KEY ACTIONS
for health service organisations

Fact Sheet 12

Assessment Framework for Safety and Quality Systems

AHSSQA Scheme

The Australian Commission on Safety and Quality in Health Care (the Commission) is responsible under the National Health Reform Act 2011 for the formulation of standards relating to health care safety and quality matters and for formulating and coordinating the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme (the Scheme).

The Commission has undertaken a comprehensive review of the Scheme and produced a series of fact sheets to outline the changes to accreditation processes for health service organisations.

NSQHS Standards (second edition)

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Commission in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality-assurance mechanism that tests whether relevant systems are in place to ensure expected standards of safety and quality are met.

Health service organisations commenced transition to the second edition of the NSQHS Standards from January 2019.

The Commission has developed an Assessment Framework for Safety and Quality Systems (the Framework) to improve the effectiveness, rigour and consistency of assessment to the National Safety and Quality Health Service (NSQHS) Standards. It incorporates a structured assessment method (the PICMoRS Method), which can be used when interviewing members of the workforce to comprehensively review the processes that make up the safety and quality systems specified in the NSQHS Standards.

Using a standardised structured assessment method allows assessors to comprehensively evaluate each component of safety and quality systems in a health service organisation. This provides a structure for conducting assessments based on evidence of actual performance from observations, interviews and records.

This fact sheet provides an overview of the Framework and the PICMoRS Method. The Framework can be found at Figure 1.
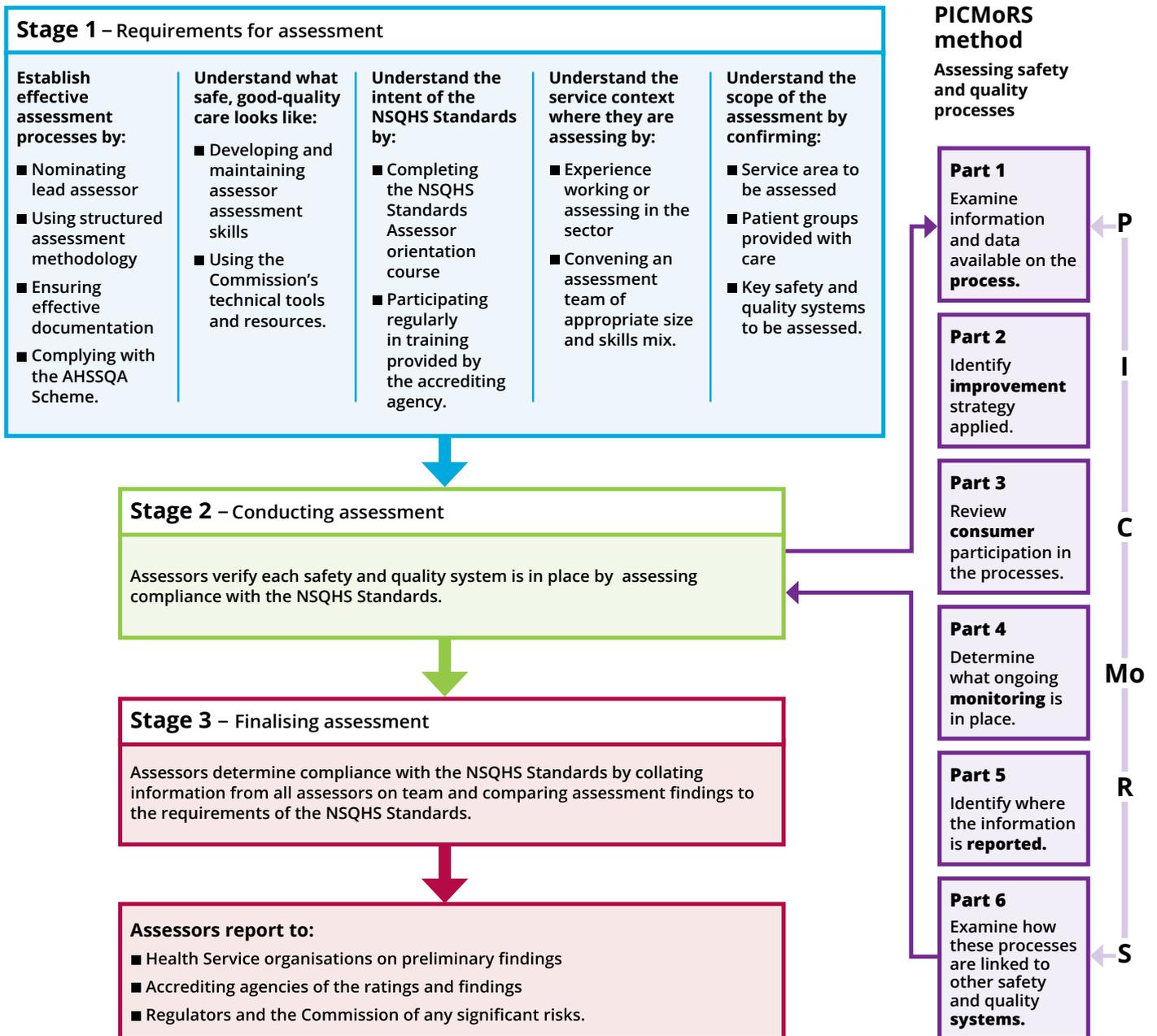
Assessment Framework for Safety and Quality Systems

The Assessment Framework for Safety and Quality Systems describes the requirements of an assessment in three stages.

AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

Figure 1: Assessment Framework for Safety and Quality Systems

Assessor roles and responsibilities

Stage 1 – Requirements for assessment

Establish effective assessment processes by:	**Understand what safe, good-quality care looks like:**	**Understand the intent of the NSQHS Standards by:**	**Understand the service context where they are assessing by:**	**Understand the scope of the assessment by confirming:**
■ Nominating lead assessor ■ Using structured assessment methodology ■ Ensuring effective documentation ■ Complying with the AHSSQA Scheme.	■ Developing and maintaining assessor assessment skills ■ Using the Commission's technical tools and resources.	■ Completing the NSQHS Standards Assessor orientation course ■ Participating regularly in training provided by the accrediting agency.	■ Experience working or assessing in the sector ■ Convening an assessment team of appropriate size and skills mix.	■ Service area to be assessed ■ Patient groups provided with care ■ Key safety and quality systems to be assessed.

Stage 2 – Conducting assessment

Assessors verify each safety and quality system is in place by assessing compliance with the NSQHS Standards.

Stage 3 – Finalising assessment

Assessors determine compliance with the NSQHS Standards by collating information from all assessors on team and comparing assessment findings to the requirements of the NSQHS Standards.

Assessors report to:
- Health Service organisations on preliminary findings
- Accrediting agencies of the ratings and findings
- Regulators and the Commission of any significant risks.

PICMoRS method
Assessing safety and quality processes

Part 1
Examine information and data available on the **process.** — **P**

Part 2
Identify **improvement** strategy applied. — **I**

Part 3
Review **consumer** participation in the processes. — **C**

Part 4
Determine what ongoing **monitoring** is in place. — **Mo**

Part 5
Identify where the information is **reported.** — **R**

Part 6
Examine how these processes are linked to other safety and quality **systems.** — **S**

Stage 1: Before an assessment

For assessors to be well prepared to undertake an assessment, accrediting agencies need to:

- Establish assessment processes that are effective. They can do this by nominating a lead assessor, providing the health service organisation with an audit schedule, training assessors to use structured assessment processes, and complying with the requirements of the AHSSQA Scheme
- Ensure assessors understand what safe, good quality care looks like. This can be achieved by training and performance managing the assessor workforce, and providing access to tools and resources developed by the Commission
- Ensure assessors understand the intent of the NSQHS Standards.
- Ensure assessors understand the service context where they are assessing.
- Ensure assessors understand the assessment scope. This would involve them identifying all of the service areas to be assessed, the patient groups involved and key safety and quality systems being assessed.

Stage 2: During an assessment

The primary purpose of the assessment is to verify that safety and quality systems are in place by reviewing compliance with the NSQHS Standards. The *PICMoRS Method* allows for a structured, standardised assessment of the multiple processes that make up each safety and quality system.

As healthcare is complex and health service organisations vary, it is not possible to predict the information or evidence that will be found during an assessment of one service area or at any one level in a health service organisation. By consistent use of the *PICMoRS Method* throughout an organisation and for different safety and quality processes within a safety and quality system, assessors will develop a comprehensive picture of the effectiveness of an organisation's safety and quality systems.

Using the *PICMoRS Method* can support assessment of any part of an organisation. PICMoRS can be applied to gathering evidence from clinicians, managers, other members of the workforce, representatives of the governing body and consumers. Who is interviewed will depend on who:

- Has overall responsibility for the process
- Is involved in implementing the process
- Is impacted by the system or process.

There are six inter-related parts to the *PICMoRS Method.* There may be situations where the assessment is not carried out sequentially. Regardless of the order, an assessor needs to investigate all six parts to fully evaluate the safety and quality process under examination.

Stage 3: After an assessment

Finalising an assessment occurs in two phases. Firstly, reports from all assessors are collected and cross-verified, with the findings compared to the requirements of the NSQHS Standards.

Secondly, assessors provide health service organisations with preliminary information about the findings of the assessment at an exit meeting, including areas that require remediation.

Assessors provide information to their accrediting agency recommending the need for a final assessment and then if accreditation should be awarded.

The PICMoRS Method

PICMoRS is a mnemonic that stands for:

P	**Process**
I	**Improvement strategies**
C	**Consumer participation**
Mo	**Monitoring**
R	**Reporting**
S	**Safety and quality systems**

All six parts to the *PICMoRS Method* must be completed to conduct a comprehensive assessment of the safety and quality processes being examined.

Part 1: Process

An assessor should first seek an explanation of the process being reviewed.

This involves identifying who in the organisation is involved in the process and where the requirements for the process are documented. Assessors can then determine who should be interviewed. This information will enable an assessor to determine if actual practice matches the practice as described in the policy and procedures.

