

# DISCUSSION PAPER

## NATIONAL SAFETY AND QUALITY ACCREDITATION STANDARDS

**This paper has been prepared by the Commission as a basis for consultation. Consultations are a key part of the development of recommendations for a new model of accreditation and standards for health services in Australia. This stage of consultations will be conducted by the Commission until 31 March 2007.**

**The Discussion Paper poses a number of questions about accreditation and seeks comments in response. It incorporates a package of proposals for a new approach to accreditation and is designed to stimulate debate, seek feedback and suggestions on other reform options.**

**This is a consultation document and the proposals it contains have not been endorsed by the Commission, Health Ministers or state and territory health authorities.**

November 2006

## **Acknowledgement**

Many individuals and organisations have freely provided their time, expertise and documentation to support the development of this discussion paper. Their input, support and cooperation are greatly appreciated.

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### NOTE

All submissions must be received by COB **31 March 2007** to be considered as part of the review.

All submissions, will be published on the ACSQHC website, including the names of individuals and /or organisation making the submission. The Commission will consider requests to withhold part or all of the contents of any submissions made.

## Abbreviations

Australian accreditation, certification and standards setting bodies:

AACS	Australasian Auditing and Certification Services PL
ACHS	Australian Council on Healthcare Standards
ACMI	Australian Midwifery Council Inc.
ACSAA	Aged Care Standards and Accreditation Agency Ltd.
AGPAL	Australian General Practice Accreditation Ltd.
BC	Benchmark Certification Ltd.
GM PL	Global Mark Pty. Ltd.
HACC	Home and Community Care
IEO	International Electrotechnical Commission
IHCA	The Institute of Healthy Communities Australia Ltd.
ILAC	International Laboratory Accreditation Cooperation
ISC	International Standards Certification Pty. Ltd.
ISO	International Organisation for Standardisation
ISQua	International Society for Quality in Health Care
JAS-ANZ	Joint Accreditation System of Australia and New Zealand
NATA	National Association of Testing Authorities
NCSI	NATA Certification Services Inc.
NPAAC	National Pathology Accreditation Advisory Council (Department of Health and Ageing body)
PHISQC	Private Health Insurance Safety and Quality Committee
QIC	Quality Improvement Council
QICSA	Quality Improvement & Community Services Accreditation Inc.
QIP	Quality In Program Pty. Ltd. (wholly owned subsidiary AGPAL)
QMS	Quality Management Services Inc.
QPA	Quality Practice Australia
RABQSA	RAB Quality Standards Australia
RACGP	Royal Australian College General Practice
RANZCR	Royal Australian New Zealand College Radiologists
SA	Standards Australia Ltd.
SAI Global	SAI Global Ltd.
TQCSI PL	TQCS International Pty. Ltd.

# National Quality and Safety Accreditation Standards Review

## 1. Introduction

This paper presents an alternative model of accreditation for health services in Australia. It 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.

Accreditation in Australia is widely recognised for substantially improving safety and quality over recent decades. The need for a new model is not because of fundamental failures with the current accreditation system. It is because changes in disease and disorder patterns, technologies, drug regimes and health services delivery require accreditation processes to evolve and keep pace with those changes. In addition, a new model is required if accreditation is to remain a sustainable process which delivers quality improvements into the future.

Today, health services are provided across a broader range of locations than in past decades. The defining characteristic of a health service is no longer a location, such as a hospital or a medical practice, but a point of care where there is a patient interaction. Health services can be provided at home, in the community, in a residential aged care facility, in a hospital or from a mobile van. Therefore any location where health care is provided is included in the scope of this review.

However, the function of care given in a location has been considered when determining which services are not health care and therefore excluded from this review. For example, residential care in an aged care facility is not health care and neither are domiciliary, disability or home help services.

Standards generally are developed for two prime reasons; firstly, to protect the public from harm, and secondly to improve the quality of service provision. Many of the standards used in health do not relate directly to health care. They form part of the fabric of a safe environment such as fire safety, food standards, storage and handling of dangerous goods that needs to be in place for the delivery of health services. Many of these requirements exist also as regulation or legislation and may be assessed as part of an accreditation process.

Standards are integral to the accreditation process as they determine what and how performance will be measured. However, the boundary between minimum standards for the safe delivery of services, standards that deal with the quality of those services and standards that measure other organisational performance areas that are only peripherally related to service delivery, is porous and differentiation of these can be arbitrary. Over time, the boundary shifts because of changes in the way services are delivered, the expectations of communities and changes in the case mix and type of services delivered.

Numerous sets of health care standards have been evaluated as part of this review. However, safe environment standards and standards that relate to education and training of health professionals are excluded.

In addition, harmonising, standardising or implementing stricter controls on standards development is being considered as part of this review to determine if that would result in benefits for patients and what those benefits might be.

## 2. Background:

In June 2006, the Australian Health Ministers' Advisory Council recommended that the Australian Commission on Safety and Quality in Health Care (the Commission):

- a. Review accreditation arrangements in Australia: consider these arrangements in light of international experiences and recommend a revised model for accreditation of health services both public and private across Australia;
- b. Provide a discussion paper to Australian Health Ministers Conference (AHMC) by October 2006, outlining the strengths and weaknesses of the current system, the benefits that can be gained in a future system and a process and timetable for recommending an alternative model for accreditation including a national set of standards by which health services would be assessed; and
- c. Provide a draft report to AHMC by June 2007 and a final report by December 2007.

The Commission has agreed this is an important body of work and in July 2006 commenced preliminary consultation with stakeholders on the issues and options for change.

In 2003 the former Australian Council on Safety and Quality in Health Care reviewed standards setting and accreditation. This involved a detailed literature review and significant stakeholder consultation and resulted in the production of three reports, including:

1. *Standards setting and accreditation literature review and report, July 2003*. This paper summarised the main systems of standards setting nationally and internationally, focusing on governance, standards setting, standards content, assessment approaches, compliance issues and public reporting.
2. *Standards settings and accreditation systems in health: Consultation paper, July 2003*. Individuals and organisations were invited to provide comment on the issues raised in the consultation document at workshops or interviews or in written submissions. The consultation document specifically sought comment on:
  - a. governance of accreditation systems;
  - b. standard setting process;
  - c. the process of external evaluation of compliance against standards;
  - d. ensuring action on the outcome of accreditation evaluations; and
  - e. promoting continuous quality improvement.
3. *Standards setting and accreditation system in health consultation: A marketing research report, 2003 unpublished*. This paper provides an overview of comments and issues about accreditation identified by stakeholders in their submissions and during consultation workshops/interviews.

These documents are available on

[www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/former-pubs-lp](http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/former-pubs-lp)

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. 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.

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<sup>1</sup> Australian Health Ministers Conference. July 2005. National arrangements for safety and quality of health care in Australia, the report of the review of future governance arrangements for safety and quality in health care. Ron Patterson, Chair Review Team.

### 3. Definitions:

Multiple definitions exist in the literature for **accreditation**. It is used:

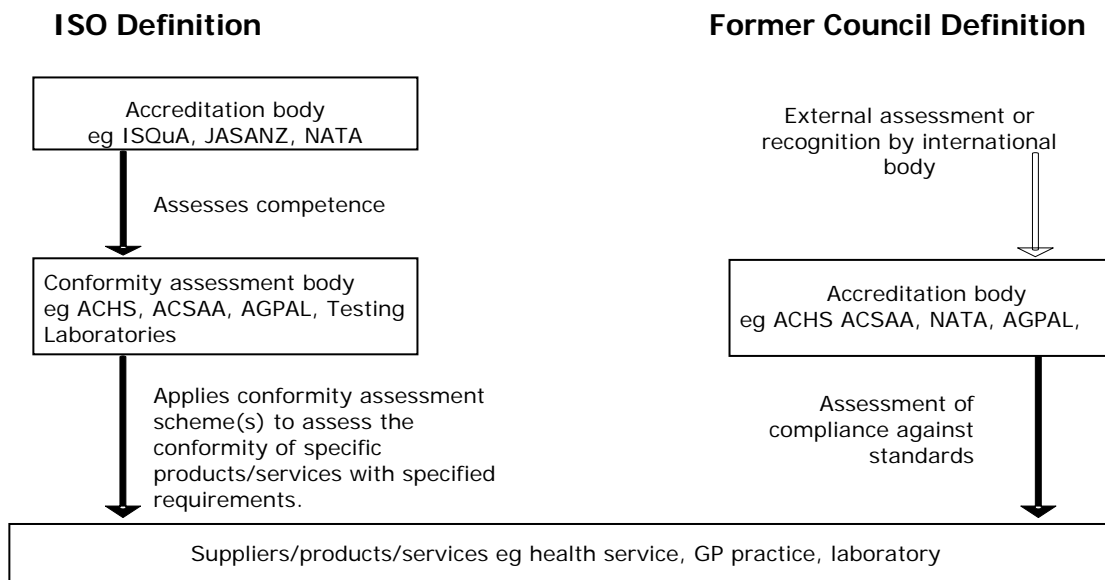
1. to describe the recognition of specialty training by professional bodies.
2. by clinical consortia and managers to recognise service delivery, and
3. by international standard setting bodies, such as ISO, as recognition by a third party of an organisation's competence to carry out certification testing of a service, product or system<sup>2 3</sup>
4. described by Shaw as a cluster of activities, rather than a single technology, which interact to produce documented processes and organisational changes.<sup>4</sup>
5. to frame a peer-consultation service that provides feedback to the accredited health service on where and how it can improve.<sup>5</sup>

The terms accreditation, certifying and conformance assessment of an organisation are different although they are sometimes incorrectly used interchangeably.

