



australian
nursing federation

National Quality and Safety Accreditation
Standards Review Submission
to The Australian Commission for Safety and
Quality in Health Care

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The Australian Nursing Federation (ANF) was established in 1924. The ANF is the national union for nurses and midwives with branches in each State and Territory of Australia. The ANF is also the largest professional organisation for nurses and midwives in Australia, with a membership of over 150,000 employed in a wide range of enterprises in urban, rural and remote locations in both the public and private sectors. The ANF's core business is the industrial and professional representation of nurses and midwives.

The ANF participates in the development of policy, regulation, health, community services, veteran's affairs, education and training, occupational health and safety, industrial relations, immigration and law reform.

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Introduction

The ANF welcomes the opportunity to comment on the *National Safety and Quality Accreditation Standards: Discussion Paper*.

The ANF generally supports the reform agenda outlined in the Paper and has provided comment against the specific issues identified for comment.

We would be pleased to assist the Commission in any further work as the reform agenda begins to roll out. Nurses and midwives are central stakeholders in much of the activity that are the focus of the standards and accreditation processes in the health system, as well as being critical contributors to the development and review of standards, surveys and other processes that constitute accreditation systems.

In the paper you will note that we refer to the health and aged care systems. This is quite deliberate and has been done for several reasons:

1. The two systems are part of a continuum of care for our community and the community does not necessarily recognise the boundaries of the two systems.
2. The residential aged care system has largely implemented many of the reforms identified in this paper as being critical to the area of safety and quality of care provision in that sector.
3. High level care in the aged care sector is very similar to the care provided in many areas of the health system; consequently there are some natural synergies that should be capitalised on.

Issue – Accreditation

1. *Effectiveness in identifying poor performance*

1.1 **What core processes or systems need to be in place to ensure poor performance is detected?**

Three key areas have been identified as being critical to ongoing vigilance in quality and safety of health care and described in the *Clinicians Toolkit* as:

- *Developing the knowledge and skills for:*
 - *understanding human performance,*
 - *understanding the systems of care, and*
 - *minimising and dealing with error.*
- *The application of methods to identify, measure and analyse problems with care delivery.*
- *Action being taken on information to improve both the individual and systemic aspects of care delivery* (NSW Department of Health 2001).

The ANF considers that if investment is made in these three pivotal areas then consumers, individual clinicians and health service organisations will be in a strong position to detect and manage the risks that might arise should there be isolated events or a pattern of performance that leads to adverse events or other risks to consumers or staff.

From the body of evidence that is arising from the analysis of critical incidents, adverse events and 'near misses' there is overwhelming substantiation that factors such as the relationships between and communication within clinical teams and other seemingly commonplace factors are critical to the performance of the individual and the team. While intrinsically 'common sense', the barriers to improvement in these areas remain profound and the investment is largely made in technology and areas where marginal gains can only be achieved if such vital pieces of the jigsaw are not attended.

Many nurses and midwives work in dysfunctional teams and constantly report their frustration at their inability to be heard and respected as valued members of the clinical team. The perpetuation of the traditional hierarchy of the health system has precluded the key evolution in development (step 1), thus minimising the benefits from the obvious investment and endeavour that has been made in application and action (steps 2 and 3).

1.2 Is this necessarily part of an accreditation process?

Accreditation provides a unique opportunity to identify an organisation's progress in ensuring that these three components are in place and evolving. Therefore the ANF is of the view that it should be a primary objective of accreditation to determine that these crucial areas are being addressed.

Certainly the most recent edition of the EQUIP Standards issued by the Australian Council on Health Care Standards (ACHS) has an obvious nexus with these requirements and if they are reviewed during the course of the Accreditation process, should reveal the level of the organisational maturity in each of these areas.

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

The reputation of accreditation processes are put at risk if there is no relationship between what is reported as a significant systems failure and the accreditation body.

For many organisations the system of accreditation that they invest in provides a framework for ensuring they have the critical governance systems in place to provide the structures and processes required to deliver safe, quality outcomes for people. Many organisations use the accreditation framework as their safety and quality blueprint.

Certainly the systems for identifying, reviewing and managing systems failures in health organisations should be part of a routine accreditation survey system. However, if there is no response from the accreditation organisation when an event or series of events occur that create significant concern within the accredited organisation or community, then the value of the accreditation process is questioned and brought into disrepute by the community and clinicians and other workers in the organisation.

The appropriate response by the accreditation organisation should be a routine and well understood process so that it is a 'normal' part of a response to an alleged serious health system failure.

A routine obligation to inform the accreditation organisation of the issue incorporating the organisations response should be a primary requirement. The accreditation organisation should then have an ongoing procedural response that is well known and can be anticipated by the accredited organisation. The introduction of unannounced visits as part of the survey process may provide a platform for this to occur. Using the lessons of the quality improvement movement, the accreditation organisation should ensure that the system failure is dealt with as 'an opportunity for improvement' and approach its response as such. An actual response is imperative.