Information about a process can be obtained by asking questions such as:

- How does this process work in your organisation?
- Is this documented? How do you access this information?
- Who is responsible for the other parts of the process?
- Where else is this process used?
- Are there places where this process is not used? Why?
- Where can you access information about this process?
- Are you confident the information is up to date and accurate?
- Can I see evidence of practice?

Collecting this information helps an assessor understand:

- The multiple elements of a process
- Who is responsible for each part of the process, therefore who else may need to be interviewed
- Where the process is being applied
- Where the process is documented
- How the workforce is kept up to date on changes to a process.

Part 2: Improvements strategies

With an understanding of the process, an assessor now needs to determine if the organisation has reviewed the effectiveness of the process and if required have they implemented any identified changes.

Where improvements have been introduced, an assessor should seek to understand the rationale for change, how the workforce was made aware of the changes, implementation strategies used and how effective the changes are.

This information could be obtained by asking questions such as:

- Has the process been reviewed?
- What were the issues that lead to the change?
- How would you get to know if there were changes?
- Who is responsible for making the changes?
- Have the changes been fully implemented?
- How did you determine if further changes are needed?

If no improvements have been implemented, the assessor should ask:

- What would prompt you to implement improvement strategies?

This information allows an assessor to understand:

- Improvements that have been made
- If planned changes are being implemented and monitored.

Where no improvements have been made, assessors can determine if the process is effective and monitoring is in place to ensure it is still fit for purpose or if the organisation is not aware of the process or need for change.

Part 3: Consumer participation

Assessors examining the NSQHS Standards evaluate consumer participation in safety and quality systems and processes, including their own care.

The form consumer participation takes will vary depending on the safety and quality process being evaluated. The safety and quality systems that relate to the Clinical Governance Standard will involve engaging with consumers in the design, monitoring and evaluation of services within a program, department or the organisation. Being a consumer partner could mean being a full member of a quality improvement and redesign team, or providing input through focus groups, feedback mechanisms, surveys or social media.

Information on consumer partnerships could be obtained by asking the workforce questions such as:

- How were consumers involved in designing, improving or evaluating the process?
- How do you provide consumers with feedback on this process?

Consumers may also be involved through the processes of care. In this case information could be obtained by asking the workforce or consumers questions such as:

- How do you engage consumers in their own care? How is this documented?
- Do you collect feedback from consumers on this process? How?

Part 4: Monitoring

Assessors need to examine the extent and type of monitoring a health service organisation conducts on its safety and quality processes and consider how this information is used to plan, deliver and improve patient care.

Effective monitoring enables health service organisations to understand day to day practice, evaluate the effectiveness of existing safety and quality processes and respond to deviations from expected outcomes. It requires the collection and analysis of data to:

- Identify areas of under and high-performance
- Prioritise areas for improvement
- Measure changes over time
- Evaluate the effectiveness of changes that are introduced.

Information for monitoring can be collected from:

- Routine data sets (sometimes called administrative data)
- Patients, carers and families (for example, patient experience surveys)
- Clinicians and managers (using their reporting and surveillance mechanisms)
- National, jurisdictional or local data sets (such as the national hand hygiene audit data or National Inpatient Medication Chart Audit).

Information about monitoring can be obtained by asking questions such as:

- How is this process monitored? Where is this documented?
- Do you use national, jurisdictional or local measures to monitor this process? Why?
- How have you used data to improve the process?

Information gained from the answers to these questions allows an assessor to understand what monitoring occurs as well as the frequency, sample size, scope and currency of data collections. It also provides information about who is involved in these processes.

Part 5: Reporting

Having determined what information is collected, assessors need to determine where this information is reported. Tracking reporting provides an example of the governance reporting system at work.

Reporting on processes may occur to and from a service area, direct line managers or committees, and executives and the governing body. An assessor should confirm if information on a process is reported to the workforce, consumers, the community and/or other health services.

This information could be obtained by asking the workforce questions such as:

- Where is information on the process reported? Where is this documented?
- How often does this occur?
- Does the information go to the consumers, workforce, management or governing body?
- Do you get feedback on information that you report?

It is important to understand where information is reported because safety and quality programs and reporting should be driven by reliable, accurate and current information.

Part 6: Safety and quality Systems

Safety and quality systems are most effective when they are integrated and inform each other. For example, processes (such as collecting outcomes data, distributing reports and developing recommendations) from a risk management system should inform policy and training systems, and the incident management system should inform the risk management system.

Information about the integration of safety and quality systems could be obtained by asking the workforce questions such as:

- Is the information from this process used to change other processes, such as risk management, policy development, training and quality improvement?
- Does the information from any other system influence how you use or change this process?
- Where is this documented?

Information on the connectedness of systems can be used to understand how effectively an organisation uses their learnings about safety and quality to improve care and improve the effectiveness of its safety and quality processes.

Questions?

For more information, please visit: **safetyandquality.gov.au/standards/nsqhs-standards**

You can also email the NSQHS Standards Advice Centre at **accreditation@safetyandquality.gov.au** or call 1800 304 056.