Standards Australia which is recognised by the Australian Government as the peak non-government standards development body, describes conformity assessment bodies (also known as certifying bodies within the industry) as bodies that perform conformity assessment services. In the health system, these bodies assess an organisation's conformity to standards for products, processes, systems or persons. Examples of certifying bodies are listed on pages 7 and 8. These bodies are largely accredited by an internationally recognised body such as, JAS-ANZ or ISQua.

Standards Australia argues that obtaining agreement around definitional issues is fundamental to consensus building and standardisation. The following internationally accepted model used by Standards Australia is used to demonstrate that the terminology commonly used in health care differs from that used by ISO and Australian Standards:

**Figure 1:  
Definitional differences<sup>6</sup>**



<sup>2</sup> Shaw C. and Heaton C., Summary of the ExPeRT Project. 2004 CASPE Research, as revised Feb14, 2004. [http://www.caspe.co.ud.expert/final\\_summary.htm](http://www.caspe.co.ud.expert/final_summary.htm), accessed 6 July 2006

<sup>3</sup> Australian Standard, AS ISO/IEC 17000-2005, Conformity assessment –Vocabulary and general principles.

<sup>4</sup> Shaw CD, Evaluating Accreditation, International Journal for Quality in Health Care. December 2003, Vol 15, No 6, pp 455-456.

<sup>5</sup> Schyve PM, Joint commission perspectives on accreditation of public health practice. Journal of Public Health Management and Practice. July 1998, Vol 4, Issue 4, pp 28-33.

<sup>6</sup> Adapted from a Figure included in the Standards Australia response to questions from the Australian Commission on Safety and Quality in Health Care 23 August 2006, amended.

The Standards Australia and ISO definition is at odds with the definition<sup>7</sup> devised by the former Council, and adopted in this paper, that **accreditation** is the granting of recognition for meeting designated standards for structure, process and outcomes, where outcome is the status of an individual, group of people or population which is wholly attributable to an action, agent or circumstance.<sup>8</sup> This definition was adopted by the Council because it was broad enough to encompass the full range of accreditation processes that operate in the health care system. However, it should be noted that some parts of the health system, for example informatics, use the Standards Australia/ISO approach.

Standards Australia defines a **standard** as 'a document, established by consensus and approved by a recognised body, that provides, for common and repeated use, rules, guidelines or characteristics for activities or their results, aimed at the achievement of the optimum degree of order in a given context'.<sup>9</sup> Standards therefore can provide standardisation of approach and achieve consistent outcomes which can be applied widely and repeatedly.<sup>10</sup>

In health, standards can be identified in policy, information bulletins, circulars, procedure, protocol, work instructions, guidelines, handbook, rules, statement, codes of conduct, regulation, benchmarks and Acts of parliament. The context can indicate the level of consensus or authority with which they are made or are intended to be used.

The definition devised by the former Council, and adopted in this paper, is that standards are an agreed attribute or process designed to ensure that a product, service or method will perform consistently at a designated level.<sup>3</sup> This definition was adopted by the former Council because it encompassed all standards that have an impact across the continuum of care whether specific to health care systems or not.

The risk in adopting the former Council's broad view of standards is that it recognises policies, protocols etc. that are only indirectly related to health care. This makes it difficult to focus in on the specific area where harmonisation, standardisation or stricter control would create benefits for patients and service providers.

An **accreditation body** therefore is one that is recognised to have the authority to assess health services against agreed **standards**. For an organisation to achieve accreditation status, it has to be assessed as having met particular standards. The two conditions for accreditation are an explicit definition of quality (ie standards) and an independent review process aimed at identifying the level of congruence between practices and quality standards.<sup>11</sup>

The focus of this paper is the accreditation processes and standards that apply to health services. While standards and accreditation are interdependent, issues around them differ. To allow for a review of the issues for both accreditation and standards the two processes are discussed separately in this paper. Not included in this paper is discussion of standards and accreditation of education and training programs, such as those in place for postgraduate clinical training of health professionals.

While adopting definitions for the purposes of this discussion paper, it is acknowledged that further work will be needed to reach agreement on definitions for accreditation and related concepts and to communicate this to stakeholders. The aim of this will be to reduce confusion and produce a clear understanding that will be shared by health care providers and patients.

The fragmentation of the accreditation system is in part due to the lack of a common understanding about what is a standard, the criteria and evidence used to assess each standard, and other key elements. To communicate effectively, provide recognition between accreditation programs and streamline processes, it is essential to use language consistently. It is also important because other bodies, such as the National E-Health Transition Authority, are looking at issues of conformity and inconsistent terminology between organisations that perpetuate the fragmentation of the system.

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<sup>7</sup> Standards Australia and ISO define 'Accreditation' as 'third party-attestation related to a conformity assessment body conveying formal demonstration of its competency to carry out specific conformity assessment tasks'.

<sup>8</sup> Medical Journal of Australia Supplement, V184, No10, 15 May 2006 pp S42.

<sup>9</sup> Standards Australia Standards Guide SG-001 Preparing Standards

<sup>10</sup> Productivity Commission 2006, Standard Setting and Laboratory Accreditation, Draft Research Report, Productivity Commission, July.

<sup>11</sup> Australian Council for Safety and Quality in Health Care \_ Standards Setting and Accreditation Systems in Health : Consultation Paper (2003) November 2006

## 4. Accreditation in Health Care

The service environment in which accreditation occurs is complex, in part because accreditation occurs across a broad range of service providers and is supported by different statutes, incentives, funding and regulatory models. Accreditation systems used in the health sector were developed for different purposes and have had very different gestation periods. However they all have at their core the aim of promoting quality and protecting the public.

Australia was an early adopter of accreditation processes. Accreditation of Australian health care facilities has been conducted for over 30 years. During this time, accreditation has been used as a mechanism for promoting safety and quality. While the initial focus of health services accreditation was on minimum safety requirements, the emphasis has shifted to quality improvement. Accreditation processes generally incorporate quality improvement, risk management and governance framework validation by an external third party as part of the process. They may include organisational development, professional regulation, financial allocation and public accountability.<sup>12</sup>

Maintaining their accreditation status is important for private health services such as day surgeries and private hospitals, because accreditation status is required to access funding from health insurers, Veterans' Affairs, accident compensation funders or before clinical training can be offered to tertiary students in health courses.

Accreditation provides a range of useful information to consumers and funders about the quality and safety of care. It is difficult to evaluate or determine the benefits that accreditation can bring to an organisation because the 'end points or products' of accreditation are hard to define. They vary according to the expectations of users and observers, the starting point of the organisation and the rigour of the accreditation process.

A high proportion of health services in Australia are accredited. Because of this, evaluation of the effectiveness of accreditation is difficult to do using methodologies such as randomised control trials as there is no genuine control group. The ACHS and University of NSW have commenced a 3 year multi-method study of the effectiveness of accreditation, but it will be some time before the results of this research are able to inform us.

There are notable gaps in accreditation of health services in Australia. A substantial and increasing number of procedures are performed in medical rooms. There is limited accreditation of services provided in medical rooms, dentistry, and a range of allied health services provided in private practices.