The liability of the accreditation organisation in relation to not identifying long standing systemic risks and failures is a serious legal issue that needs to be debated and resolved.

2. Transparency

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

The ANF supports much greater transparency in all the activities around safety and quality improvement initiatives in the health and aged care systems, with accreditation being one mechanism in a suite of tools used to test the robustness of those systems in an organisation.

The involvement of consumers, the organisation's constituent community and key health clinicians and other workers in all aspects of an organisation's planning, policy development, monitoring, review and evaluation activities is a fundamental step in reducing the perception of and the potential for an organisation to be secretive and obfuscating in response to concerns in relation to the quality and safety of the services it provides.

Policies such as 'open disclosure' and comprehensive public reporting are crucial to rebutting concerns about the responsiveness to risk and appropriate and ethical conduct of an organisation's business.

The health and aged care systems have been naturally nervous about the challenges of public reporting and active engagement with consumers as there have been some spectacular examples of the destructive and demoralising effects of media exposés. However, the ANF takes the view that trust comes with the provision of routine information and an engagement of all the key parties, including the community. Media 'feeding frenzies' are the result of opacity and secrecy which provide fertile ground for conspiracy theories to develop.

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

The provision of information about the accreditation status of residential aged care facilities that is now freely available to the community and other interested parties has proved to be a positive outcome of the reforms in aged care in Australia since 1997. While initially causing a flurry of criticism and concern that it would undermine the public's trust in the industry, it has proved to be a very positive initiative from a number of perspectives:

For consumers and their families: it gives them more realistic and independent information on the strengths and weaknesses of an organisation they may be considering for their own or a family member's care, or which they support within their own community.

For organisations providing care: it gives them an important added incentive to ensure that any recommendations are addressed expeditiously as well as having an opportunity to market their service on their commendations. A threat to funding is the ultimate incentive in ensuring that improvements are made without delay. However, threat to reputation as a safe, quality provider of care is also a powerful driver of improvement.

For professionals and workers employed by the organisation: they have often been attempting to remedy safety and quality issues from within the organisation with minimal or no success. When these are identified during the accreditation process and publicly reported upon, their concerns can be validated and addressed to the benefit of all. It can be an act of faith for staff and an important part of the quality monitoring and review cycle.

Therefore the ANF supports full and frank disclosure in real time, of the findings, recommendations (and timeline for achievement), commendations and current status in relation to accreditation. It is also important for the community and other interested parties to have access to the standards and information about the accreditation processes so they can understand the scope of the system, what it is capable of achieving and its limitations.

3. Governance

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

There are innate tensions in relation to a single organisation being the standards development and review body; surveyor selectors and trainers; as well as the body that certifies against the standards. The potential for a conflict of interest to arise is very real. However, the benefit of complex and multiple roles is the potential, in the long term, for the reduced likelihood of disengagement of some parts of the system.

Organisations with responsibilities in this area, whether in one or all capacities, cannot be vulnerable to the influences of current political exigencies (local or broader). They must have robust accountability frameworks that ensure that they conduct their business in a way that meets all the requirements of effective and efficient governance. The ANF supports a governance framework that is based upon the following principles:

- **Accountability:** organisations with any or all of the responsibilities of standards development and certification against such standards should be accountable to the community for their decisions and operations by submitting themselves to appropriate scrutiny.
- **Transparency and openness:** the decision-making processes of these organisations should be open, clear and understandable and have the confidence of consumers, health professionals and other workers, employers, policy makers and government.
- **Integrity:** involves straightforward dealing based on honesty, objectivity and high standards of propriety and probity in the conduct of the organisation's functions and in the exercise of their powers.
- **Stewardship:** board members and other officials, staff and members of these organisations must exercise their powers on behalf of the community. The resources they have are held in trust and most are not-for profit or not privately owned; hence they are stewards of these resources and have the concomitant obligations that go with that privilege.
- **Leadership:** the functions and powers of standard setting and certification organizations, invest them with influence and authority within the health and aged care systems, which brings responsibility to provide conscientious leadership across these sectors for the primary purpose of protecting the public while at the same time showing fairness and consistency.
- **Efficiency:** the resources expended and the administrative burden imposed by accreditation on the health and aged care systems should be justified in terms of the benefits to the community with a commitment to evidence-based strategies for improvement.
- **Effectiveness:** the accreditation system has a role in protecting the public from harm and supporting and fostering equity of access and the provision of safe, high quality care.

- **Fairness:** accreditation agencies should maintain an acceptable balance between protecting the rights and interests of health consumers and those of the employers, employees in the systems.
- **Flexibility:** the accreditation system should be able to respond to emerging issues in a timely manner as the health and aged care systems evolve and change.
- **Consistency:** as far as possible, there should be consistency across Australian states and territories in the accreditation processes for health and aged care services (Australian National Audit Office. 2003: p.8; Victorian Government Department of Human Services. 2003: p.10).
- **Consumer participation:** consumers should have an active role in the governance and operations of organisations offering comprehensive or selective accreditation services in health and aged care.
- **Regulatory controls:** should give a level of community protection where this is indicated in requiring compliance in critical areas of safety and quality.

