



**THE ROYAL AUSTRALASIAN COLLEGE OF MEDICAL ADMINISTRATORS**

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**5 October 2007**

National Safety and Quality Accreditation Standards Review  
GPO Box 5480  
SYDNEY, NSW 2001

Dear Sir

The Royal Australasian College of Medical Administrators (**RACMA**) appreciates the opportunity to comment on the consultation paper: *An Alternative Model for Safety and Quality Accreditation of Health Care (the Paper)*.

We continue to support reform of Australian health care accreditation systems.

We make the following specific comments.

**Reform objectives**

Generally, we support the reform objectives put forward in the paper, although we suggest that it will never be possible to "create a system that guarantees minimum safety of health services" (our emphasis). No safety and quality system, and in particular accreditation on its own, will never guarantee safety of health services - but we would expect that a sound accreditation system would make a significant contribution towards improving the safety of, and reducing the risk associated with, the delivery of health services.

**Matters excluded from reform proposals**

We note the discussion about requirements relating to state and territory licensing and safety and quality reporting mandated by health funds, indemnity insurers and program funding not being included in the review process. Whilst we understand the complexity of these issues, we encourage the Commission, which has significant links to all jurisdictions and, therefore, the potential to influence, directly or indirectly, licensing arrangements as well as health insurer requirements, to take a very broad view of the opportunities for longer term reform. In our view, the credibility and efficiency of accreditation processes are contingent on resolving duplication between various regulatory and accreditation systems, and the Commission is ideally placed to address this difficult problem.

### **Separation of safety assurance and quality improvement assessment processes**

RACMA has significant concerns about this approach, which we consider will result in further fragmentation and, potentially, duplication of both compliance and surveying aspects of accreditation.

RACMA Fellows have considerable experience in health service accreditation since its inception over 30 years ago. This experience is as both surveyors and as health service management involved in being surveyed. Over this period, our Fellows have seen major changes in the delivery of health services related to integrating quality improvement into accreditation processes and more latterly safety issues. Those health services that provided the highest standards have demonstrated an integrated quality improvement / safety approach. This integrated approach has engaged clinical staff in a way that a pure safety approach has failed to do. In addition this integrated approach has engaged non clinical staff who are critical to maintaining standards in health services. Clinical staff on their own cannot maintain health care standards.

Research has shown that employees will do what is seen to be valued by the organisation and what is clearly measured. Once measurement ceases, quality improvement initiatives are also likely to decrease and this will impact on both hospital standards and safety. Disintegration of quality improvement and safety will have a profound impact on health care standards in the medium to longer term. This has been clearly demonstrated in organisations that have opted out of ACHS accreditation over a 10 year period and have recently taken up ACHS accreditation again.

We do not believe that it is possible to separate standards for 'safety' from standards for 'quality' meaningfully. Organisational systems need to encompass all domains of quality, of which safety is one. For example, an infection control system needs to be structured to achieve satisfactory performance in all of the domains of quality which, as well as safety, include effectiveness, efficiency, appropriateness and acceptability. In addition, broader organisational factors such as culture and approach to competency and training are integral to the safety of infection control systems. Accreditation should assess both compliance with minimum standards across all domains of quality (including but not limited to safety) and whether there is evidence of a quality improvement approach that ensures continuous improvement across all domains of quality.

RACMA believes that simply focusing on the safety aspects of infection control systems for example, will result in a partial and potentially misleading understanding of the adequacy of those systems and also will result in the 'quality improvement' aspects of infection control systems (which we presume are intended under this model address the domains of quality other than safety) requiring separate surveying processes, leading to considerable duplication and cost.

We strongly recommend that the Commission to 'revisit' the presumption that safety standards should be defined and compliance with them assessed separately from other

aspects of quality. We suggest that the Commission reviews the accreditation approach to residential aged care facilities, which is based on a philosophy of quality improvement but also requires compliance with minimum standards. We understand that this system is now viewed by many providers as satisfactorily combining compliance with quality improvement objectives and we support consideration of this approach in the acute sector.

