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# Tasmania's Response to the Australian Commission on Safety and Quality in Health Care's Alternate model for Safety and Quality Accreditation of Health Care 2007

Department of Health and Human Services  
Tasmania



# Summary

While it is acknowledged that the scope of the Commission's proposal is quite clear in stating that the Terms of Reference for the review are limited to accreditation of health services, there remains a desire expressed by practitioners working in a variety of community settings for their settings to be comprehended. These include disability services, Home and Community Care (HACC) and aged care.

The alternative model proposed would see health services provided by registered health professionals complying with national minimum safety standards and implementation of a quality improvement framework. The scope of the model however would exclude HACC and aged care. A number of registered health professionals within DHHS are funded to provide services within the HACC and Aged Care programs and to the broader community.

For example, within the DHHS community nurses are funded under the HACC program and also through state funding. As the role of the community nurses spans HACC, post acute and palliative care (Non HACC services) and as the role shifts to include more chronic disease management and other non HACC type care services, it is possible that these services could be considered as health services for the purposes of the model and thus be required to meet the safety standards and quality improvement requirements. An increased focus on patient safety and quality improvement in this type of service is welcome. The difficulty might be in determining how these standards are applied when a health professionals' work spans 'in scope' and 'out of scope' health services.

While supporting improved safety and quality accreditation process, there are substantial financial and other resource implications for jurisdictional health services in the proposed process, among which are:

- contributing to the development of standards,
- piloting of new methodologies,
- facilitation of surveyor training,
- requirement of additional surveyors,
- education programs associated with the reform,
- trialling and implementation; as well as
- the need for additional recurrent funding to enable organisations to undertake the process.

The Department expects that healthcare organisations would need additional funding to participate, not withstanding reduced waste that might follow improved service safety and quality.

The proposed National Entity would need to be adequately resourced to fulfil the intended functionality, as jurisdictions are already working at capacity to meet national and state safety and quality requirements.

# Specific Comments

### Comments on the key elements of the alternative model

1. Separation of safety assurance and quality improvement assessment processes
  - One of the challenges faced by health service providers has been the complexity of quality and safety accreditation requirements across the health care sector. The proposed model would, in the main, address this issue.
  - For health services that are currently not accredited (e.g. rural hospitals, community nursing) the focus on first assuring patient safety and then moving onto quality improvement would appear to be an appropriate priority of actions. However if the facility/service never moves beyond safety standards compliance to embrace quality improvement, then the sustainability of the systems supporting the achievement of the safety standards is likely to be difficult to maintain over time.
  
2. Separation of safety and quality standards development, and assessment of health services
  - Separation of standard development and assessment by the proposed establishment of a National Entity to manage development of standards and registration of accrediting bodies is supported.
  - This was considered an appropriate way of splitting roles and reducing risks of clash of organisation roles. Nationally consistent training for all surveyors is supported as a way to ensure consistency of application.
  
3. Accreditation of all settings of care where services are provided by registered health professionals
  - The Department agrees that settings of care where services are provided by registered health professionals should be accredited, however there are likely to be inconsistencies due to the variation of registration requirements of health professionals from state to state. Given these inconsistencies, it may be prudent to first address the issue of national registration of health professionals, and then move to accreditation of all settings of care. This is not a strongly held view.
  - Accreditation in new settings would involve the use of significant additional resources – human and financial, for both implementation and maintenance of the system.
  
4. Development of national minimum safety standards that apply across all (similar) settings of care
  - There is general agreement with the proposal, and that endorsement of the standards by Health Ministers is desirable since the community hold them responsible for deficiencies of health service provision. The Department agrees that Health Ministers should have a formal mechanism to influence the accreditation process and review outcomes.
  - The Department's view is that the system should be simple and easy to apply.
  - The Department feels that the experience in the Aged Care Sector is that transparency, i.e. public reporting, results in significant improvements in a short period. This prospect can, however, be daunting at first. A more suitable **initial** process for managing “pass” or “fail” services may be to benchmark a site's performance with comparable services and provide this information only to the service that is assessed, moving to open reporting of results of the service in subsequent accreditation cycles.