Accreditation in Australia involves a large number of independent organisations (both for, and not for, profit). While there is information about most of these organisations available, there is no one place where consumers or health services can access a list of these all the organisations operating in health.

Key independent not-for-profit bodies that undertake accreditation (conformance testing) include:

- Australian Council on Healthcare Standards
- Australian General Practice Accreditation Ltd.
- National Association of Testing Authorities
- Quality Improvement Council
- The Pharmacy Guild of Australia

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<sup>12</sup> Shaw CD, Evaluating accreditation, editorial. International Journal for Quality in Health Care. Dec 2003, Vol 15, Issue 6, pp 455-456.

In addition to these bodies, there are a growing number of independent, largely for-profit bodies providing accreditation or certification of health services or are licensed by accrediting bodies to assess health services on their behalf. Some operate within defined area of the health sector while others provide services to a range of organisations with different service remits. These bodies include:

- Australasian Auditing and Certification Service Pty. Ltd.
- Benchmark Certification
- General Practice Australia
- Global Mark Pty. Ltd.
- The Institute for Healthy Communities Australia Ltd
- International Standards Certification Pty. Ltd.
- NATA Certification Services Inc.
- Quality Improvement & Community Services Accreditation Inc
- Quality In Practice Pty. Ltd.
- Quality Management Certification
- Quality Management Services
- Quality Practice Australia
- RAB Quality Standards Australia
- SAI Global
- TQCS International Pty. Ltd.

A third category exists that is part of government, not-for-profit bodies. This category includes:

- Aged Care Standards and Accreditation Agency
- Child Care Accreditation Australia
- Breast Screen Accreditation Services Australia
- HACC and community aged care packages

Others may exist, but because they are not listed on the website of an external accrediting body (eg JAS-ANZ) or apparent from web-based searches, they were not identified by researchers for inclusion in this paper.

There is over-arching, international accreditation of most of these bodies by organisations such as ISQua, ISO, JAS-ANZ and ILAC. These international agencies assess the competency of the accrediting bodies to test conformity of services, suppliers and products.

For consumers, accreditation should provide an assurance that health services they access will provide safe and high quality care and the definition used by the former Council carries with it the concept of competence. Consumers are not able to test prospectively the quality and safety of a health service themselves. Therefore a consumer could reasonably assume that an accredited health service is competent to provide health service, when in fact, the service basically conforms to a set of standards, as measured periodically. Standards Australia argue the notion of 'accreditation' is potentially misleading to consumers. Further they argue if the result of external assessment of a health service was 'certification' (as defined by Standards Australia) that the health service complied with a set of standards then consumers could look at those standards and make some judgement as to whether they thought that met their needs.

Regardless of the position taken, it is apparent that the lack of agreed definitions and limited availability of standards impact on consumers' capacity to make informed decisions and transparency of processes.

While consumers should be able to rely on appropriate and credible bodies evaluating health services and attesting their level of safety and quality it is unclear to what extent consumers are aware of the accreditation status of services they access or what choices they would make when there is both an accredited and non-accredited service, or when there is only an non-accredited service nearby. Referral patterns often determine where consumers go, not consumers themselves, so community consultation is required on what decisions consumers expect to make on the basis of accreditation status and what information they need to make those decisions.

Funders understand that the provision of good quality services can improve health outcomes and the efficiency of health service delivery.<sup>13</sup> For governments, health insurers and other funders, this means more, or better, good quality services purchased for the same level of investment.

In response to two reports, *Learnings from Bristol, The Department of Health's response (2002)* and the white paper, *Delivering the NHS plan: next steps on investment, next steps on reform (2002)*, Department of Health in the United Kingdom commenced a process of rationalising and integrating accreditation inspection regimes.<sup>14</sup>

In 2003, the Government in the United Kingdom issued a Policy on inspection of public services, which set out 10 principles for effective inspections by surveying organisations. These are paraphrased below:

- The purpose of an external assessment is to pursue improvement.
- The focus of an accreditation visit is patient outcomes.
- The patient's perspective is the lens through which surveyors should assess services.
- The assessment effort should be proportional to the risk.
- Managers should be encouraged to undertake self assessment.
- Impartial evidence should be used where possible.
- The criteria used to assess services are disclosed.
- The process is open and transparent.
- The assessment process has regard to value for money, including that of the inspecting body.
- The assessment process supports continuous improvement and continual learning.

As a result of the United Kingdom's investment in reform to achieve consistent safety and quality standards across the health care system, and to remove duplication of accreditation and inspection processes, a code of objectives and practices has been developed. This code has facilitated the coordination and mutual recognition between accrediting organisations. There are currently 20 signatories to a voluntary agreement that sets out what can be expected of an accrediting body, and how these bodies will work together to remove unnecessary duplication and bureaucracy associated with accreditation.

The processes of most accreditation agencies ensure regular review of standards, accreditation programs and processes. These processes are largely consultative, inclusive and receptive to the needs of many of its stakeholders and support the development of standards and guidelines. It is important that the best features of the current processes be harnessed and retained.

While the focus of much of the discussion about accreditation is on surveys, the accreditation process is more comprehensive, and includes self assessment against a set of standards and ongoing monitoring of safety and quality factors, development and implementation of quality plans, and implementation of survey recommendations.

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<sup>13</sup> NcNamara P, Purchaser strategies to influence quality of care: from rhetoric to global applications. Accepted for publication 5 April 2006. Downloaded from [www.qshc.bmjournals.com](http://www.qshc.bmjournals.com) on 4 June 2006

<sup>14</sup> Concordat, Working in Partnership: Getting the best from inspection, audit, review and regulation of health and social care. May 2006. [www.concordat.org.uk](http://www.concordat.org.uk) accessed 11 September 2006

## 5. Standards in Health Care

The primary objective of health care standards is to improve safety, effectiveness, cost and efficiency for the benefit of the community. Standards provide an alternative to regulation, although many standards are embedded in regulation and law. Standardisation (as distinct from standards) also has the potential to cut costs and save money.

Use of standards is one way of systematically reviewing a complex system and measuring improvements in care. Therefore it is important the standards keep pace with improvements in care and remain relevant to the service that is being measured.

Standards can be:

- **Minimum safety standards**  
These specify a minimum requirement to ensure processes, products and systems are consistently safe and reliable and play a protective role by addressing basic safety concerns. They are generally reflective of the views of organisations, governments or professional peer groups' on the structures, processes and outcomes that represent acceptable practice.
- **Best practice**  
These may disregard cost and other practicalities inherent in implementation.
- **Optimal achievable**  
These set targets of quality improvement in an organisation, but remain within the reach of high performing organisations.<sup>15</sup>

A 2004 British review<sup>16</sup> of standards formats and content for accreditation, ISO, Quality awards and professional peer review found that, while initially very different, there has been increasing convergence between these standard types.

Standards against which compliance is assessed need to be both firm and credible while applicable to varying health service environments. The credibility of standards used in the Australian health context is significant factor in the credibility of the accreditation process and the willingness of stakeholders, whether they are consumers, funders, owners, regulators practitioners or health service providers, to accept an accreditation decision.<sup>17</sup> Therefore, where standards have a strong evidence base, such as clinical standards, there is a greater likelihood of them having stakeholder support.

Standards setting bodies in Australia generally fit into one of five categories<sup>18</sup>:

1. Government departments and agencies;
2. National bodies such as: disease based foundations, professional associations, colleges, scientific societies and peak bodies;
3. National standards and accreditation agencies developing health specific and general standards;
4. International standards organisations that develop health specific and general standards;  
and
5. Institutions such as health insurers, facilities, and private health service organisations.

Table 1 details the key Australian health care standards setting bodies and lists the related accrediting/certifying bodies.

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<sup>15</sup> Schyve PM, Joint commission perspectives on accreditation of public practice.

<sup>16</sup> Shaw C, Heaton C, Summary of the ExPeRT Project. Accessed via [www.caspe.co.uk/expert/final\\_summary.htm](http://www.caspe.co.uk/expert/final_summary.htm) 6 July 2006.

<sup>17</sup> Ibid

<sup>18</sup> Michael Legg and Associates, Standards Used in the Australian Health Sector, A Report for Standards Australia, August 2003, unpublished, reproduced with permission of Standards Australia.

