Australian Commission on Safety and Quality in Health Care – Consultation Paper:

An Alternative Model for Safety and Quality Accreditation of Health Care

QIC response to Consultation Paper, September 2007

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Introduction

As indicated in its response to the Commission's Discussion Paper in March 2007, QIC welcomes this review of standards and accreditation. There are certainly barriers to the effectiveness of health accreditation programs in Australia, and QIC is committed to working with the Commission to address these matters.

In our March response, we called for a broad and visionary approach to planning the future of accreditation in the context of other quality activities. With such an approach, we believe accreditation can achieve its full potential, and expectations about its outcomes would be both realistic and method-appropriate.

We supported a coordinated effort to make accreditation a more efficient and less duplicated experience for service providers, and we encouraged the Commission to recommend a balance between a compliance-oriented system and a quality improvement oriented system. Our response also recognised the paucity of evidence in accreditation world-wide and called for an ongoing program of research and evaluation so that policy could be built on a solid evidence base in the future.

The Commission's August Consultation proposes a dual track system, with a mandatory set of minimum standards endorsed by Ministers, compulsorily assessed by approved bodies. Poorly performing organisations would be remediated by the relevant authorities. Additionally, service providers could opt for accreditation for quality improvement. The paper called for mutual recognition of accreditation. It also outlined a framework for a governance body to administer accreditation.

We wish to take up several matters raised in the August Paper.

1. Separation of Safety and Quality

We fully accept the priority given to the prevention of harm and government's role as the principal guardian of safety in health care. We therefore support the need for some mandated requirements concerning safety. The advantages of universal safety requirements are that consumers and other stakeholders can be reassured that all health services are being assessed and held accountable for their safe practices. If the proposed system were implemented, QIC would readily adapt its program and provide accreditation services as proposed.

The proposed way of mandating safety however, risks several problems which should be anticipated and addressed in the Commission's final recommendations.

Minimum standards don't drive improvement

Minimum safety standards are likely to promote minimal compliance, with little incentive for performance improvement or organisational learning. It is suggested that although safety standards are to be assessed under a separate arrangement from quality improvement standards, the two should be linked.

Minimum standards could fragment systems

The separation of safety from quality could undo gains in recent years concerning the establishment and maintenance of sustainable systems. Infection control, for example is an outcome of a range of systems including clinical governance, knowledge management, human resource management, property management, risk management, and legal compliance. To simply

require certain infection control inputs, processes and structures through a compulsory standard for example while leaving the abovementioned systems to a separate and voluntary process, could weaken performance. We suggest that the safety standards be drafted with cross references to other enabling standards, and encouragement to build and maintain supporting systems.

Government owned safety standards could rigidify
There is a danger that government owned standards could become inflexible over time, despite changes in the field, professional practice, and forms of evidence. Government owned standards are notoriously difficult to change once published, a point made repeatedly about the Aged Care Accreditation Standards. This rigidity arises partly because changes have to be managed through risk-averse departments and politicians, and partly because there is a separation between the standards owner, and those who use the standards from day to day. Unlike most not-for-profit accreditation bodies, Government is not routinely advised by those who assess against the standards ('surveyors'/ 'auditors'/ 'reviewers') about relevance, assessability, and validity of standards.

One consequence of such rigidification is that accreditation providers will develop their own formal or informal interpretive guides. Government could then have the problem of differential interpretation between accreditation providers – a factor which could undermine inter-rater reliability.

2. Quality improvement
The paper recognises a role for accreditation within a national framework for quality improvement as one of an unspecified range of quality improvement programs, opting for "greater flexibility on what, how and when they invest in quality improvement". Of course multiple quality initiatives already exist: most health care providers participate in a range of quality, performance and legal compliance activities of which accreditation is but one.

The paper however appears to be going a step further: saying that the Commission would encourage lots of forms of quality improvement without especially promoting accreditation. If this meaning is intended, we believe that any loss of confidence in accreditation as a major quality improvement strategy by the Commission - should be argued and justified especially since this is a review of accreditation in Australia.

The national framework for quality improvement should in our view, recognise and map the range of available quality improvement activities, identifying the role and expected outcomes from each form of initiative, including accreditation. It should then particularly spell out the Commission's plan for maximising the effectiveness for a national system of accreditation for quality improvement. It should identify how accreditation can continue to develop over the next 10 years, proposing structures and processes to enable that to occur.

3. Research and evaluation
The Consultation does not deal with the need for evidence about accreditation. As stated in our earlier response, there is a marked lack of research evidence concerning accreditation, and there is also almost no evidence base regarding national policies to make accreditation more effective. QIC would want to see evaluation occurring at both levels.

A national body charged with oversighting accreditation should be responsible for promoting, gaining resources for and disseminating the findings of research and evaluation of accreditation

under a variety of accreditation models, in relation to many health service types, throughout Australia. Similarly the change program proposed by the Commission should be implemented with a built-in evaluation program, with findings periodically disseminated.

4. Review of surveyor training

QIC accepts the importance of systems for specifying surveyor competence, and maintaining a range of learning and performance management strategies to ensure that competence is achieved. We would suggest the use of the term 'surveyor competence' rather than 'training' which is but one of many strategies for assuring competence.

QIC has recently undergone a rigorous organisation and program accreditation assessment by ISQua against it's ALPHA standards including several standards concerning these matters. It is most important that the Commission does not duplicate or compete with the ISQua or JAS-ANZ. It is also important that a single model of reviewer preparation is not proposed, as each accrediting body is working with a range of unique variables. A resourcing, networking, research dissemination role is likely to be more effective.

5. Multiple standards and accreditation regimes

We note with some disappointment that this issue was not addressed by the Consultation Paper. There is clearly a need to address the proliferation of standards and separate accreditation systems, to reduce the burden on organisations in the field – with all the cost and efficiency implications. In order to achieve mutual recognition, there is a need to establish equivalence between standards as well as between assessment practices. It is not simply a matter of mapping words or intentions. In our view, it cannot be achieved by once-off arbitrary declaration. There is a need for an ongoing strategy (including an independent structure and a credible process) to foster mutual recognition. Standards and accreditation regimes are being constantly redesigned and re-aligned so a sustainable response to multiple and overlapping programs must be dynamic.

It must also recognise that although they often have an objective evidence base, standards are artifacts of their sponsors, who for the most part have developed them after extensive consultation and engagement with consumers and other stakeholders. The creation of standards and assessment equivalence should involve standards owners and accreditation bodies in an efficient conciliated and ultimately arbitrated process, enabling interested parties to present a case about the consequences of an equivalence decision. The reasons for a determination of equivalence should be published.

In the longer term, say a 5-10 year lead time, the standards and accreditation body could develop a national standards framework, according to which all Australian health standards would have to comply – much like the National Competency Framework in the vocational education and training system. This approach would promote standards alignment while recognising that standards developers have different targeted service types and different historic value bases.

Conclusion

While welcoming the Commission's progress in reforming standards development and accreditation in Australia, the Quality Improvement Council continues to encourage a visionary ongoing, evidence-based and sustainable approach. Australia's long experience in accreditation should be regarded as an asset rather than a problem. We would like the Commission to lay out a plan about how to advance standards and accreditation in conjunction with other quality initiatives,

recognising the importance of creative, responsive and ongoing partnership between the key bodies and stakeholders.