centered and quality improvement foci to be depicted in data that may be collected at national level. Combined, a more comprehensive picture can be generated in the evaluation of health services. It is also of value to health service providers by providing feedback to individual continuous quality improvement programs and informing risk identification. Establishing "risk indicators" within the dataset would provide valuable guidance to accrediting agencies (eg in identification of priorities

for conduct of unannounced surveys and tracer methodologies) and external agencies such as the HQCC in the ongoing assessment of quality in health care.

The HQCC would support the establishment of a steering committee to explore mechanisms necessary and opportunities available under the proposed reforms to strengthen this link.

If the ACSQH is to coordinate improved management of accreditation data, their role would dovetail well with that detailed above, namely coordination of registration of accrediting bodies and accreditation database management. In addition, it would be beneficial to establish a process whereby working parties for remediation can be initiated by the ACSQH when analysis of trends in accreditation detects deficiencies in quality of patient care.

An avenue for sharing and learning from information gained through accreditation could afford great benefit to health service providers and managers. A multifaceted approach to this information sharing must be taken and should involve published data (electronically and through peer reviewed journals) and open forums (conferences and professional development programs).

The HQCC notes that currently data available to inform accreditation processes is not subject to external scrutiny and therefore may not provide a true reflection of service provider status. The rigour of accreditation could be strengthened through a process whereby data could be verified against evaluation data from external sources.

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## **5: System wide accreditation against safety and quality standards**

*ACSQH proposes the use of a range of regulation, funding and policy levers to ensure health services participate in a registered accreditation and quality process*

### **Question:**

***Which health services should be accredited as a priority, and how can this be best achieved?***

The HQCC recognises the importance of levers to enforce policy instruments, however, the question posed does not address the fundamental issues noted in the opening comments regarding the roles of accreditation in governance of quality and safety issues.

In principle, the HQCC supports the use of system-wide accreditation against safety and quality standards, but given that accreditation also addresses other standards not associated with safety and quality of patient care, further consideration of the complexity of the key stakeholders and their purpose is required.

The HQCC would advocate for establishment of priorities for accreditation to be determined by:

- risk assessment of: the provider; potential and frequency of adverse outcomes;
- potential for benefit; or
- areas of known harm or poor quality

Collaboration with authorities such as registering or licensing boards, the State Coroner, Quality Commissions, and Quality Councils in each state or territory would be necessary to achieve this proposal. The legislative requirements of these authorities would need to be considered.

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## **6: Introduction of unannounced surveys**

*ACSQH proposes that unannounced surveys be introduced by all accreditation providers; the purpose being to generate a shift in culture regarding preparation for a scheduled visit toward one that promotes constant compliance with health service standards.*

### **Question:**

***What needs to be done and by whom to introduce unannounced surveys in a timely and effective way?***

Further information is required in order to determine the issue this recommendation is attempting to address.

In principle, the HQCC supports the use of methodologies that require quality and improvement processes during the entire accreditation period, rather than a process focused on the accreditation visit. Whether this method is optimal for achieving the outcome, or introduces further logistic issues would require the provision

of further information. Further clarification is required regarding the intended focus and how the methodology should be used. This is inclusive of the triggers that may be used to initiate application of the methodology. As discussed in item 4, above, examination of the national accreditation dataset would enable risk analysis to be conducted and this process would enable identification of triggers that might necessitate this type of survey.

It is recognised that there may be overlapping jurisdictions that would utilise the methodology and that a mechanism to manage conduct of these surveys would be required. A Memorandum of Understanding between jurisdictions such as the HQCC and the accreditation registering authority would facilitate this management process.

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## **7: introduction of Tracer Methodology in external accreditation reviews**

*ACSQH proposes implementation of Tracer methodology nationally by all accrediting health services.*

**Question:**

***What needs to be done and by whom to introduce Tracer Methodology?***

In principle, the HQCC supports the use of patient focused methodologies (eg tracer methodology) as one of many tools that may support the accreditation process. Horizontal audits currently in use (eg in pathology laboratories) provide a similar function as does Root Cause Analysis, especially if the trigger for use of the methodology is a sentinel event. As with unannounced surveys, inter-jurisdictional management is required to prevent overlap.

Introduction of new methodology raises resourcing issues and undue burden should not be carried by the service provider. Piloting the methodology across a variety of service providers types is warranted. The cost-benefit balance should be examined before introducing a further process.