Standards development bodies include:

<b>Standards Setting Body</b>	<b>Title of Sets of Standards</b>	<b>Scope of Standards</b>	<b>Accrediting Body (s)</b>
Australian Council on Healthcare Standards	EQuIP 4 (from Jan 2007)	Public and private health sector, corporate health services	ACHS
DoHA in conjunction with Aged Care Advisory Committee	Aged Care Standards	Residential and home care standards covering management systems, staffing and organisational development; health and personal care; resident lifestyle and physical environment and safe systems	Aged Care Standards and Accrediting Agency Ltd.
DoHA and expert input	Packaged Care Guidelines, 2004	Community Aged Care Packages and Community Options Programs	Desk top audit based on Quality Reporting Mechanisms requirements, and external evaluation by DoHA staff
Royal Australian College General Practitioners	RACGP Standards for General Practice 3 <sup>rd</sup> Edition	GP Practices	Australian General Practice Accreditation Ltd. Quality Practice Accreditation.
Quality Improvement Council	Quality Improvement Council Standards	Community based health programs (including community health centres, drug and alcohol services, community mental health) and community services (including counselling services, family and children's services)	Licensed provider assessing on behalf of QIC <ul style="list-style-type: none"> <li>o Institute of Health and Community Australia Ltd..</li> <li>o Quality Improvement &amp; Community Services Accreditation Inc.</li> <li>o Quality Management Services</li> </ul>
	Integrated Health Services Standards	Small rural integrated services such as Multipurpose Services.	
International Organisation for Standardisation (ISO)	ISO Standards	Public and private health sector, corporate health services	Australasian Auditing & Certification Services Pty Ltd. Benchmark Certification Global Mark Pty Ltd. Institute of Health and Community Australia Ltd. International Standards Certification Nata Certifying Service Inc. National Association of Testing Authorities (NATA) TQCSI Pty Ltd.
Standards Australia Limited	Australian Standards	Public and private health sector, corporate health services	SAI Global

<b>Standards Setting Body</b>	<b>Title of Sets of Standards</b>	<b>Scope of Standards</b>	<b>Accrediting Body (s)</b>
			ACHS
DoHA, National Mental Health Working Group and project consortium	National Standards for Mental Health 1996	Mental health services	ACHS QIC
Royal & Australian New Zealand College Radiology, being revised in conjunction with DoHA	Accreditation Standards for Diagnostic and Interventional Radiology	Medical imaging provided by radiologists	NATA
DoHA in conjunction with National Pathology Accreditation Advisory Committee	Various technical standards related to pathology services	Pathology	NATA
DoHA in conjunction with former Private Hospitals Safety and Quality Committee	2 <sup>nd</sup> Tier Standards – Private Health Insurance	Private hospitals and day surgery centres	ACHS Australasian Auditing & Certification Services Pty. Ltd. Benchmark Certification Global Mark Pty. Ltd. Institute of Health and Community Australia Ltd. International Standards Certification SAI Global Inc. TOCSI Pty. Ltd.
DoHA and Expert Breast Screening Committee	National Accreditation Standards for Breast Screening	Breast Screening Services	Breast Screening Australia
Palliative Care Australia	Standards for providing Quality Palliative Care	Palliative care services in public and private sector	Not surveyed independently. Included as part of: ACHS QIC
Australian Physiotherapy Association	Australian Physiotherapy Association Standards for Practices – 8 <sup>th</sup> Edition 2006	Private community based physiotherapy practices	Quality In Practice Pty. Ltd.
Home and Community Care Program	1998 HACC National Standards Instrument and Guidelines	Services provided to aged and disable people in community settings	Assessed against standards, but not a formal accreditation process: <ul style="list-style-type: none"> <li>o Institute of Health and Community Australia Ltd.</li> <li>o Quality Improvement &amp; Community Services Accreditation Inc.</li> <li>o Quality Management Services</li> </ul>

<b>Standards Setting Body</b>	<b>Title of Sets of Standards</b>	<b>Scope of Standards</b>	<b>Accrediting Body (s)</b>
Department of Veterans Affairs		Quality guidelines for provision of services to veterans and their families in all service settings	-
Optometrists Association Australia	Optometrists Association Australia Practice Standards	Private community based optometry practices	Quality In Practice Pty.Ltd.
South Australia Health Department	Service Excellence Framework	Applicable broadly across all health services	Quality Management Services (SA) ACHS
State and Territory Postgraduate Medical Education Councils	State specific standards with work underway on a national set of standards (These standards fit in both service type and education type standards)	Both facility and education / training standards for junior medical officers across all service setting where they are employed	State and Territory Postgraduate Medical Education Councils
The Pharmacy Guild of Australia	Quality Care Pharmacy Program	Business management and professional requirements	Pharmacy Guild of Australia licences independent bodies to undertake assessments on its behalf.
National Blood Authority	Guide to preparation, use and quality assurance of blood components, 11 <sup>th</sup> Edition	Blood products quality systems, technical and transfusion procedures	-
Cancer Services- including Australian Cancer Network, NSW Cancer Institute, Victorian Department of Human Services Cancer Coordination Unit.	Currently being finalised.	Cancer services	Yet to be determined
Australian Quality Council	Australian Quality Awards Business Excellence Framework	Quality business management	-
Australia College of Midwives Inc.	Midwifery Practice Review Standards	Midwifery practice in private and public settings	Australian College of Midwives Inc.

A large number of the standards are developed with the support of governments, through expert and stakeholder committees. For example, there are national Home and Community Care (HACC) standards and HACC standards that have been developed by States and Territories. The Department of Health and Ageing has supported, or facilitated, the development of at least seven sets of standards covering pathology, aged care, integrated care, health and community standards, breast screening, 2<sup>nd</sup> tier standards for private hospitals, blood services and mental health.

A preliminary attempt at mapping health care standards has shown this is a complex task and outside the scope of this review. The complexity is partly due to differences in terminology between sets of standards, as well as variation in the structure, style and intent of the standards. It is not therefore possible to identify the extent of the duplication in standards, nor the gaps in safety and quality standards that may exist. It is however, work that the Commission recommends is undertaken as it is important to identify gaps, duplication and conflicts between sets of health safety and quality standards.

## 6. Accreditation Issues

In 2003, the former Council reported that there was limited robust national or international literature on accreditation. Subsequently there has been little new literature with case reports being the norm and comprehensive evaluations rare. From the available literature, review of former Council consultation documents and discussions with stakeholders, the following issues with the accreditation system have been identified.

Stakeholders' expectations of the accreditation process vary enormously, from accreditation as an imposition that must be endured to access funding, to an effective tool for managing ongoing improvement. This difference is reflected in the concerns that stakeholders identified with the current accreditation system. These concerns include:

### 1. Effectiveness in identifying poor performance

In the USA, there has been growing criticism over the last decade of the effectiveness and relevance of accreditation processes.<sup>19</sup> These in part, relate to cost but also to the relevance of the accreditation surveys to quality care.

In Australia, the process of accreditation has been criticised by health service managers, funders and the public for not reliably detecting poor performance, while others argue it has been effective in identifying high risk behaviour and unsafe practice. However, when a health service is found to be performing poorly after having been assessed and accredited, it undermines the credibility of accreditation and lowers its value to consumers and others. It also limits the value of accreditation for health services that use these internal and external assessment tools as a mechanism for identifying under-performance.

Critics of the survey process suggest that accreditation processes are not effective at identifying patient outcomes, in part because they do not test the transference of policies and procedures by clinicians when and where patients are treated.

**What core processes or systems need to be in place to ensure poor performance is detected? Is this necessarily part of an accreditation process?**

**Where there is a systems failure, how should the accreditation body respond?**

### 2. Transparency

Three issues relating to transparency of accreditation processes have been identified by stakeholders. The first relates to the transparency of decision making processes, the second relates to reporting on the outcome of the accreditation process and the third is public access to information.

Accreditation is not a single event. It consists of a sequence of events that can occur, generally in a 3 to 5 year cycle. It usually involves:

- self assessment against a set of standards,
- preparation and submission of pre-survey documentation,
- external review by a team of surveyors,
- reporting and feedback on the outcome of the review,
- quality improvement planning and implementation,
- internal and external monitoring over time.

<sup>19</sup> Morrissey J, Changing the rules. Modern Healthcare, Chicago Oct 7, 2002, Vol 32, Issue 40, pp 8-10.

The external assessment and feedback processes are generally the final steps in the accreditation cycle and are associated with the conferring or renewal of an accreditation award.

The Patterson Report noted that the outcome of accreditation surveys is not always transparent to stakeholders and, in particular, there is not a vigorous and consistent method of responding to organisations which are found to pose an unacceptable safety and quality risk. This concern also pertains to the appropriate management of the results of assessment.