While there needs to be a traditional 'separation of powers' approach to ensuring clean hands and minimal opportunity for conflicts of interest in each aspect of the business: the benefits of the coordination of the processes that make up accreditation systems; the benchmarking benefits; and the development and review of standards, suggest that with appropriate firewalls in place, accreditation organisations can provide the range of services that organisations such as ACHS currently provide.

4. Duplication and overlap

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

It is essential that the current multiple layers of accreditation and duplicate systems are rationalised. In the health system there is currently a largely voluntary 'cherry picking' process to select an accreditation system and provider that is pragmatic but not always based on sound governance principles or a strong ethical foundation.

While accreditation has essentially become mandatory across the health and aged care systems, there remains a sense of 'choice' for providers, at least in the health system, to select the accreditation system of their choice. The fact that the sets of standards and the accreditation systems are not consistent nor cover the same aspects, or indeed all aspects of the areas of service delivery that go to providing a safe, quality service provision system adds to the difficulty of the claim of accreditation or certification having any meaning to the community, governments or health professionals and workers.

This is particularly apparent for facilities that cover a range of services. For example, an aged care service provider who also provides community services and is considering providing rehabilitation, step-down or respite care may be required to undergo accreditation for each aspect of their service. They may also wish to pursue ISO 9000 accreditation. The result is extensive duplication and inefficient use of scarce resources.

An evaluation of the *raison d'être* for accreditation and the scope and capacity of the current systems of accreditation to meet the requirements for assuring a safe system that is designed to produce quality outcomes should enable some common sense to prevail. What has developed is an aggressive competitive market attempting to meet the multiple priorities of health and aged service providers, such as:

- a robust framework for reviewing the safety and quality systems and outcomes of the organisation,
- community and other market reputation,
- financial affordability,
- maximisation of funding opportunities,
- minimal intrusion and impact upon the day to day service provision, and
- credibility.

The ANF recognises that many of the initiatives suggested in the proposed accreditation model go to enabling comparability, consistency, and where necessary mutual recognition of like standards and certification processes which are important components if a national framework for accreditation.

5. Resource Requirements

5.1 How can accreditation be made more cost efficient and effective?

The accreditation systems in the health and aged care sectors have, over many years, evolved to provide a framework for quality improvement, which was the sole driver for accreditation. Gradually standards and the survey process have been developed to ensure some robustness and a more holistic approach. The challenge has been in ensuring that the standards and third party review against these is applicable to the extraordinary range of different services across these systems. The level of risk posed by the service should be the key to the scope and complexity of the survey requirements and process. One size does not have to fit all.

It is interesting how investment in quality and safety monitoring and review systems is seen as an 'add on' extra cost in a budget that excites ongoing interest and ever zealous attempts to reduce it. Yet audit, accounting and other financial governance strategies are embedded into an organisation's budget in such a way that it is an intrinsic, scarcely commented on routine expense.

While efficiency and effectiveness of the safety and quality monitoring and review systems should be evaluated, there is a need to ensure that they are embedded into the governance systems of the organisation in an equally unremarkable way as are the financial management systems. As with financial management systems, that means there should be an ongoing quest to improve the efficiency and effectiveness of these systems. There may be a need for regulatory requirements to assist in this embedding process.

6. Surveyors

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

Intra and inter-rater reliability has been a constant challenge for accreditation organisations and those health and aged care organisations being accredited. Ensuring consistency requires not one but a range of solutions such as:

- credible, well educated surveyors with contemporary knowledge about, and practice within the health and/or aged care systems;
- comprehensive and well understood standards and criteria for measuring performance against those standards;
- systems to support consistent decision making eg. electronic decision support and reporting systems;

- expert coaching, coordination and support for the surveyors and teams during surveys;
- comprehensive orientation and ongoing professional development for surveyors;
- fora and mechanisms for testing and analysing the consistency of decision making before, during the course of, and after a survey; as well as in hypothetical situations;
- active performance management of surveyors involving feedback from co-surveyors, organisations undergoing accreditation and other relevant parties;
- merit based selection of surveyors using robust recruitment and selection processes; and
- active steps to reduce the capacity for surveyors to become part of a 'club' of surveyors by having a quantum of surveyors with a constant changeover of persons in the role and a mixing of teams of surveyors.

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

The ANF proposes that an accreditation surveyor secondment model would ensure a steady supply of appropriate, credible and competent surveyors. This model would tie provision of surveyors to the organisations accreditation requirements. The pro bono scheme that has operated in the legal system for many years could be one model for this scheme.