## **PROPOSED STANDARDS REFORM STRATEGIES**

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### **8: Registration of sets of health care standard:**

*ACSQH proposes that registration of healthcare standards becomes mandatory.*

**Question:**

***Which organisation is best placed to manage the longer term register of standards?***

As with accreditation, in principle, registration of health care standards has the potential to increase coordination and allow greater consistency in compliance monitoring. To make this approach feasible, consensus between agencies responsible for standards development and standards publication is essential. If consensus is not achieved, monitoring of healthcare standards is at risk of fragmentation rendering the registration of standards ineffective. Further information is required to enable an assessment of benefit and cost.

The ability for the registering organisation to act as a "clearing house" for standards would require further investigation. Consideration is required to standards published outside of the accreditation process to which the industry is required to demonstrate compliance; such as those that may be independently published by Quality Commissions.

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### **9: Harmonisation of health service standards:**

*ACSQH proposes that the language and definitions of accreditation be standardised and that guidelines be developed to assist convergence in the format and structure of standards.*

**Questions:**

***What are the barriers to standardisation of language and definitions?***

***Who needs to be involved in this standardisation process?***

As with accreditation, consistency of language in standards is supported by the HQCC.

Harmonising standards through the convergence of format or structure is seen as a separate issue and although supported by the HQCC, it is recognised that there are considerable political barriers to gaining consensus on this issue. These barriers derive from inter and intra jurisdictional boundaries between state and federal approaches to accreditation, legislation and other processes inherent in the current systems.

The harmonisation process is underpinned by successful detailed mapping of the standards (refer point 10 below). This strategy will make significant contributions to Mutual Recognition of Standards and Accreditation Processes, discussed below.

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### **10: Detailed mapping of standards:**

*ACSQH proposes that a detailed process of analysis and mapping of all existing Australian health care safety and quality standards be undertaken.*

**Question:**

***Who needs to be involved in this mapping process?***

In principle, the mapping of standards would allow the detection of duplication in processes and an understanding of the governance arrangements and purpose of the current reporting requirements. Detailed mapping of standards would be required for registration and harmonisation of health service standards. However, the process for mapping and resource implications would require consideration. In addition, the result would be a retrospective review that would require ongoing resources to maintain currency.

In order to proactively utilise this process, a standards framework for quality and safety would be required to underpin the process.

The ACSQH is best placed to fulfil this function, providing it is adequately resourced. As substantial inter and intra jurisdictional liaison will be required, establishment of a steering committee to support the direction and progress of this project may be advantageous.