Not all accrediting agencies recognise the rights of owner organisations<sup>20</sup> to access and comment on draft survey reports. For accreditation to have maximum impact, there must be a clearly identified and accountable entity that has the authority to implement recommendations and make improvements. Owners share accountability so, for a process to be effective, owners need to comment on and then implement, accreditation recommendations.<sup>21</sup>

The increased emphasis consumers place on improving the quality of health care has created greater pressure on health services for public disclosure of information. Consumers are looking for access to the accreditation status of a service and for detail concerning good and poor quality service.<sup>22</sup> Critics of public disclosure argue that disclosure of accreditation outcomes will discourage the full declaration of sensitive information by health services.<sup>23</sup> With the exception of aged care reports on accreditation, information available to the public on accreditation outcomes is limited to information on the period that accreditation has been awarded or brief agreed statements on accreditation outcomes.

**What is essential to ensuring all accreditation processes are open and transparent?**

**What minimum information should be publicly available on the accreditation status of health services?**

### 3. Governance

Governance for the bodies that set and measure standards is an extremely important issue. Standards setting bodies in Australia are largely separate from accrediting bodies, with the exception of the ACHS and a limited number of professional bodies such as the Australian College of Midwives Inc. and the Australian Pharmacy Guild. Other health sector organisations that have the dual role of setting standards and accrediting against them are principally professional education and training bodies.

In The USA, JCAHO has been criticised for its dual role as “paid partner for quality improvement and agent for government scrutiny”.<sup>24</sup> The Canadian Council on Health Services Accreditation (CCHSA) also has both standards setting and accrediting roles.

The benefits associated with the dual role are access to a pool of accreditation data for development and verification of standards, benchmarking of facilities and reporting. However, the dual role may risk a conflict of interest by, for example, encouraging the development of standards not integral to measuring safety and quality or influencing decisions about standards compliance.

<sup>20</sup> Owner organisations may be or may not be different to funding organisations. State Health Departments may consider themselves owners and funders, where as private organisations that operate health services are owners only.

<sup>21</sup> Schyve, *ibid*

<sup>22</sup> Ito H and Sugawara H, Relationship between accreditation scores and the public disclosure of accreditation reports: a cross sectional study, *Quality Safety Health Care*, 2005; 14:87-92.

<sup>23</sup> Schyve PM, Joint Commission perspectives on accreditation in public health practice. *Journal of Public Health Management and Practice*. July 1998, Volume 4, Issue 4, pp 28-33.

<sup>24</sup> Morrissey J, Eyeing the watchdog. *Modern Healthcare*, Chicago, April 2002, V 32, Issue 16, pp 8-9.

Any proposal that health funders take on responsibility for accreditation of their recipient health services would raise similar conflict of interest concerns in the absence of an external and independent assessment process.

**What governance issues must be addressed by organisations setting standards, training surveyors or accrediting health services?**

#### **4. Duplication and Overlap**

Health services report that they are required to participate in an increasing number of accreditation processes. Many of these accreditation processes have overlapping objectives directed at the same outcome, but different (and detailed) process requirements. Patterson reported that many health care organisations are required to undergo repeated accreditation surveys by different organisations, where an organisation wide approach would be more efficient and appropriate.

For example, a service may be accredited for its overall compliance with service standard via ACHS, ISO or QIP and then be subject to accreditation of specific services such as scientific laboratories, specific service area such as surgery, palliative care, mental health or aged care. Each process represents an additional cost and time burden.

Recently some accrediting bodies have attempted to more closely align overlapping accreditation processes. Synergies have been explored between community base care and general practice accreditation in Aboriginal medical community care services. Without national agreement on a mechanism to recognise the accreditation processes or standards of another organisation, accreditation programs cannot become mutually supportive or integrated.

**What needs to be done to integrate and streamline overlapping accreditation processes?**

#### **5. Resource requirements**

In 2003, the WHO reported that since 1990, the number of accreditation programs around the world has doubled every five years.<sup>25</sup> Similarly in Australia, there has been an increase in the number and scope of accreditation processes which health services are being asked to implement. In addition, stakeholders report that the growing number of standards has increased cost of preparing for, participating in and complying with accreditation processes. The evidence for this however is anecdotal.

The accreditation costs are separate from the costs associated with implementing the recommendations that are conditional for maintaining accreditation. External accreditation reviews often result in quality improvement recommendations, some of which may be mandatory and with short implementation timeframes. While health services should include continuous quality improvement as part of general operations, some of the recommendations may not align with the service priorities, and therefore managers face potentially competing pressures associated with implementing quality changes within budget constraints. Trade-offs are inherent in these decision making processes, involving decisions around priority and non priority initiatives.

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<sup>25</sup> Shaw CD, 2003. *ibid*

Some stakeholders report that much of the documentation required for assessment by external surveyors is prepared specifically for that purpose. There may however be a mismatch between their expectations to provide documentation and the requirements of the accrediting body. Further, they complain that the format is not always consistent with the health service's usual business format or descriptions, which makes preparation resource intensive. While preparation of pre-survey and survey documentation has the potential to raise an organisation's awareness of policy and procedures, there is little evidence that this process results in the *implementation* of policy, bringing into question the cost effectiveness of the documentation requirements pre-survey.

There is also stakeholder comment that the cost of the investment in accreditation is disproportional to the gains that are achieved in safety and quality. They report that they incur costs associated with engaging an accrediting body and survey, staff hours involved in the preparation of documentation, lost productivity during a survey and attendance at training workshops, which are increasingly becoming a mandatory part of some accreditation programs.

For small facilities, the cost of undertaking accreditation is great. Comments have been made that small organisations do not have the resources required to engage a quality manager and, because they have fewer staff overall, the completion of pre-survey documentation is a greater impost on them. Further some note the existing accreditation system does not always facilitate the embedding of safety and quality processes into the day to day operations of service providers. This has resulted in a culture, particularly among clinicians and medical practitioners that safety and quality initiatives are 'someone else's' responsibility.

### **How can accreditation be made more cost efficient and effective?**

## **6. Surveyors**

Along with the standards, surveyors are the most important part of an accreditation program.

Inter and intra-surveyor reliability is a key issue for funders, health services and accrediting bodies and has been a source of contention for accrediting bodies in Australia and overseas.<sup>26</sup> Inter-surveyor reliability is the degree to which two surveyors operating independently assign the same value for the attribute they are measuring, and intra surveyor reliability is the degree to which a single surveyor assigns the same value when measuring the same attribute at different times.<sup>27</sup>

Accreditation bodies continue to work to reduce surveyor variation in accreditation processes. Training is provided for surveyors, although not all training bodies assess an individual surveyor's competency. Some organisations require new surveyors to attend a specified number of surveys as an observer or in a trainee capacity before being allowed to fully participate in a survey and additional training may be required to be a team leader or convener. Performance management of surveyors, particularly where they survey infrequently and are voluntary, can be problematic. Some organisations have a mix of paid and voluntary surveyors to allow for better management of performance issues. Other organisations require regular retraining of surveyors.

If the current system of accreditation is maintained, surveyors will need to be available more frequently or more surveyors will be required to accommodate the growing number and scope of accreditation. This will place greater pressure on employers to release staff to undertake surveys. Alternatively, smaller survey teams will mean accreditation visits become progressively longer. Neither option is sustainable.

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<sup>26</sup> Morrissey J, 2002, *ibid*.

<sup>27</sup> Gropper EI, Expect truly unannounced surveys (and more) from the joint commission. *Nursing Management*, Chicago, October 1999, Vol 30, Issue 10, pp 36-38.

Health services have demanded that surveyors be both credible and competent, which has meant they need expert knowledge of the health system – or the specific section of the health system that they are assessing. They also expect that survey teams include people with clinical skills. Some health services see it as particularly important for surveyors with experience and skills relevant to their service and sectors, public or private, only to be involved on surveys. These health services also want continuity in the individual or pool of surveyors that assess their sector. Accrediting bodies know that with a primarily volunteer workforce this is not always possible.

Health workforce shortages are likely to make it more difficult for accrediting bodies to recruit and retain a pool of surveyors with the required skills and health experience to staff survey teams. Accrediting bodies, particularly the for-profit organisations employ surveyors and this practice may become more wide spread as workforce shortages worsen.