We also understand that child care regulatory and accreditation processes in Australia separate regulatory compliance, which is the responsibility of the states, from quality improvement, which is overseen by the Commonwealth and linked to its funding program. We encourage the Commission to review this system, which we understand remains subject to criticism about duplication.

Finally, we ask whether the Commission can provide information about a model of accreditation that separates functions in the way which is proposed, and that has been demonstrated to be working effectively.

### **Separation between safety standards development and assessment of health services**

We support this proposal. We do not have significant concerns about conflict of interest by accrediting bodies - we see no evidence of this having occurred - but the separation of these processes will allow the development of a single set of standards, which we strongly support.

We do not believe that this separation should be limited to 'safety' standards for the reasons articulated in the previous section of this submission. Rather, we consider that there should be a common set of standards covering all domains of quality.

### **Accreditation of all settings of care where services are provided by registered health professionals**

We support this proposal in principle, but believe that a feasibility study should be undertaken because the implications for cost are enormous - there is a vast number of small independent providers who currently are not accredited.

We consider that it is reasonable to limit this initiative in the first instance to health care providers who are registered in all jurisdictions.

In addition, there may be benefit in all jurisdictions reviewing their Public Health Acts (or equivalent) to assess the limitations on practice that apply in various settings and determine whether greater commonality would assist to assure quality.

### **Development of national minimum safety standards that apply across all (similar) settings of care**

Please see our comments earlier in this submission. Whilst we believe that the areas of practice that have been identified for the development of these standards are appropriate, we consider that such standards should cover all domains of quality within those areas, including but not limited to safety. The National Standard already in place for

credentialling and scope of practice in fact provides a good model that already has created significant national momentum for change.

We strongly support the development of standards that will apply across all settings of care.

We would be pleased to participate in more detailed consultation about the issues raised on page 23 of the paper. RACMA Fellows have significant experience in these areas but they are complex issues which require more detailed discussion.

### **Assessment of non-clinical and technical competence**

We strongly support the proposal for mutual recognition of existing regulatory requirements and specific technical accreditation processes.

### **Development of a national framework for quality improvement**

Subject to our reservations about the proposed conceptual separation of safety from quality, we strongly support this proposal. There are several frameworks now in place which we consider are extremely useful in conceptualising quality and assisting providers and regulators to systematically plan, implement and monitor the adequacy of quality systems. We consider that the Victorian and NSW frameworks are particularly helpful.

There should be a single set of Standards for quality, not just for safety.

### **Establishment of a national body to lead and coordinate changes**

We note that this was proposed by the previous Safety and Quality Council. Although there were concerns about cost and additional bureaucracy, we consider that establishment of such a body is essential if change is to be progressed. This body needs to be independent of standard setting and accreditation provider organisations and should play a key role in facilitating change and coordinating and monitoring the complex accreditation system.

We would be pleased to participate in more detailed discussions about the optimal structure and role of such a body.

### **Review of surveyor training**

We strongly support this proposal. We believe that currently there is significant variation in surveyor knowledge and capability which undermines the effectiveness of accreditation. However it is important that the training is carried out by people who are both excellent educators and really understand the principles of accreditation, using at least some surveyors from the field who are able to teach both practice and principles.

### **Associated reforms**

We support unannounced surveys; endorsing or developing a best practice guide to standards development and review; mapping standards; developing appropriate mechanisms, timing and format for public reporting of accreditation outcomes; and developing a process for mutual recognition of accreditation processes and outcomes.

We believe that the introduction of unannounced surveys should be prioritised. The other proposed reforms are important but should be implemented progressively once fundamental reform has been achieved.

### **Conclusion**

We trust that this submission is of interest and assistance to you. Thank you for the opportunity to comment. RACMA is concerned with improvements in the health care system as a whole and we would be very pleased to participate formally in ongoing consultation about these important changes.

Yours sincerely

Dr Karen Owen  
Chief Executive