For example, an organisation such as a health service has an obligation to ensure that they enable senior staff (clinicians, managers, engineers etc) to be available to the accreditation organisation for a proportion of their annual working year eg. two weeks or 10 days. This could be a term within employment contracts for clinical and operational leadership positions and other senior positions on recruitment and would enable a larger pool of surveyors to be available for the accreditation process.

Benefits of a system like this could be:

- The investment by organisations would be more even across the health system, with smaller organisations requiring less accreditation services having to provide less surveyor resources and larger organisations having a higher obligation to supply surveyor resources.
- There would be a shared responsibility for provision of competent surveyors.
- All organisations would have an inside understanding of the accreditation process ie. are inside the process offering a constructive critique rather than being destructively critical from outside the process.
- The costs to the system would be more evenly distributed and the actual up front costs of accreditation could be minimised with the surveyors salaries being paid by participating organisations. The only surveyor costs would be for the travel, accommodation and meals, and possibly the costs of a paid coordinator from a smaller pool who is expert in that role and paid by the accreditation agency.
- Potentially the orientation and ongoing professional development of surveyors could be conducted regionally drawing from all the regional participants in the accreditation scheme.
- Should a staff member not be able to meet their survey obligations there may be a means to set a system like the carbon credit system in the global environmental movement where effective and fair trade-offs for that person's time can be made.

- There would be a larger pool to provide an even spread of competent personnel with contemporary experience in the health system available for the survey process without having to rely on over-using a smaller pool of personnel.
- Facilitation of a higher level of understanding of the accreditation process across all organisations.

7. Information to support accreditation

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

First there must be agreement on the purpose for collecting and using such data across the system.

There then needs to be investment in the development of a valid and reliable data set that has universal application across the health and aged care systems that can provide meaningful data that can in turn be transformed into useful information about the benchmarks for performance of health and aged care services across Australia.

There also needs to be a regulatory or contractual mechanism to enable the use of the data across the system and there needs to be careful attention paid to any privacy issues in relation to the data. This process should be mandatory to ensure that all health and aged care services are included in the aggregated data.

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

This issue has been dealt with to some extent in Section 2.2 of this submission. However in addition to those comments, there probably needs to be Government commitment and regulation to require this information to be available, at least in the first instance, with the emphasis being upon benchmarking for safety and quality improvement purposes.

Issue - Standards

8. Proliferation of standards

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

Given the proliferation of different organisations with a role in standards development, there needs to be a Council of Australian Governments (COAG) driven initiative to steer efforts in order to coordinate and harmonise standards.

The model of the national push for the regulation of health professionals and the accreditation of educational preparation of these professionals is a useful one to consider. Needless to say, there are many models for harmonisation but a key ingredient is high level sponsorship and leadership.

Some of the more cogent work in this area has been distilled by Opeskin (1999) in his paper on models of harmonisation of law. Although the specific focus of his paper was on the harmonisation of public health law, it has strong resonance for the attaining a more uniform and rational approach to this vital area of safety and quality in the health system, the development of consistent standards and accreditation processes. The table below is very skeletal summary of Opeskin's meta-analysis of the literature and law on harmonisation across jurisdictions.

Table 1 - Opeskin's models of harmonisation of law in a federal system¹ (Opeskin BR 1999)

MODELS OF HARMONISATION	BRIEF DESCRIPTION	EXAMPLES
UNILATERAL APPROACHES		
1. Unilateral Federal action	Use of centralised power	
i. Federal legislation	Australian <i>Constitution</i> specifically assigns certain powers to the federal legislature, particularly Section 51 eg the corporations power, the communications power, the external affairs power, the trade & commerce power.	Used in the <i>Dams</i> case to prevent the damming of the Franklin River
ii. Fiscal coercion	Although the states have a level of independence in other areas of government they are increasingly dependent upon the Federal Government for financial support. The introduction of GST has further curtailed that fiscal independence. Under Section 96 of the Constitution the Federal Government has the power to grant financial assistance to the States on terms & conditions it deems appropriate. Three types of grants have traditionally been made with the latter of the 3 relevant for the purposes of harmonisation: <ul style="list-style-type: none"> • Special assistance grants - one off grants for immediate relief • General revenue grants – Provided to States by the Federal Government as part of their general budget to compensate the States for the taxes that are collected centrally such as income tax & GST- usually these grants are untied & can be used for any purpose. • Specific purpose grants – Federal government gives financial assistance to states on condition that it is used for specific purposes eg health, or that the states implement specific policies. This category of grants has potential for driving reform in many areas of administration, not least of which is the regulation of health professionals. 	The Australian Health Care Agreements often have very specific areas of reforms required by the Federal Government for the States to receive their full revenue allocation – quality & safety initiatives have been a feature of recent Agreements and the development of standards could be part of the next.
2. Unilateral State action	Borrowing of legislative arrangements from other jurisdictions as models for developing new legislation or improving existing legislation. This is not an interactive process but where one jurisdiction ' <i>observes, interprets & copies</i> ' the legislative model or another. This tends to lead to ' <i>common behaviour without identical outcomes</i> '.	Many of the current health professional statutory regulatory frameworks reflect their borrowings from other jurisdictions.

