National Safety and Quality Health Service Standards Overview

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The National Safety and Quality Health Service Standards, developed by the Australian Commission on Safety and Quality in Healthcare

(NSQHS Standards, www.safetyandquality.gov.au): 256 Actions, 209 Core

What's different about the National Safety and Quality Health Service Standards?

- The National S&Q Standards are focused on the **process of care: *what happens and how things are done every day*** at point of care, whereas previous accreditation standards were more management system focused

- The Standards aim to **promote consistency and use of evidence**, and reduce variability in clinical practice across the organisation

- The Standards **raise the bar:**
  - Some requirements are more demanding than the practices most health services currently have in place
  - They require *consistent* use of evidence based practice and tools across the organisation
  - They will highlight patient risk more effectively

- Achieving the standards across the health service is not a desktop exercise: requires *focus, planning, effective change management and* ***everyone working together*** **from the Governing Body down.**

Why do we need them? Because ensuring care safety and quality in healthcare has been a very slow work in progress and it's time for strong action

- Adverse events increase the case cost up to 7X and $1 in every $7 spent on healthcare in Australia is used to treat a healthcare-associated injury

(Ehsani J, Jackson T, Duckett S (**2006**) The Incidence and Cost of Adverse Events in Victorian Hospitals, 2003–04. MJA, vol 184 no 11, pp. 551–55)

- 27% patients experience healthcare-associated harm in the US in 2012 - 48% of these are preventable and up to 83% incidents are not reported
  (US Office of Inspector General, **2012** study of Medicare patients in 189 hospitals)

- 43% of patients do not receive care based on best available evidence via guidelines

(Runciman WB et al. CareTrack: assessing the appropriateness of healthcare delivery in Australia. Medical Journal of Australia **2012**;197(2):100-105)

Some differences from other accreditation standards

There are Core and Developmental actions

Core actions are critical for safety and quality. All core actions must be met before a health service organisation can be accredited to the NSQHS Standards.

Developmental actions do not need to be fully met in order to achieve accreditation, although health service organisations need to demonstrate activity in these areas.

Ratings are more absolute:

- **Not Met** – the actions required have not been achieved.
- **Satisfactorily Met** – the actions required have been achieved.
- **Met with Merit** – in addition to achieving the actions required, measures of good quality and a higher level of achievement are evident.

The Standards' workbook contains the requirements of the Standards, including reflective questions and evidence requirements. The monitoring tool is an Excel spreadsheet with many features for capturing and displaying progress.

Demonstrating compliance with the Standards: the workbooks and monitoring tool identify the way in which you can demonstrate we're meeting the standards:

- Audits
- Policy, Procedure and Protocol
- Clinical record documentation
- Direct observation (yours and accreditation surveyors/assessors)
- Indicator data?

But we're not restricted to these methods only.

Are there opportunities?…each health service has to decide

Worst case	Best case
It's like aged care accreditation all over again	It revitalises our quality program by raising the bar and appealing to staff
Our 'quality program' is a pseudonym for complying with more standards	We use the standards as a vehicle to discuss and improve our care quality more broadly
Q Manager and staff quality roles will shrink and be focused on demonstrating evidence: **'I am audit'**	Ownership from the Board and Exec and more rigorous governance systems and consumer participation
The investment will be in meeting the standards only	The investment is in the whole care experience
Increases the divide between redesign and quality	Unites redesign, quality and all areas of our organisation in common aims

Key components of Standard 1 (Governance – those in bold have new/increased focus or requirements from what previous accreditations have required.)

Governance and QI	Clinical Practice	Performance and skills	Incident and complaints	Patient rights and engagement
• P&P system – clinical and corporate • Compliance with legislation and standards • **Impact on patient safety and quality of care is considered in business decision making** • **Roles and accountabilities – and corresponding support and training** • **Mandatory and competency based training to meet the standards' requirements (D)** • Org-wide CRM and QI system	• Best available evidence • **Early ID of high risk patients** • Integrated clinical record	• Credentialing and SOP • Performance development and review system • Ongoing training and development • **Workforce engagement with the Q system**	• Reporting and investigation system • Complaints system • Open disclosure (D)	• Charter of rights • **Patients as partners in their care** • Confidentiality • Patient feedback

Partnering with Consumers overview

Consumer Partnerships in Service Planning	**Consumer Partnerships in Designing Care**	**Partnerships for measurement and evaluation**
Governance structures for Partnerships (D) Policy (D) Orientation and training (D) Advising on patient information	Partnering to redesign care (D) Training for all staff on partnering with consumers	Providing the community with S&Q information Participation in analysis and improvement (D) Evaluation of feedback data and development of action plans (D)

Applying the standards at point of care to provide more consistent, better quality and safer care requires a whole of organisation response