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

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

## **7. Information to support accreditation**

Increased emphasis on quality health service provision is translating into a growing requirement for public disclosure of organisational performance and assessment information. The disclosure of data has the potential to promote improvements in quality through comparisons and review of performance over time, to supporting accountability, and by allowing consumers to make informed choices.

Currently, publicly available information on accredited health services is limited. Most organisations publish the institutional name and the period for which accreditation has been awarded. Exceptions are aged care, where accreditation reports are available on the web site<sup>28</sup>, and ACHS provides a public agreed statement on accreditation outcomes which is available for approximately 4 percent of health services, although it is largely health services that determine what information becomes publicly available. There is very little additional information on accreditation outcomes, conditions or the areas and timeframes for which recommendations are made. There is no comprehensive list of health service organisations with accreditation awards as each accrediting body publishes this information separately. Retrospective data that show the length of previous accreditation awards is not available.

A large volume of information is collected by accrediting bodies as part of accreditation, self assessment and accreditation survey processes. With a few notable exceptions, including the ACHS performance indicators report and performance information provided on request to individual health services, there is limited utilisation of these data across facilities or nationally. Even the ACHS data has limitations because of the 'opt-out' option for health services on performance reporting. These data, if they were available nationally, represent a rich source of information that could be used to determine existing or emerging safety and quality trends and areas of concern. The Patterson Report suggested that national quality and safety data from accreditation, if used optimally, will inevitably drive system-wide improvement. A comprehensive and coordinated national approach to analysis and reporting of accreditation would be more likely to drive effective improvement. This could be enhanced if the work of the National Health Information Group (a body set up by health Ministers) concerning generation of national health statistics included the use of accreditation data.

In the USA, when JCAHO suggested a release of data across a broad range of performance indicators, health care providers agreed that the release of data could improve the credibility of health services with the community as well as provide incentives for internal quality improvement. However, there

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<sup>28</sup> Reports on individual aged care residential facilities available at <http://www.accreditation.org.au/ReportsOnHomes>

was concern that accreditation reports would be misinterpreted and there would be an over reaction to negative data particularly in the media. Data release in the US remains limited.

Access to comparative indicator information would also support implementation of different models of accreditation, such as unannounced surveys and tracer methodologies (see section 7). Where performance information can be collected on a national basis, individual service performance can be plotted against this information and accreditation visits can be focused on areas where there is high volume, high risk, under performance or other circumstances that pose a safety / quality concern.

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

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

## 7. Standards Issues

Organisations develop standards for a variety of reasons. They have been developed to improve safety concerns, standardise processes or implement quality improvement practices. They have also been developed to defend an area of professional practice or provide quality markers for payment systems.

### 1. Proliferation of Standards

The growth in service types and changes in delivery have been supported by the creation, appropriately, of an array of new sets of standards to measure performance. For health organisations wishing to develop standards, there are few external barriers to developing a set of service, disease or other set of standards. Health organisations are not required to assess the need or cost benefits of developing a new set of standards, nor consider alternatives before commencing development, although organisations such as ACHS, Standards Australia and Quality Improvement Council clearly do. Organisations can develop standards without a sustainable plan or funding to implement the uptake or assessment against the new standards. For example national standards have recently been developed for cancer care services without having in place a mechanism to implement the standards or to conduct external assessments of services compliance.

The recent Productivity Commission Report on Standards Setting and Laboratory Accreditation found that:

*“there must be clear and appropriate criteria for determining the need for standards and priorities, and these must be applied transparently and consistently ... there should be a broad assessment of impacts, documenting the justification for the development of all proposed standards at the project initiation phase, and ongoing consideration of impacts throughout the development of a standard – such assessment should be readily available to the public”.*<sup>29</sup>

While these findings relate specifically to Standards Australia, the principles are extendible to other standards setting bodies, since the cost of developing and conforming to standards is significant.

While the creation of new standards may be appropriate, a greater number of standards represent a greater investment in time and resources to ensure compliance by health services. The health system also incurs the costs of the development of these standards by their necessary participation in the development process. This investment may be warranted if it results in improved safety and quality for patients, but there is a lack of evidence that provides a direct link between additional standards and better quality patient care.

Governments have supported the development of service standards across a wide range of areas, but without centralised coordination or standardisation of the format or structure of these standards. For example, the Department of Health and Ageing supports, or facilitates, standards development across a broad range of areas including pathology, nuclear medicine, aged care, radiology, blood services (via the Therapeutic Goods Administration), Home and community care (HACC) and integrated care. Differences in the structure, format and scope of these standards demonstrate little, or no, standardisation in development and drafting. While it is not envisaged that standards need to be identical, harmonising the structure, format and scope will reduce duplication.

Duplication of standards also exists in areas where national standards have been adapted and rewritten for a local environment. HACC standards are an example where national and state specific standards exist.

With the large number of standards in existence, health services need to dedicate resources and establish systems to ensure they are accessing the most recent version of the standards. This is particularly an issue where there are large numbers of individual standards as with Standards Australia.

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<sup>29</sup> Productivity Commission 2006, pg 92.

The increasing number and scope of standards add to the complexity of the accreditation processes and increase the compliance requirements for health services.

**What initiatives are required to coordinate and harmonise standards development?**

## 2. Access to Standards

Many of the health standards are only accessible to members of a standards setting body or at substantial cost, for example ISO standards. The former Council and the Patterson Report called for standards to be accessible to all stakeholders, including the general public. In the USA in 1998, a US presidential advisory commission on consumer protection recommended that public and private programs of external review should make their standards, survey protocols, decision criteria, and results available to the public at little or no cost. These standards, protocols and processes are not yet public in the USA.<sup>30</sup>

For some standards setting bodies in Australia, the sale of standards is an important revenue raising stream and general publication of standards is likely to be met with resistance. The Productivity Commission's draft research report on *Standard Setting and Laboratory Assessment*, suggests the need for low cost access to standards.<sup>31</sup> While this relates to standards cited in regulation, it could also apply more broadly to situations where policy encourages accreditation, self-regulation is the preferred model or where behavioural changes are influenced by the accreditation status of a service (ie referrals being directed to accredited rather than non-accredited services).

**What minimum information should be publicly available on accreditation standards?**

## 3. Process of developing standards

The Patterson Report notes that standards development is not always transparent and the level of consumer involvement in standards development differs between organisations.

ISQua and ISO have developed guidelines for the development of standards that detail best practice in the structuring, consulting and drafting of standards. While these best practice models are adopted by bodies with a relationship to ISQua and ISO, not all standards setting bodies routinely use a best practice methodology.

Clinical and technical standards, such as those developed for breast screen services, pathology and medical imaging services are strongly based on scientific evidence. However, the validity of other standards is not always apparent. There is wide variation in the language, definitions and quality of standards writing.

**What aspects of Australian health care standard development should be standardised for more streamlined, effective and efficient standards development?**

<sup>30</sup> Shaw CD, Evaluating Accreditation. International Journal for Quality in Health Care. December 2003. Volume 6, Number 6. pp 455-456.

<sup>31</sup> Productivity Commission 2006, pg 91

#### 4. Appropriateness of standards

A number of sets of standards, ACHS and ISO in particular, are used to assess health services across a range of health service environments from large hospital networks, small day surgery and other small health facilities, administrative offices such as Area Health Services and Divisions of General Practice. Some stakeholders have raised concerns about the appropriateness and applicability of a single set of standards assessing this range of services.

Particular concerns have been raised about ISO standards as an effective tool for measuring and maintaining safety and quality in health services. These standards were not developed specifically to measure patient care or health outcomes and the scope of the standards is limited in comparison to other safety and quality standards such as QIC and ACHS. However, the growing number of organisations in the market place assessing against ISO standards suggests increasingly, health services are being certified against these standards.

**How do you ensure the standards being assessed are appropriate?**

## 8. Future Systems and Processes

Fundamental changes are required to sustain accreditation and to address concerns with the existing system. The Commission proposes an integrated package of reforms to be applied nationally across all sectors in the health care system.

The changes are aimed at:

- streamlining and harmonising existing accreditation and standards processes to ensure they are efficient and effective;
- re-orienting accreditation systems to increase the focus on patients, rather than processes, protocols and policies;
- increasing the robustness and credibility of accreditation as a mechanism for continuous safety and quality improvement;
- identifying mechanisms that detect and respond to systems failures;
- implementing structural change of accreditation and standards development;
- using best practice model(s) and appropriate harmonisation/standardisation of processes for the development of standards; and
- moving to mutual recognition of standards and accreditation processes nationally, including accreditation processes for accreditation of education programs for the health workforce.