¹ This has been adapted from the National Nursing and Nursing Education Taskforce and A. Adrian (2006g) *Toward consistent regulation of nursing and midwifery in Australia: a select analysis of the legislation and professional regulation of nursing and midwifery in Australia. Final Report* 22 August 2006. http://www.nnet.gov.au/downloads/rec4_mapping_report.pdf.

MODELS OF HARMONISATION	BRIEF DESCRIPTION	EXAMPLES
MULTILATERAL APPROACHES – based upon inter-governmental cooperation		
3. Reciprocal schemes	<p>A low level form of harmonisation that permits variations in the laws of participating jurisdictions while enabling one jurisdiction to recognise, on a reciprocal basis, a status conferred by another jurisdiction.</p> <p>The difference between this process & unification is: unification is about the definition of uniform standards; schemes like the mutual recognition scheme are about recognising possibly divergent standards.</p>	Mutual recognition schemes.
4. Mirror legislation	<p>Ministerial agreement on a detailed draft piece of legislation, which is then enacted by separate legislation in each jurisdiction.</p> <p>This produces virtual uniformity in the beginning, but this diminishes over time as local legislators respond to home based political pressures & issues, & introduce amendments that are not extrapolated in the same legislation in the other jurisdictions.</p>	Hire purchase from the 1950s & 1960s and company law schemes.
5. Application of laws	<p>Enactment of legislation in one jurisdiction (the host jurisdiction), & the application of that law in other participating jurisdictions. The host legislation contains all the substantive provisions that are to be enacted with the precise terms being agreed to by the relevant Ministerial Council prior to enactment by the host.</p> <p>Each participating jurisdiction then passes legislation giving the host legislation the force of law within that jurisdiction. Later amendments then require legislative change in only the host jurisdiction.</p>	Australian & New Zealand food standards.
6. Agreed policies: separately drafted laws	<p>Ministerial Councils agree to detailed policies rather than specific legislation. These policies must then be implemented by appropriate legislation in each State.</p> <p>This method is less prescriptive than other methods of cooperative harmonisation as each jurisdiction has some flexibility in deciding the precise manner in which the agreed policies are implemented. The more detailed the agreed policies, the greater the degree of harmonisation but the less autonomy of the States in drafting their own legislation.</p>	The introduction of 'uniform' gun laws introduced following the Port Arthur massacre.
7. Complementary schemes	Used when no jurisdiction can achieve a desired objective alone. Complementary legislation must be enacted cooperatively in several jurisdictions if the intended aim is to be achieved.	Therapeutic goods – where the Federal constitutional power does not extend to regulating unincorporated bodies engaged in purely interstate trade. State

MODELS OF HARMONISATION	BRIEF DESCRIPTION	EXAMPLES
		legislation was required to fill in the gaps.
8. Joint Federal-State bodies	The establishment of a permanent Federal-State body with the responsibility of joint administration in a specific area. Usually, the body is established by federal legislation & given specified powers by other participating governments.	Murray River Commission.
9. Reference of power to the Commonwealth	<p>Section 51 (xxxii) of the <i>Constitution</i> provides a mechanism by which State & Federal governments may cooperate to solve problems that arise because of the limitations of the federal legislative power. This can occur in 2 ways: a State can refer power to the Commonwealth for the Commonwealth to cover the field; or a State can later adopt a Commonwealth law that has been made after the reference of power from another State. A reference of power is limited to the subject matter and duration of the reference.</p> <p>A matter referred to the Commonwealth by a State:</p> <ul style="list-style-type: none"> • can be in either specific or general terms. If made on general terms, then the Commonwealth has discretion in relation to the legislation it passes in response to the reference • the legislative power over the referred matter is not exclusive to the Federal Parliament – the power can be exercised concurrently • may be made for a limited period • may be conditional eg on the occurrence of a particular event or dependent upon other States making a similar reference of power. 	Aged care services including the establishment of the Aged Care Standards and Accreditation Agency and the standards that have been developed for that purpose.

A number of these models may have some application in achieving the changes required to achieve the reforms envisaged by the Australian Commission for Safety and Quality in Health Care in relation to both the development of standards and as well as the rationalisation of accreditation processes.

9. Access to standards

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

While it can be argued that the standards are valuable intellectual property that give a commercial organisation the right to using a commercial-in-confidence approach to safeguarding that property, the ANF takes the view that the standards that are being discussed here are generally so fundamental to ensuring the integrity of the safety and quality and governance systems of the health and aged care systems that there should be total transparency in relation to the standards, as is the current situation in relation to the Aged Care Standards.

Therefore the standards should be broadly promulgated and understood across the health and aged care systems, local and national health and aged care policy across the board, even linked to funding. To achieve this it would seem necessary that these standards are at least sponsored by Government(s).

