中華人民共和國香港特別行政區政府總部食物及衞生局

Food and Health Bureau, Government Secretariat
The Government of the Hong Kong Special Administrative Region
The People's Republic of China

本函檔號： *L/M to FH CR6/3921/09 Pt.2*　　電話號碼： *(852) 2973 8203*
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香港中環
昃臣道 8 號
立法會
衞生事務委員會秘書
黃麗菁女士

黃女士：

在公營醫院進行醫院認證計劃的進展情況

有關立法會 CB(2) /10-11(02)號文件跟進行動一覽表內第 5 項，在二零一一年五月九日的立法會衞生事務委員會會議上，委員要求政府當局提供下列資料 —

(a) 推出醫院認證先導計劃(下稱「先導計劃」)的詳情；
(b) 香港中文大學那打素護理學院就先導計劃進行的兩項研究的結果；
(c) 參與先導計劃的公立醫院的醫療事故數字；及
(d) 澳洲醫療服務標準委員會的《評估及質素改進計劃標準》。

對(a)項的回應

在二零零九年五月，醫院管理局(醫管局)與澳洲醫療服務標準委員會合作推行爲期三年的先導計劃，以持續改善服務質素。五間公立醫院(即明愛醫院、東區尤德夫人那打素醫院、伊利沙伯醫院、瑪麗醫院及屯門醫院)參與先導計劃。

澳洲醫療服務標準委員會獲委聘爲認證機構推行先導計劃，工作包括：爲香港制訂適用於本地的認證標準；發展本地評審員團隊進行醫院認證；以及透過進行機構評審，評估參與先導計劃的醫院的表現。這項計劃的服務費爲 1,250 萬元，分項數字如下 —

項目	金額 (百萬港元)
1. 培訓及參與 - 包括爲約 2 000 名員工舉辦約 40 節培訓課程，到五間先導醫院考察交流，讓員工對認證工作有更多的了解；並由 10 位澳洲顧問和質素管理經理提供實地及持續支援，協助醫院工作小組進行質素改善及認證工作。	3.16
2. 顧問對五間先導醫院所作的差距分析及報告 - 包括由四位澳洲評審員在每間醫院進行爲期五日的實地評審，以及就此擬備報告，提出相關改善建議。	2.98
3. 對五間先導醫院進行認證 - 包括五隊評審員隊伍(由六位澳洲及四位本地評審員組成)在每間醫院進行爲期五日的機構評審，以及就此擬備報告，提出相關改善建議；並在隨後四年一周期內持續對醫院提供支援及跟進，例如審視醫院年度自行評估報告，然後由評審員隊伍進行跟進實地評審。	4.30
4. 評估先導計劃及日後的協作報告	0.26
5. 評審員培訓 - 包括爲 46 位評審員候選人，舉辦兩個評審員培訓工作坊、安排他們在本地和海外醫院進行評審實習，並安排導師指導；以及爲評審員提供週年持續發展工作坊。	1.80
總數	12.50

對(b)項的回應

香港中文大學那打素護理學院就先導計劃進行的兩項研究，初步結果載於**附錄 A**(報告只有英文版本)。最後研究報告將於八月完成。

對(c)項的回應

醫管局於二零零九年四月一日至二零一一年三月三十一日的整體嚴重醫療事故於**附錄 B**。

對(d)項的回應

澳洲醫療服務標準委員會的《評估及質素改進計劃標準》，其框架包含 3 項功能、十三項標準和四十五個準則，涵蓋醫院管理的不同範疇，包括臨床護理、支援服務和機構制度。考慮到本地情況後，當局制訂了香港版的《評估及質素改進計劃標準》，內載一套經調整後適用於本地的認證標準，其後於二零一一年三月獲國際醫療認證機構(International Society for Quality in Health Care) (ISQua)認可。評審員採用第 1 部分香港版的《評估及質素改進計劃標準》，對香港的醫院進行認證評審，第 1 部分載於**附錄 C**(認證標準只有英文版本)。由於第 2 至 4 部分屬於補充參考資料，我們沒有將它們包括在回覆內。

食物及衞生局局長

(章景星 代行)

副本送：
醫管局 (經辦人：彭飛舟醫生)
衞生署 (經辦人：莫天娜醫生)

二零一一年六月二十七日

附錄A

Appendix A

Steering Committee on Hospital Accreditation

9 March 2011

EVALUATION STUDIES OF PILOT SCHEME OF HOSPITAL ACCREDITATION BY THE CHINESE UNIVERSITY OF HONG KONG

A. STUDY ON THE PERSPECTIVES OF CHIEF HOSPITAL MANAGERS OF THE PILOT SCHEME AND THEIR VIEWS OF THE FUTURE IMPLEMENTATION OF HOSPITAL ACCREDITATION IN HONG KONG