Implementing the reforms requires coordinated action by governments, private health funders and providers, accrediting and standards setting bodies and a broad range of stakeholders, including consumers.

The accreditation and standards issues identified are not unique to Australia and a variety of solutions are being implemented internationally. This reform proposal incorporates international experience and adapts it to the Australian context, recognising that accreditation processes in this country are well developed and broadly employed. The reforms are not designed to impose a single assessment approach but a more consistent and cohesive approach to accreditation and standards setting.

These initiatives are interdependent and the timing and phasing of their introduction will form part of stakeholder discussions. As with any reform process, there will need to be ongoing evaluation mechanisms built into the implementation process to measure the changes achieved against the stated aims.

## 8.1 Accreditation Reform Strategies

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The following proposals represent strategies to streamline and harmonise existing accreditation processes. They are largely measures that can be implemented in the short term, following consultation and some preliminary work with key stakeholders.

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### 1. Register of accrediting bodies

It is proposed that registration of health care accrediting bodies becomes mandatory.

The benefits of such a proposal are that:

- a. Registration would identify and track organisations that are accrediting health services. For consumers there is no single site where information on a health provider's accreditation status can be accessed. The register of accreditation bodies could publish a user friendly list of accredited health services, agreed and useful information on accreditation outcomes and links to relevant accrediting bodies.

For funders and service providers it will facilitate the identification of accreditation providers from the growing number in the market place and the scope of services they accredit.

- b. Accreditation bodies would be required to provide easy public access to the standards which they accredit against or, as a minimum, advice on the scope of the standards. Currently there is little information or explanation of what accreditation has tested and what that means for the consumer.
- c. Accreditation bodies would be required to uniformly introduce agreed changes to the survey methodology, including the commencement of unannounced surveys and use of tracer methodology (see section 8.1).
- d. A nationally agreed set of accreditation data can be collected from accreditation bodies that will form the basis of a database on safety and quality. This information can be used to identify trends in safety and quality and target accreditation assessments using the tracer methodology.
- e. The registration body could monitor the up-take, adequacy and evolution of accreditation nationally and against international trends.
- f. A register of health care facility surveyors could also be established with a view to ensuring appropriate and regular training and making the most efficient use of surveyors as a valuable resource.

It is not proposed that registration of accrediting bodies be an expensive or bureaucratic process. Minimum requirements for gaining registration are likely to include accreditation by a recognised, external accrediting body, such as ISQua, JAS-ANZ or IPAC; accreditation of nationally recognised standards, use of recognised health care standards; and agreement to provide data on a regular basis.

Consultation will be needed on policies and processes required to implement this change. It is anticipated that the Commission would undertake the first phase of this work, to develop these policies and processes. However a longer term strategy for the implementation, monitoring role and ongoing management of registration will need to be identified as the Commission does not have long term implementation of projects in its Terms of Reference.

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

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

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

It is proposed that the language and definitions of accreditation be standardised.

The benefits of this proposal are that:

- a. One of the contributing factors to the fragmentation of the accreditation system will be reduced.
- b. Defining accreditation provides clarity about what accreditation status means and what can be expected from an accredited health service for those involved in the process and for consumers.
- c. Standardisation will support mutual recognition by accreditation bodies. To move to sharing information and recognising each others processes, it will be necessary to have a baseline understanding that is common to all organisations.
- d. There would be consistency between bodies that are involved in health certification, accreditation, compliance testing such as NIHG, Council of Australian Government initiatives to establish a National Education Accreditation Body; and with bodies that interface with health but also interface in other industries, such as NEHTA.

The Commission could take a lead on this work or could coordinate independent or interested stakeholders to progress this issue.

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

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

It is proposed that training and assessment requirements of surveyors be reviewed across the sector with a view to ensuring all surveyors are suitably qualified and trained, with the skills necessary to implement new accreditation methodologies.

The benefits of this proposal are that:

- a. A review provides an opportunity to measure the size, location, skills and mix of the surveyors in Australian. A better understanding of the demographics of this 'workforce' will help accreditation bodies manage this resource as well as recruit and offer training in areas where it is most required.
- b. Surveyor training can be adapted to incorporate a common core curriculum on the knowledge, attitudes and skills required of assessors. With the introduction of new accreditation methodologies, it will be essential to ensure surveyors are taught to make the connection between the care of the patient and the standards against which they are measuring.
- c. The introduction of core training requirements supports the development of reciprocal training programs.

The success of the reform package is largely dependent on the re-orientation of surveyors to a new approach of accreditation that focuses more on patient-care performance to standards compliance instead of using the standards to test for systems weaknesses.

A review of training and competency testing of surveyors will require the involvement and cooperation of all those bodies currently involved in training and assessing surveyors. This has a time and cost implication for training bodies that will need to be addressed as part of the planning for this review.

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

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

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

It is proposed that the Commission explore opportunities to use data from a number of collections, to provide a more comprehensive picture of health service outputs and outcomes.

The benefits of this proposal are that:

- a As most data sets are imperfect, the use of a number of data sources allows surveyors to compensate for the limitations of individual data sets and gain a more comprehensive view of relative utilisation, health status, outputs and outcomes at service level and across the system.
- b Better information systems support the introduction of new accreditation methodologies by providing data that can be used to identify safety - critical areas for assessment by external surveyors.
- c Information can be used to identify safety and quality trends over time, which should form part of the ongoing evaluation of the effectiveness of accreditation of services.

If accreditation is to effectively measure health outcomes, satisfaction and costs, then data systems require relevant outcomes measures, standardised algorithms for calculating those outcomes, reliable data collection techniques, risk adjustment techniques that allow for differences in patient populations and useful analysis and feedback systems.

The current approach to data collection is fragmented, under-utilises the data that is already collected and as a result limited patient centred information relevant to accreditation is produced. The key to effectively implementing new approaches to accreditation is the collection and the proficient use of data to identify critical areas of concerns about safety and trends in quality.

The Commission could take a lead on this work and coordinate the work of other independent or interested stakeholders to progress this issue. This work would align well with other data work being undertaken by the Commission.

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

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

It is proposed that a range of regulation, funding and policy levers be used to ensure all health services participate in a registered accreditation and quality process.

The benefits of this proposal are that:

- a Minimum safety standards and continuous quality improvement processes will be implemented across all health services, many of which are currently not subject to any external or peer review.
- b Consumers can more confidently expect that minimum safety standards apply across all service settings
- c Enforcement of safety and quality requirements will be consistent across all health service locations, which is consistent with changing service deliver models.
- d Accreditation systems and processes exist that can easily be adapted to provide accreditation in all health care settings within a limited timeframe.

The Commission would work with governments, health funders, service providers, professional organisations, consumers and a range of other stakeholders to progress this issue.

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

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The following proposals represent a paradigm shift in the way accreditation processes currently operate. They are innovative methodologies recently implemented in the USA by the Joint Commission on Accreditation of Healthcare Organisations. For these changes to be operationalised in the medium term there will need to be:

- broad stakeholder consultation;
  - considerable preliminary work in training surveyors and educating organisations;
  - development of assessment tools that are appropriate for Australian health services; and
  - development of evaluation methodologies that are embedded in all the changes so their effectiveness can be monitored.
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## **6. Introduction of unannounced surveys**

It is proposed that unannounced surveys be introduced by all accreditation providers.

Unannounced surveys are full or part onsite accreditation assessments of an organisation with no advanced notice of the timing of a survey team's arrival to conduct a survey. They commence after the initial accreditation assessment cycle has been completed, ie organisations are not subject to an unannounced survey for their first accreditation survey visit.

The purpose of an unannounced survey is to generate a shift in attitude and culture in health services from one of preparation for a scheduled survey to assessment of an organisation that is constantly in compliance with the standards. The standards then form the basis of operational improvements, patient safety and quality care.

The potential benefits of an unannounced survey are that:

- a. Surveyors assess organisational performance under normal working circumstances, which gives a truer picture of how organisations operate;
- b. The resource investment in the "ramping up" for survey is eliminated, reducing the burden of preparing assessment specific documentation, eliminating the need for staff resources to be dedicated to survey preparation;
- c. The focus for health services becomes safe and high quality care at all times, not just in advance of a survey;
- d. Encourages the use of accreditation as a management tool, rather than a process somewhat separate from the normal business of health service delivery; and
- e. It requires quality improvement to become embedded into the routine operations of clinical practitioners.