How the standards are packaged and disseminated via education and training and information systems may be areas where commercial benefits may be open to commercial enterprises.

10. Process of developing standards

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

This has largely been addressed in the two previous sections. Participation by stakeholders is critical and investment in research for the purposes of prioritisation and validation is also important.

The multiple areas where standards are developed; the technical and clinical standards versus the health service evaluation standards require some careful unpicking, mapping and classification for this work to be cogent. There is great utility in capturing the endeavours of many in the past as well as having a nationally agreed process for the development, adoption and review of standards that minimises duplication of effort and resources.

The ANF argues that consumer and clinician involvement in the process is imperative and some of the work of the National Health and Medical Research Council (NHMRC) in relation to such subjects as the conduct of research involving humans may be useful in developing a model for this development. Also, the existing organisations involved in the setting of standards eg. ACHS and Standards Australia have been improving their methodologies and must be key players in the decision making in this area.

11. Appropriateness of standards

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

As discussed above, one size does not fit all of the hugely diverse services across the health and aged care systems. Clearly significant effort does need to be invested in developing a flexible system of determining and selecting relevant standards to review the service against that are appropriate to the risk level posed by the service. This has been accommodated in the past by the creation of yet another organisation developing a set of specific standards for a specific sector of the health system, be it laboratories within health services or whole health services such as community health services or the primary care services provided by general practitioners.

Involvement of key stakeholders (always including consumers) is critical in ensuring that the suite of standards used in an accreditation process are designed to achieve the outcome required in relation to evaluating the systems that minimise risk and improve the safety and quality of services.

Accreditation Reform Strategies

Many of the initiatives discussed above in relation to the reform strategies required around the accessibility and harmonisation of standards also apply to the reform of accreditation, such as the strategies requiring high level sponsorship and leadership; the involvement of consumers, clinicians and other stakeholders; the need to minimise duplication by introducing strategies for harmonisation and mutual recognition, and so will only be briefly noted below.

12. Register of accrediting bodies

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

For this to occur, it is necessary to debate the purpose(s) of registration and the model of registration that is necessary to achieve those goals. The models can range from a simple recording of accreditation organisations by a registration agency, such as the Department of Fair Trading in NSW system of registration of business name. This system would require minimal details in relation to the scope of their accreditation system and subsidiary processes, and the standards they use to accredit against.

The other end of the spectrum is the establishment of a statutory body with powers to scrutinise and test the governance infrastructure and operational integrity of organisations in order to register them as accreditation organisations.

This can include setting requirements for the accreditation process, possibly even being the sponsor and driver of the standards development and review for accreditation purposes.

Clearly this is an aspect of the brokering of the proposed accreditation model that will have to involve agreement by AHMAC and health ministers and ultimately may need to be led by COAG.

Consideration should be given to using an existing body such as the Joint Accreditation System of Australia and New Zealand (JAS-ANZ), which takes responsibility for overseeing accreditation bodies including their processes for decision-making, review, complaints and appeals. The advantages of JAS-ANZ is that it is a well established, government appointed accreditation licensing body with a strong reputation for a quality framework.

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

This will depend on the model of registration that is agreed. The first model may lend itself to vesting the registration role in a census, data management, research organisation such as Australian Institute of Health and Welfare (AIHW). Alternatively, if a more complex registration system is agreed to, there may be a need to establish an agency with the specific purpose of leading the accreditation and standards management activities across the health system such as the Aged Care Standards and Accreditation Agency. The evolution in the role and functions of an existing organisation such as ACHS may be a means of achieving this with the latter model.

13. Standardise accreditation language and definitions

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

See comments in Sections 8.1 and 10.1 relating to the standards.

14. Training and competency testing of surveyors

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

See commentary in Sections 6.1 and 6.2.

The ANF suggests that some of the skills, competencies and attributes required by surveyors include (this list is by no means exhaustive):

- Skills, knowledge and experience in audit, service evaluation, systems review, safety and quality methods that identify, measure and analyse problems with care delivery.
- An understanding of the policy and funding infrastructures of the health and/or aged care systems.
- In depth understanding of the intent and meaning of the standards and criteria against which they will be surveying an organisation's compliance.
- Fairness and consistency in reviewing services and systems that may not have the same characteristics as those they are familiar with.
- In depth understanding of the structures, processes and reasonable outcomes for at least several areas of: clinical treatment and care, management, risk management, environmental services, governance and/or the other areas central to review in the course of an accreditation survey.
- Proficient interpersonal skills that enable interaction with a wide range of people during a survey.
- A strong ethical foundation.

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

See comments in Section 6.1.

A comprehensive educational program delivered by an expert provider is required with the following features:

- in depth orientation covering the standards and all aspects of accreditation and associated processes;
- ongoing professional development in all areas of the surveyor competencies, accreditation and standards development;
- identification of areas for special support and coaching related to gaps and the outcomes of the performance management system for providers; and
- competent educators and coaches.