## 11: Identification of core safety and quality areas:

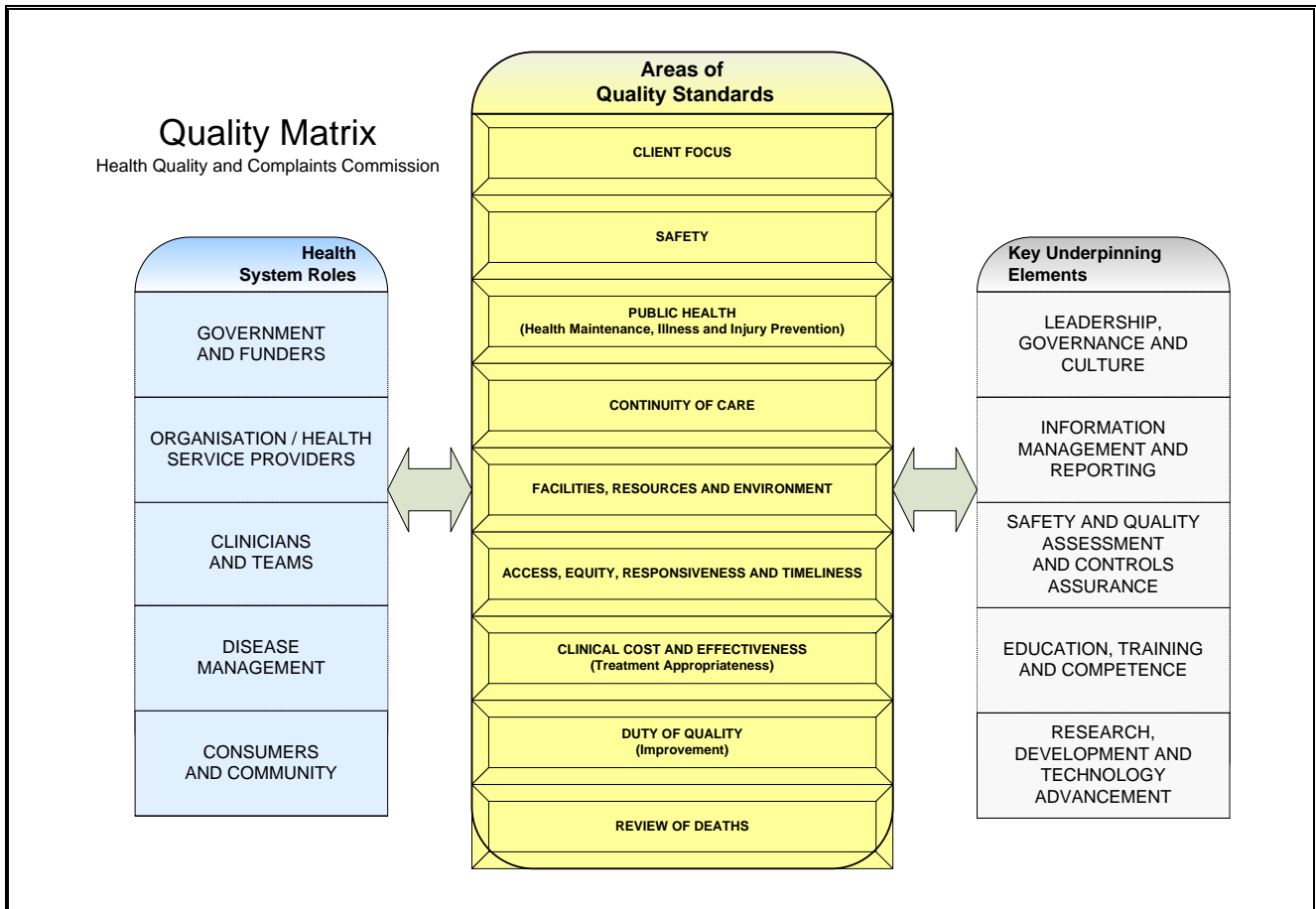
ACSQH proposes that the ACSQH identify core safety and quality areas that are to be reflected in all registered sets of health safety and quality standards.

### Question:

**What priority areas should be included in core safety and quality standards?**

The HQCC endorses establishment of a set of core standards that address both safety and quality. Priority “Areas of Quality Standards” are identified by the HQCC are noted in the matrix below.

Areas of Quality Standards are founded upon a set of “Key Underpinning Elements” and the priority areas are applicable across the spectrum of “Health System Roles”.



The following priority standards are being developed by the HQCC in 2007:

- Providers' Duty to Improve the Quality of Health Services
- Credentialing and Scope of Clinical Practice
- Review of Hospital-related Deaths
- Management of Acute Myocardial Infarction Following Discharge
- Hand Hygiene
- Surgical safety (a cluster of standards including appropriate antibiotic prophylaxis, prevention of unintended surgery and prevention of venous thromboembolism)
- Complaints management

## **Mutual Recognition of Standards and Accreditation Processes**

*ACSQH proposes that the ACSQH work with stakeholders to remove duplication and overlap in the standards and accreditation system, including that which exists for accreditation of education and training programs. This will involve merging of surveyors, reductions in repeat requests for information and the number of survey visits.*

*The implementation of the short and medium term strategies listed above is designed to refocus the health system towards mutual recognition of standards and accreditation processes. Further, specific initiatives will be identified as a result of this work that will improve the coordination of processes.*

*Broad stakeholder consultation will be needed on any further policies and processes required to implement mutual recognition. It is anticipated that the ACSQH would coordinate this work in the first instance, however a longer term strategy for the implementation, monitoring role and ongoing management of mutual recognition will need to be identified as the ACSQH does not have long term implementation of projects in its Terms of Reference.*

### **Question:**

***What is required to implement mutual recognition of standards and accreditation processes in the Australian health care system?***

In order to implement mutual recognition of standards, it is essential to ascertain and recognise the powers of all stakeholders and other jurisdictions involved in the development and implementation of standards in healthcare. The HQCC would request to be engaged in further policy development discussions relating to this issue.

To assist in the assessment of whether standards and accreditation processes should achieve mutual recognition, a process would need to be established that assessed if the standard or process:

- reflected evidenced best practice;
- demonstrated measurement of patient centred outcomes; and
- incorporated quality improvement processes.

Again, it should be acknowledged that currently, there is poor correlation between accreditation and quality