OVERVIEW

The evaluation of the Pilot Scheme was entrusted to an independent, credible third party evaluator to avoid any bias factor. At the request of the ACHS, the Chinese University of Hong Kong (CUHK) conducted an evaluation study of the pilot scheme. This study solicited the perspectives of chief hospital managers of the pilot scheme and their views of the future implementation of hospital accreditation in Hong Kong. The findings of the study have provided important insights into the feasibility, acceptability and implications of hospital accreditation in Hong Kong. This paper presents a preliminary report of the findings obtained from the questionnaire and interview of the CUHK study.

OBJECTIVES

The evaluation objectives were to:

i) determine the extent to which the outcomes of the Pilot Scheme were met satisfactorily, including an assessment of the efficiency and effectiveness of the ACHS in terms of mobilisation and utilisation of resources;

ii) identify factors that contributed towards the success and shortcomings of the pilot scheme; and

iii) draw lessons for future intervention and extension of hospital accreditation scheme in Hong Kong.

METHODOLOGY

The study method adopted was in the form of a qualitative survey which was designed by CUHK comprising a survey questionnaire and structured interview. The target participants of the study were chief hospital managers selected from the five pilot public hospitals and three pilot private hospitals which had undergone an Organisation-Wide Survey. Apart from the three private hospitals nominated to be part of the pilot scheme evaluation, an additional private hospital was included in the survey in an effort to broaden the scope of this study. The chief hospital managers of these hospitals completed a questionnaire and participated in an individual in-depth interview. The interview and evaluation of the study was conducted by Professor

Diana T.F. Lee, Chair Professor of Nursing and Director of the Nethersole School of Nursing, the Chinese University of Hong Kong.

SURVEY QUESTIONAIRE

The questionnaire comprises five sections, covering various aspects of the accreditation scheme: engagement, readiness, surveyor workforce, standards and feasibility. Details of the questionnaire are as follows:

1. **Engagement component**

   Q1: The EQuIP 4 accreditation program as a continuous quality improvement framework has been clearly introduced.

   Q2: The pilot project scheme, timeline and commitment of participating hospitals have been clearly outlined.

   Q3: What is your overall satisfaction with the meetings and presentations provided by the ACHS project team in the engagement process?

2. **Readiness component**

   Q1: What is your overall satisfaction with the introductory and specialty workshops on EQuIP 4?

   Q2: What is your overall satisfaction with the on-site support provided by the Australian quality managers and ACHS project team members?

   Q3: The consultancy gap analysis is useful in assessing individual hospital's readiness to conduct the organisation-wide survey.

3. **Surveyor workforce**

   Q1. What is your overall satisfaction with the selection of local surveyors?

   Q2. What is your overall satisfaction with the surveyor training program?

4. **Standards**

   Q1: The EQuIP standards are adequate and appropriate with reference to the legality, adaptability and practicality of the local context of Hong Kong.

5. **Feasibility**

   Q1: Taking on the experience of the pilot scheme, hospital accreditation is acceptable in Hong Kong.

   Q2: Taking on the experience of the pilot scheme, hospital accreditation is feasible in Hong Kong.

Q3: Do you support the full implementation of hospital accreditation scheme in Hong Kong?

The return rate of the questionnaires was 100%. Their responses were based on the following five-point Likert scale by circling each question with one of the responses that best reflects their views:

1 = Strongly disagree

2 = Disagree

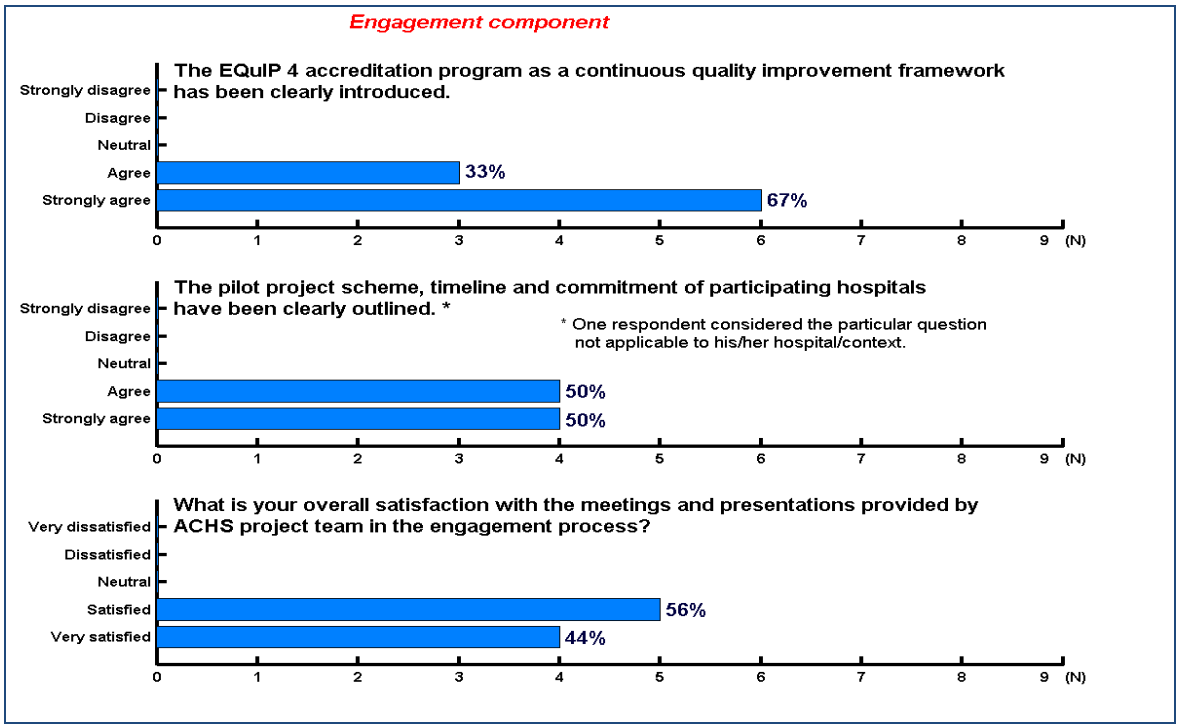
3 = Neutral

4 = Agree

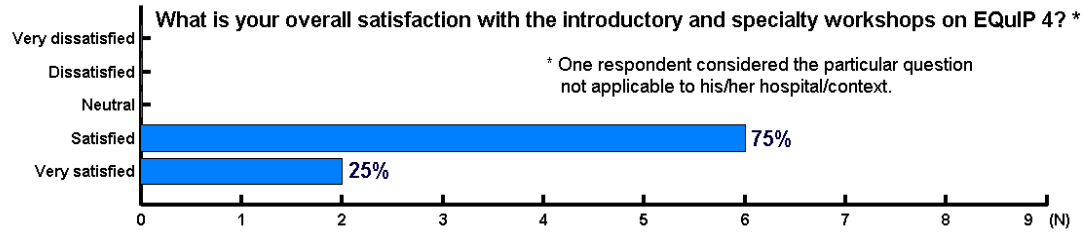
5 = Strongly agree.

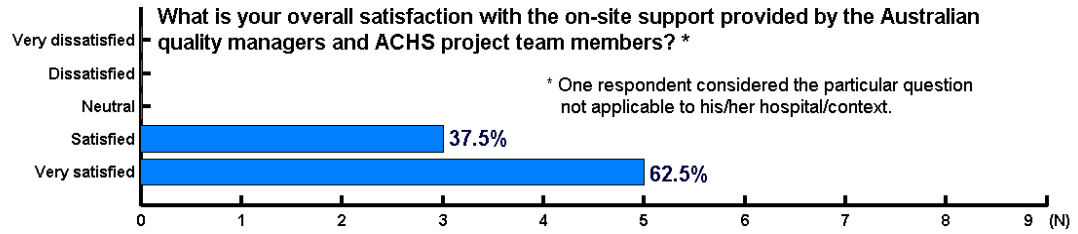
Results were reported in Figure 1 below.

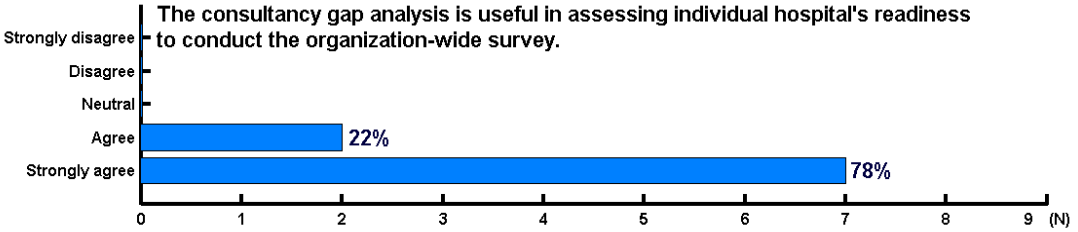
Figure 1: Evaluation of pilot hospital accreditation scheme (N=9)