The Commission believes these are compelling economic and safety and quality arguments for expanding the use of unannounced surveys across all health services.

In Australia, unannounced surveys are currently being used across a range of inspection industries including food services, building compliance and random speeding checks and breath-testing for drivers and this methodology has recently been incorporated into aged care accreditation.

The USA Joint Commission introduced unannounced accreditation surveys from January 2006 and in Australia it is proposed that random assessment of medical imaging services be introduced as these health services move into mandatory accreditation to access Medicare payments.

Introduction of unannounced surveys for Australian health services will need to be accompanied by broad consultation with all stakeholders on how to most effectively and efficiently introduce this methodology and how to embed ongoing evaluation of its effectiveness into accreditation systems.

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

## 7. Introduction of Tracer Methodology in external accreditation reviews

It is proposed that tracer methodology be implemented nationally by all bodies accrediting health services.

Tracer methodology involves a surveyor tracking an **individual's experience** of health care, treatment and service provision through a health service and across sectors, where appropriate. For example, patients, entering a hospital, moving from an emergency department, through a range of wards and discharged into the care of the General Practitioner, are followed.

The process involves interviewing patients, direct line carers and managers at all points of care, to assess the quality of care provided, look at the output of the care and where there are deviations from standard clinical protocols, and review the decision making processes that were used to make changes to an individual's care.

The use of national health indicator data and health service specific patient outcome data would support the selection of patients that would be tracked. Selection of patients could also be based on criteria such as patients with high risk illnesses, patients where there is statistically poor health outcomes, patients that are casemix or length of stay outliers.

The potential benefits of this proposal are that:

- a. Consumers are directly involved in providing input into the accreditation process;
- b. This methodology puts patients at the focus of the survey and allows close inspection of patient handover points, within and between service provider organisations, where safe and high quality care is at greatest risk;
- c. Accreditation validates a health service's potential performance that may occur because policies, processes and systems are in place, by adding a patient outcome focus;
- d. Surveyors would track an individual's experience of a system of care, timely and quality treatment and service across health services, to assess the effectiveness of policy and protocol implementation; and moves survey assessments away from primarily reviewing policy documentation;
- e. This methodology eliminates the need for some of the pre-survey documentation and reinforces it with ongoing implementation and monitoring of patient care policy and procedures by operational staff;
- f. Because this methodology follows the patient's journey of care, it is well suited to the assessment of patients with chronic care. It moves across the range of locations where patients with chronic diseases access care for acute episodes, ongoing care in the community, care in the private sector, or with a general practitioner;
- g. Process design could potentially achieve efficiencies in the way surveyors are utilised for accreditation surveys and the time spent assessing health services; and
- h. Tracer methodology can also be used to track the use of equipment and performance management systems; and so is applicable across services such as pathology laboratories and medical imaging services.

The tracer methodology has been developed and implemented by in the USA by the Joint Commission on Accreditation of Healthcare Organisations. In the USA, the focus of external reviews is on operational systems critical to the safety and quality of individual care – known as the 14 Priority Focus Processes that includes infection control, communication, equipment use, information management, medications management, etc. It sits within a framework of core safety and quality standards and unannounced surveys. It represents an innovative way of accrediting health services and, because of its recent introduction in the USA, neither its weaknesses nor its full potential have yet been rigorously tested. The Commission is aware of the need for piloting the methodology and building in evaluation processes.

**What needs to be done and by whom, to introduce tracer methodology in a timely and effective way?**

## 8.2 Standards Reform Strategies

### 8. Registration of sets of health care standard

It is proposed that registration of health care standards become mandatory.

The benefits of such a proposal are that:

- a. Registration would identify all health care standards that are produced with which health services will be asked to comply. The register of standards could be published as a user friendly list of current standards, with information on the year they were reviewed or due to be reviewed, and the scope the standards cover;
- b. Standards setting bodies would be required to comply with best practice in the development of standards, including consultation with consumers and service providers for standards to be registered. Standardisation of the structure, format, definitions and language used in each set of standards would be addressed. This could facilitate the mutual recognition of standards between standards setting bodies. Guidelines for best practices could be developed to assist in the implementation of and compliance with accreditation standards;
- c. The standards registering body could ensure that there is a regular program of review of standards to keep them current with service requirements and delivery models;
- d. All sets of standards developed would be required to include mandatory safety and quality domains identified by the Commission; and
- e. The registering body could ensure that clear and appropriate criteria are developed to assess the need for additional safety and quality standards that include a broad impact of the standard. This could include a process of review of options for restructuring standards to simplify implementation.

It is not proposed that registration of standards be an expensive or bureaucratic process. Minimum requirements for gaining registration are likely compliance with a standardised format and best practice model of standards development.

Consultation will be needed on policies and processes required to implement this change. It is anticipated that the Commission would undertake the first phase of this work, to develop these policies and processes. However a longer term strategy for the implementation, monitoring role and ongoing management of registration will need to be identified as the Commission does not have long term implementation of projects in its terms of reference.

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

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

### 9. Harmonisation of health service standards

It is proposed that the language and definitions of accreditation be standardised and that guidelines for the convergence in the format and structure of standards be developed.

The benefits of this proposal are that:

- a. One of the contributing factors to the fragmentation of the accreditation system will be reduced;
- b. Defining the elements of a set of standards, the criteria that must be met, the scale of achievement against a standard and the evidence required to assess compliance, would provide clarity about the scope of the standards and the requirements for compliance for those health services being assessed against the standards;

- c. Standardisation will support mutual recognition by standards setting bodies. To eliminate or reduce duplication and promote mutual recognition, it will be necessary to have a baseline understanding that is common to all organisations; and
- d. Standardisation provides an opportunity to maximise the use of appropriate international standards on safety and quality.

The Commission could take a lead on this work, or could coordinate independent or interested stakeholders to progress this issue.

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

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

## **10. Detailed mapping of standards**

It is proposed that a detailed process of analysis and mapping of all existing Australian health care safety and quality standards be undertaken.

The potential benefits of this proposal are that it will:

- a. Identify gaps, duplication and conflicts between sets of health safety and quality standards with a view to decreasing any unnecessary repetition, resolving conflicts and recommending the development of standards in key safety and quality areas;
- b. Identify difference in the language, format, context and structure of standards so as to focus on variation and promote potential standards harmonisation; and
- c. Test the variation that exists in compliance requirements, taking into consideration the context in which standards assess the safety and quality of health services, to enable comparisons between different sets of standards.

The Commission could take a lead on this work, or could coordinate independent or interested stakeholders to progress this issue.

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

## **11. Identification of core safety and quality areas**

It is proposed that the Commission identify core safety and quality areas that are to be reflected in all registered sets of health safety and quality standards.

The benefits of this proposal are that:

- a. Consistency in the key safety and quality items assessed in all health services;
- b. Clarity for health services and consumers, who can reasonably expect that between sectors, states / territories and health services the same core safety and quality issues have been addressed as part of accreditation against a set of registered standards; and
- c. This work is consistent with the Commission's role in establishing a national strategic framework for safety and quality. The Commission would be responsible for undertaking this work in consultation with a range of stakeholders.

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

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The following represents a long term proposal that requires substantial preliminary work before being implemented. It does, however, represent an opportunity to eliminate the duplication from multiple accreditation processes and standards compliance. It will make the most efficient use of resources such as surveyor's time and maximises the use of data collected through the accreditation process.

A Concordat is now operational in the United Kingdom to maximise return from inspections, audit review and regulation of health and social care. This work could be adapted for implementation in Australia.

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

It is proposed that the Commission 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 benefit of the proposal is that:

- d. Efficiencies can be achieved, reducing the cost and time involved in accreditation surveys by the implementation of consistent and coherent programs for survey across organisations, and reducing any unnecessary compliance burdens from multiple surveys on operational and management staff;
- e. It improves the understanding of the accreditation and standards requirements and deliverables because of national harmonisation and consistency;
- f. There is the potential to achieve efficiencies in the training of surveyors because of consistent training content and skills requirement;
- g. It provides an opportunity to more effectively utilise surveyors across settings because of complementarity of skills sets; and
- h. Communication is improved, including data sharing between organisations, understanding of the role of each of the organisations in standards and accreditation as well as coordinated planning for surveys.

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 Commission 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 Commission does not have long term implementation of projects in its Terms of Reference.

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

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