15. Better use of data for evaluation of health service performance

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

In all health services there are a multiplicity of data sets and information systems that are used for many aspects of the health and/or aged care service's business. Currently surveyors have to be capable of being able to interrogate and interpret information from these diverse sources to be able to obtain the information they require for the purposes of reviewing the organisation's conformity to with the standards. The work being undertaken by National e-Health Transition Authority (NeHTA) and others in attempting to define a consistent and universal system should also ensure that the data set allows for comprehensive evaluation of health services as a priority.

16. System wide accreditation against safety and quality standards

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

The ANF is of the view that any health service that provides care and has the potential to place the consumers of that service at risk of harm should have mandatory accreditation or certification requirements.

Currently, there is a gap in this area for a number of private health services that are not part of the regulation of private hospitals and day procedure centres or accreditation systems for general practices etc. More and more complex and high risk procedures are being undertaken in cosmetic surgery and laser clinics, endoscopy procedure rooms, acupuncture centres, as well as imaging centres, all of which have no formalised accreditation requirements.

The ANF would strongly support a requirement for the mandatory accreditation of oral health and dental services which to date, have largely been outside the accreditation system although a number of the larger dental services have sought accreditation status.

Many mechanisms have been used as incentives for organisations to participate in accreditation eg. CEO contractual requirements, regulation, conditions for funding etc. These may have application in these situations also.

There are certainly relevant standards and models of accreditation that could be adapted without great difficulty to accommodate those services currently not part of an accreditation system.

Protection of the community from risk should be the driver of the broadening of the requirement for accreditation – the development of criteria, such as those established by AHMAC, in relation to identifying which health professionals should be regulated by government would be a useful means of establishing where the bar should rest.

17. Introduction of unannounced surveys

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

As with a number of other areas discussed above there may need to be high level agreement and action, perhaps regulatory in nature to impose this requirement. The Australian Government has introduced it in relation to residential aged care facilities and it is now an accepted part of the accreditation process.

As mentioned above, unannounced visits enable the oft heard criticism of the accreditation process in relation to 'window dressing' for accreditation to be rebutted. Nurses and midwives have often reported that the staffing levels are manipulated and investments are made for the short term gain only so that the organisation can meet the requirements of the standards. Whether this is folk lore or real, the unannounced survey is one way to see an organisation without the heightened awareness, expectations and extraordinary efforts that formal accreditation surveys undoubtedly generate in order to show off the organisation to its best advantage.

As long as organisations have the 'right to reply', so they can provide information on eg. extraordinary events or situations that may have been encountered on the day, then unannounced surveys may not be the threat that they have been perceived to be.

To minimise the disruption to the organisation when an unannounced visit occurs, the organisation should develop a plan to ensure they are able to respond in the most practical way and ensure the information and personnel are available for the surveyors visiting without extensively disrupting the day-to-day services of the organisation. The accreditation agency can assist in this process by clearly outlining their expectations for unannounced surveys and assisting the organisations to plan for these.

18. Introduction of Tracer Methodology in external accreditation reviews

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

Clearly consumer organisations need to be actively involved in developing an appropriate model for accreditation in Australia. This is an area where research is being conducted overseas which can be used as a foundation; however a culturally specific model does need to be tailored to the Australian health system with appropriate piloting to ensure its suitability and relevance.

The ANF supports the introduction of the tracer methodology for gaining an assessment of consumer experiences in a health service for the purposes of testing compliance with the standards.

The experiences of the consumer (and their nearest and dearest) are critical outcomes that have not been traditionally measured as part of accreditation. Consumer satisfaction methodologies have been around for many years, yet these have not always been useful in enabling a clear picture of consumers' expectations and needs being matched with their real experiences of the care and services provided by the health service. The tracer methodology if introduced in a meaningful and valid way is potentially a powerful tool for tracking this important outcome data.

Standards Reform Strategies

As with the accreditation reform strategies, many of the comments made above are relevant to this section and will not necessarily be repeated.

19. Registration of sets of health care standards

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

The ANF supports the central registration of health care standards to identify and track organisations that are accrediting health services.

For consumers, policy makers and health and aged care providers, a single site where key information can be accessed such as: the accreditation processes; health providers' accreditation status; useful information on accreditation outcomes; links to relevant accrediting bodies; and easy public access to the standards and the scope of these standards which they accredit against, would assist in many areas of decision making and planning. The benefits of identifying trends in safety and quality and target accreditation assessments as well as monitoring the up-take, adequacy and evolution of accreditation nationally and against international trends are compelling.

As mooted above high level leadership such as at the COAG level and possibly the leverage of regulation is needed to ensure that the broad range of health and aged care services are

brought into the frame with a more consistent and rational approach to the development of standards and the review against these which is accreditation.

Clearly consultation and attempts to broker agreement across the stakeholders is warranted, though this may be very difficult to achieve given the variety of interests. 'Community interest' must be the primary driver for the strategies.