- Preparation is about improvement of clinical care, not a ‘rush to get ready’ for a paper based accreditation process
- Preparation requires an organisation wide approach, with buy in from all levels of an organisation
- There are many tools and resources available to assist
- Networking between health services and peers in other health services is a great and efficient way to support preparation
- All levels within the organisation require knowledge about the new standards and process and how they relate to their area

Everyone has a role

- **Front line staff:** work with the requirements of the standards to provide safe, quality care

- **Corporate/support/back of house staff**: understand and enact your role in supporting front line staff in providing quality care (Standard 1, and other standards as relevant)

- **Executive and managers:** support front line staff with leadership of Standards 1 and 2, resources, information and systems

- **Quality Manager:** coordinate, provide education and information and pull required evidence together

What does NSQHS Standard 1 mean for Boards and Executives?:

Board: Oversight, leading, some planning, delegating implementation to CE and monitoring progress
Executive: Leading, Planning, Resourcing, Delegating, Implementing and Monitoring

The key requirements of Standard 1 – governance systems - are important elements of everyone's role and feature in each of the other standards

- **Roles and responsibilities** for providing safe, quality care are clarified in JDs, delegated, supported (including orientation, training, competencies, professional development)and enacted (including locums): supported by policy and procedure, evidence based guidelines and pathways
- **Staff are credentialed** and have SOP, supervision (where appropriate) and performance review; service planning considers clinical capability; intro of new tech considers SOP
- **Business decisions** and allocation of resources **consider patient safety and quality**: through strategic planning, business cases, corporate meeting agendas etc.
- **Plan and implement an organisational quality system** (define quality care and strategies for improvement; engaging consumers; monitoring and feedback) and receive feedback from staff on their understanding and engagement
- **Plan and implement org-wide risk management system** (incidents, risk register, complaints – in partnership with consumers) and monitor the impact of the system on managing and reducing risk
- **S&Q reporting is resourced, scheduled and sufficient** to know about and act on key aspects of safety and quality
- **Processes are in place** to identify patients at increased **risk of harm**
- **Use of integrated**, accurate, accessible, confidential **clinical record**
- **Open disclosure** and Australian Charter of Healthcare Rights
- **Systems for patient involvement in their care** and decision making through information, collaboration, advance care

Achieving the NSQHSS requires a mature quality system

Health Service Organisational Quality System Maturity Scale (*Cathy Balding, 2013*)	
Maturity Level	**Characteristics**
1. Informal	• Lack of systematic approach: random improvement activities based on minimal and poor data. • Managerial response to quality problems largely dependent on staff 'trying harder'. • Limited staff input into identifying problems and improvements.
2. Compliance	• Problem based and reactive approach with minimal systematic collection or analysis of data on key issues. • Focus on compliance with external/funding requirements. • 'Doing quality' is staff code for auditing and other data collection with little implementation or follow up. • Lack of relationship between quality system mechanics and quality of care – 'quality' still seen as the responsibility of the quality manager.
3. Reactive Risk	• Focus on risk management and compliance with accreditation and other external requirements. . • Systematic tracking of key indicators, consumer feedback and incident reporting. • Evidence of some system improvement and follow up. • No agreed change and improvement model in use. • Reliance on policy shifts and education as key change tools. • Leaders are developed to improve safety.
4. Proactive Continuous Improvement	• Quality system is a key component of clinical/quality governance system and is integrated at operational level, with plans for improvement at organisation-wide and local levels. • Lack of common and uniting goals with the improvement program comprising a series of (possibly unrelated) monitoring, improvement and redesign projects. • Minimum dataset reported across all quality dimensions, • Data are analysed and reported through the organisational levels to the governing body, and there is evidence of effective systems improvement as a result. • Strategies in place for developing leaders to engage staff and consumers in improvement across the dimensions of quality.
5. Strategic	• The desired quality of the consumer experience at point of care is defined with staff and consumers, and achieving it is a strategic priority. • The organisational quality plan is designed and systematically implemented to create the defined quality consumer experience, through developing people and improving systems. • Roles and responsibilities at all levels of the organisation for creating the quality consumer experience are described and supported. • Governance systems are owned by the governing body and executive team and designed to support staff to create the quality consumer experience. • A model for change and improvement is in use.

New: Advisories, mediation and advice line

- You may request mediation during an accreditation survey to clarify interpretation
- Advisories explain the interpretations provided and are an excellent guide to requirements – keep an eye on the Commission website
- Advice line is there to be used.

New: Significant Patient Risk

Where a surveyor identifies one or more major risks in a health service organisation that could result in significant harm to patients the following actions are to be taken:

- 1. Surveyors are to notify both the health service organisation and their accrediting agency that a significant issue has been identified
- 2. Surveyors and / or an accrediting agency is to negotiate with the health service organisation a plan of action and timeframe to remedy the issues
- 3. An accrediting agency is to notify the relevant regulator that a significant issue has been identified and confirm the action being taken as soon as practical, usually within one working day.