5. Assessment of non-clinical and technical compliance

- The Department advises that it is important that health services are operated and viewed as integrated entities and monitored as such. Clinical, non-clinical and technical systems are dependant on each other and integration in operation and assessment/monitoring is vital for system effectiveness and patient/client safety.
- Mutual recognition of accreditation processes is vital for the success of the proposed rationalisation and to prevent duplication. It should be an integral component of a new model from the outset. Certification by the relevant authorised body needs to be provided to the accrediting body (eg fire compliance is assessed and certified by the State Fire Department, and then certification is provided to the accreditation body). It would be necessary to have a checking system to ensure that components are not missed.

6. Development of a national framework for quality improvement

- The Department supports the need for a structured framework to guide quality activity, but care needs to be taken to ensure that its design still allows flexibility, innovation and creativity.

7. Establishment of a national body to lead and co-ordinate changes

- There is support for a national body to be established to lead and control the quality of health service delivery. This would include:
  - mapping, development and setting of health service standards;
  - changes in the registration of health services to include minimum quality standards that are relevant to the type and size of service;
  - accreditation programs set within flexible parameters to ensure appropriate standard of service;
  - registration ensuring competency of all health professionals;
  - registration of all accreditation agencies and surveyors.
- This could be established under the aegis of the Australian Commission on Safety and Quality in Health Care, using its existing structures and consultation frameworks. This would also potentially minimise timeframes for establishment of the entity.

8. Review of surveyor training changes

- Priority – The Department recommends that this should commence as soon as possible.
- Scope –Following identification of desirable attributes for surveyors there would need to be an evaluation of existing surveyors. The question arises as to who is best placed to undertake this role, given that: –
  - It would require people with considerable expertise and credibility in surveying.
  - There would also need to be comprehended various areas of expertise.
  - There would need to be two streams of training available –introductory training and refresher training.
- Timeframe – Identification of suitably skilled personnel to develop an assessment package and training packages is a high priority and could commence before development of the final model.

## Specific Comments

Assessment of current surveyors should commence as soon after that as practicable. Assessment and training competency should be conducted within an academic framework and appropriate recognition provided.

- Resource Implications
  - Individuals who are highly sought after to become surveyors are often proficient clinicians with many competing demands. To date they have largely donated their time and expertise, but with requirements for all healthcare facilities to be accredited it follows that there will be need for an increased number of surveyors.
  - To encourage high quality personnel to become involved, financial support for skills development and training should be provided as a minimum, and training should be provided in all jurisdictions perhaps through a University or College.
  - Absence of skilled clinicians from the workplace while participating as surveyors has the potential to disrupt service delivery so compensation should be available to the organisations involved to allow back fill of positions.
  
- 9. Associated reforms – unannounced surveys, tracer methodology, developing standards, mapping standards, public reporting, and mutual recognition.
  - Relative priority
    - Development of the standards, mapping standards and developing processes for mutual recognition seem to naturally link together. The Department considers mutual recognition to be highly desirable, and if not introduced in the initial phase other mechanisms will be needed in the interim which will perpetuate the multi-layering of accreditation processes. Therefore these components should be developed prior to developing tracer methodology and unannounced survey formats.
    - Public reporting of outcomes is necessary to assure the community of transparency; however the community may become confused if it is introduced prior to the new system being implemented. It would seem sensible to commence public reporting once the new system is in place and sufficient time has elapsed to enable sufficient information to be available.
  
  - Scope & Timeframe
    - It may be prudent to progress carefully and not rush the process. Pilot sites will be necessary in a variety of settings for trialling tracer methodology (eg acute hospitals, smaller regional hospitals and community settings) once key components have been identified and core standards developed.
  
  - Resource Implications
    - There are substantial costs associated with the establishment of standards, which has been proposed to be undertaken by working parties comprising jurisdictional representatives.
    - Organisations undergoing accreditation for the first time will need substantial support to enable employment of additional personnel to coordinate and educate staff regarding the requirements for the accreditation process, and to manage ongoing requirements.
    - Funding for pilot sites will also be required to enable employment of dedicated project management staff to educate, implement, and evaluate the process.