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

This will very much depend upon the model of registration that is agreed upon - see comments in Section 12.2.

20. *Harmonisation of health service standards*

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

The ANF strongly supports the standardisation of language and definitions. However, we also recognise that the barriers to achieving this are considerable. Understanding the endeavor and substantial resources that have been invested over many years to achieve the current multiple sets of standards, each with its own unique language and definitions suggests that the negotiation to achieve this standardisation will be very challenging.

Once again high level leadership and incentives will be required to achieve this preliminary step in the schema of strategies that make up the reforms outlined by the Commission.

20.2 Who needs to be involved in this standardisation process?

Clearly the key stakeholders as discussed above need to be involved, including: consumers; health service providers; health professionals; other health workers and managers; current developers of standards; accreditation organisations; other agencies that have a remit and/or expertise in this area of language and classification such as NeHTA, health information management specialists, plain English specialists etc.

21. *Detailed mapping of standards*

21.1 Who needs to be involved in this mapping process?

The standards that are in existence are the contemporary 'evidence base' for the development of new standards and should be respected. The ANF supports the mapping initiative that should assist in the standardisation of language, definitions and also of purpose (ie. what is the purpose of the standard intended to be the measurable benchmark).

Obviously those who are intimately familiar with the current standards, their objectives, audiences and assessment mechanisms are important informers to this process. There is also other expertise and skills required including:

- the ability to compile a meta-analysis of complex subject matter,
- standards expertise,
- an understanding of risk and risk management,
- an understanding of the national health regulatory and policy environment across all jurisdictions,
- experience at the operational frontline for the application of the standards such as clinicians, managers, financial and business practitioners, non-clinical service providers eg hotel and engineering services, suppliers, and

- facilitation and leadership of a very high quality.

22. Identification of core safety and quality areas

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

A primary focus on the service consumer's (and their significant others, as they are often the commentators) journey through the health and aged care systems is a useful model. Using this, the key risks can be identified that impact on that journey as well as the risks upstream from this direct consumer contact. These risks can be cut in many different ways but the priorities should be around the acuteness of the risk and the safety, quality and other risk management systems that should be in place to minimise these risks. For example one way to classify the core risks is to focus on:

- **Consumers:**
 - Understandable information for consumers to make informed decisions throughout their experience in the health and aged care systems;
 - Communication mechanisms and sensitivity to issues such as culture, gender, age, disability, educational level, social and economic situation;
 - Open disclosure about errors, complications and adverse events; and
 - Follow-up of health outcomes and experiences in the health system.
- **Safety of clinical practice:**
 - The skills, knowledge, experience, health and conduct of the health professionals and workers providing treatment and care to consumers;
 - Recruitment and selection, credentialling and ongoing performance review and management;
 - The knowledge and skills for understanding human performance, the systems of care and for minimising and dealing with error;
 - Application of the methods to identify, measure and analyse problems with care delivery eg incident monitoring, sentinel event monitoring, effective review of clinical indicators, clinical review, complaints; and
 - The action that is taken in response to information to improve both the individual and the systemic aspects of care delivery.
- **Safety of the environment in which care is provided:**
 - Occupational health and safety for consumers, workers and guests including hygiene, appropriate work practices, food preparation, air conditioning, infection control etc.
 - Asset management – maintenance, repair and replacement.
- **Governance responsibilities of the organisation:**
 - The organisational responsibility for systems to support safe, quality health service delivery.
 - Availability and accountability for appropriate resources to provide services in a safe way.

Mutual Recognition of Standards and Accreditation Processes

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

Mutual recognition is not an unknown concept in Australia. Regulation has been introduced in areas such as the sale of goods and the registration of occupations across the jurisdictions in Australia and New Zealand. It:

...was formulated in response to frustration about the extent of regulatory differences across Australia and the resultant adverse impacts on industry of operating in the multiple regulatory environments of the States and Territories. Prior, to its inception, businesses trading in more than one jurisdiction had to:

- *satisfy the multiple regulatory standards of the various jurisdictions;*
- *package and label goods differently for sale in different jurisdictions; and*
- *satisfy product testing requirements of other jurisdictions prior to sale in those jurisdictions.*

Similarly, different regulatory standards for the registration of occupations across Australian jurisdictions were seen as inappropriately inhibiting the movement of skilled people.(Productivity Commission 2003; xvi).

Similar frustration is evident in the health system in relation to the proliferation of standards and accreditation schemes. However, until the mapping exercise is conducted to establish the scope, consistency and effectiveness of both the accreditation systems and standards, introducing a mutual recognition scheme will be nigh on impossible.

Specialised certification programs and standards need to be mapped to the broader governance system standards in the more organisation-wide accreditation schemes.

Clearly it is an area where some form of regulation may be required to drive a mutual recognition scheme to enable it to have effect in the health system, though some level of consensus and high level leadership will also be required.

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