Significant Patient Risk Example: Standard 1

- ● A process for credentialing staff does not exist and insufficient action is being taken to address this issue.

- • Patient care records do not accurately reflect care provided, notes are missing, documentation is fragmented and no action has been taken to address deficiencies in medical records

New: Dataset: (check current requirements re this on the Commission website)

Dataset includes:

The Performance and Accountability Framework – Initial Indicators for hospitals includes:

- 6.2.1 Effectiveness – safety and quality
- 6.2.1.1Hospitalstandardisedmortality ratio
- 6.2.1.2Death in low-mortality diagnostic related groups
- 6.2.1.3 In-hospital mortality rates for:
- • acute myocardial infarction
- • heart failure
- • stroke
- • fractured neck of femur
- • pneumonia.

- 6.2.2.1 Measures of the patient experience with hospital services

New: What if we don't do well?: the jurisdictional Regulator Role

- 120 days remediation period in 2013, 90 days from 2014
- Under the AHSSQA Scheme each state/territory health department has responsibility for verifying the accreditation status of public health services.
- Check your jurisdictional accreditation regulatory requirements and response

Where you have gaps

- Perform a risk assessment to prioritise the issue and ensure ir is considered by senior managers
- Address the high risk issues first: if necessary, put a short term measure in place while you're developing the plan for the longer term achievement of the requirements of the standard
- Show that you've got a action plan in place – and that' it's happening, and being monitored at a senior committee

Standard 3: Summary of requirements

- Effective governance and management systems for healthcare associated infections are implemented and maintained.
- Strategies for the prevention and control of healthcare associated infections are developed and implemented.
- Patients presenting with, or acquiring an infection or colonisation during their care are identified promptly and receive the necessary management and treatment.
- Safe and appropriate antimicrobial prescribing is a strategic goal of the clinical governance system.
- Healthcare facilities and the associated environment are clean and hygienic. Reprocessing of equipment and instrumentation meets current best practice guidelines.
- Information on healthcare associated infection is provided to patients, carers, consumers and service providers.

Standard 4: Summary of requirements

- Health service organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing, manufacturing, compounding and monitoring of the effects of medicine.
- The clinical workforce accurately records a patient's medication history and this history is available throughout the episode of care.
- The clinical workforce is supported for the prescribing, dispensing, administering, storing, manufacturing, compounding and monitoring of medicines.
- The clinician provides a complete list of patient's medicines to the receiving clinician and patient when handing over care or changing medicines.
- The clinical workforce informs patients about their options, risks and responsibilities for an agreed medication management plan.

Summary of requirements

Standard 5

- At least three approved patient identifiers are used when providing care, therapy or services.
- A patient's identity is confirmed using three approved patient identifiers when transferring responsibility for care.
- Health service organisations have explicit processes to correctly match patients with their intended care.

Standard 6

- Health service organisations implement effective clinical handover systems.
- Health service organisations have documented and structured clinical handover processes in place.
- Health service organisations establish mechanisms to include patients and carers in clinical handover processes.

Summary of requirements

Standard 7:

- Health service organisations have governance systems in place for the safe and appropriate prescribing and clinical use of blood and blood products.
- The clinical workforce accurately records a patient's blood and blood product transfusion history and indications for use of blood and blood products.
- Health service organisations have systems to receive, store, transport and monitor wastage of blood and blood products safely and efficiently.
- Patients and carers are informed about the risks and benefits of using blood and blood products, and the available alternatives when a plan for treatment is developed.

Summary of requirements

Standard 8

- Health service organisations have governance structures and systems in place for the prevention and management of pressure injuries.
- Patients are screened on presentation and pressure injury prevention strategies are implemented when clinically indicated.
- Patients who have pressure injuries are managed according to best practice guidelines.
- Patients and carers are informed of the risks, prevention strategies and management of pressure injuries.

Summary of requirements

Standard 9

- Health services use organisation-wide systems consistent with the National Consensus Statement to support and promote recognition of, and response to, patients whose condition deteriorates in an acute health care facility.
- Patients whose condition is deteriorating are recognised and appropriate action is taken to escalate care.
- Appropriate and timely care is provided to patients whose condition is deteriorating.
- Patients, families and carers are informed of recognition and response systems and can contribute to the processes of escalating care.

Summary of requirements

Standard 10

- Health service organisations have governance structures and systems in place to reduce falls and minimise harm from falls.
- Patients on presentation, during admission and when clinically indicated, are screened for risk of a fall and the potential to be harmed from falls.
- Prevention strategies are in place for patients at risk of falling.
- Patients and carers are informed of the identified risks from falls and are engaged in the development of a falls prevention plan.