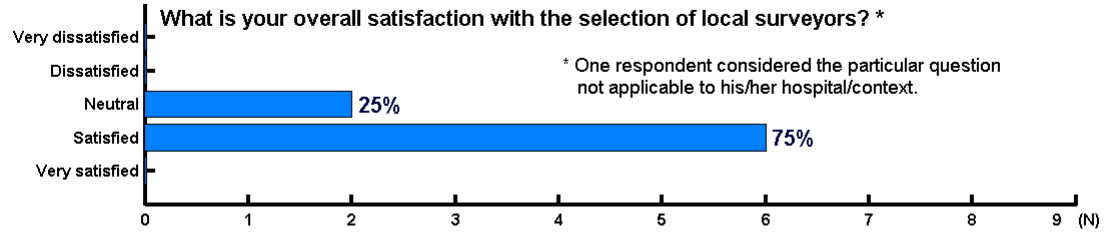
Readiness Component

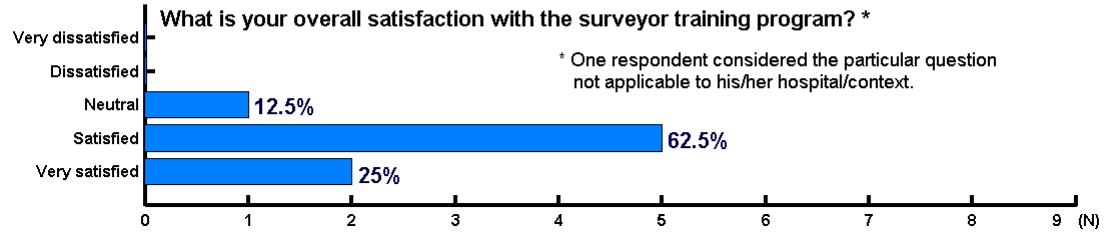


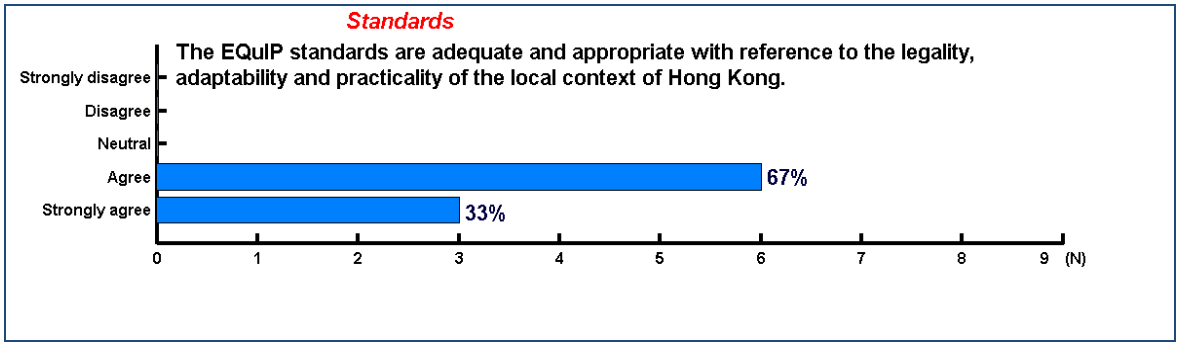


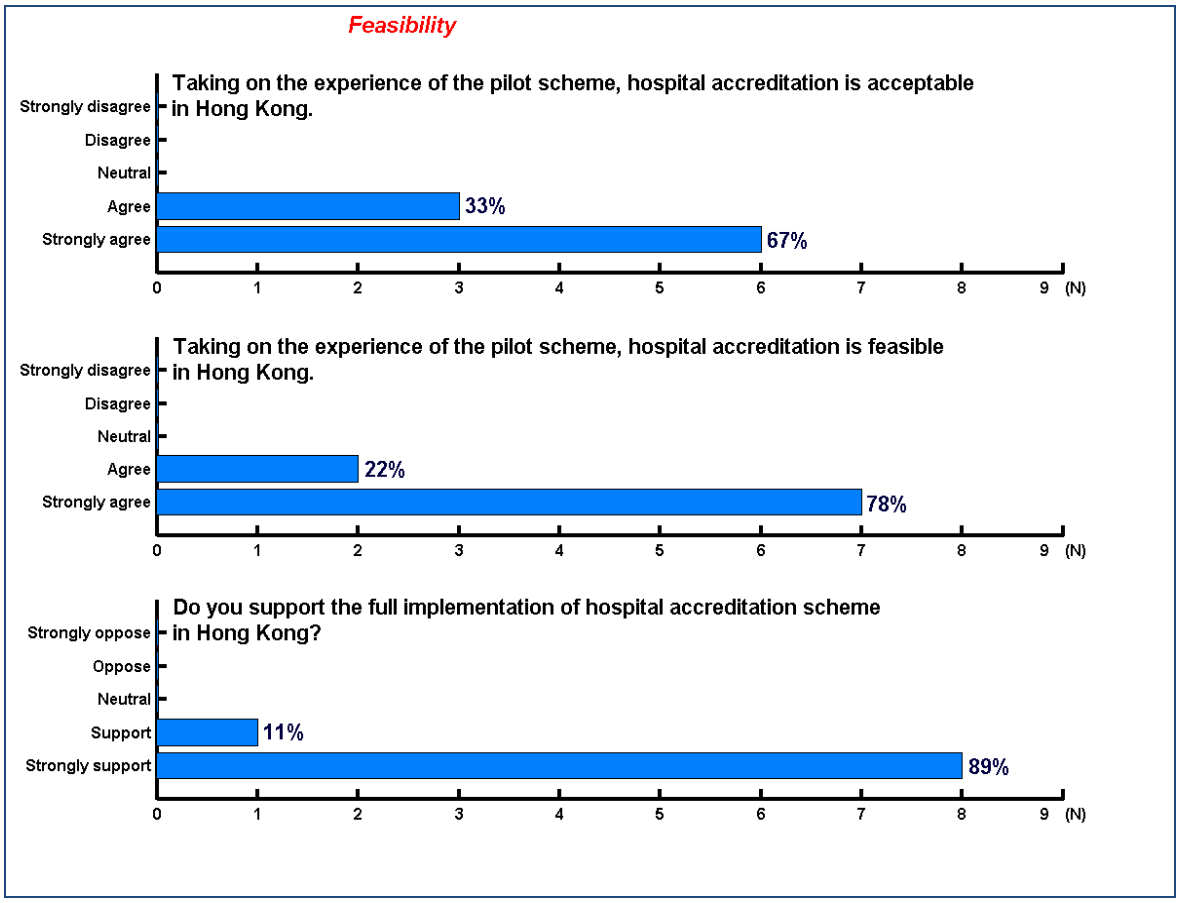


Surveyor workforce









Key Findings of the Questionnaire

In general, participants of the study were satisfied with the engagement process and various strategies used to assist hospitals to prepare for the accreditation survey. They also perceived the EQuIP 4 standards to be adequate and appropriate with reference to the legality, adaptability and practicality of the local context of Hong Kong. Taking on the experience of this pilot scheme, all participants perceived hospital accreditation as acceptable and feasible. They also strongly supported the full implementation of hospital accreditation in Hong Kong. Of note is the evaluation result on the surveyor workforce. One participant did not attempt to answer the two questions of this section. Of the eight participants who answered this section, two

(25%) had not indicated their satisfaction with the selection of local surveyors. The findings of the questionnaire were further explored in the subsequent interviews with the chief hospital managers.

INTERVIEW SURVEYS

Nine hospital chief managers were interviewed to:

1. Discuss their responses indicated in the questionnaire
2. Further explore their experiences with the pilot scheme and their recommendations with regard to the future implementation of hospital accreditation in Hong Kong.

The following guidelines were used in the interviews:

Q1: Can you share with me your overall experience with the pilot hospital accreditation project?
Prompts: *Engagement / Readiness / Surveyor / EQuIP standards / Acceptability and feasibility*

Q2: What do you regard as the most successful aspects of this pilot hospital accreditation project?

Q3: What do you regard as the least successful aspects of this pilot hospital accreditation project?

Q4: What are your suggestions with regard to the future implementation/ model of hospital accreditation in Hong Kong?

Q5: Are there any other issues with regard to hospital accreditation that you would like to share?

The participants' perspectives of the pilot accreditation scheme and their experiences with the various aspects of the accreditation such as engagement, readiness, surveyors, EQuIP standards, acceptability and feasibility of the model are presented hereunder.

Overall experience with the pilot accreditation scheme

All chief hospital managers described the overall experience of the pilot hospital accreditation scheme as very positive and rewarding:

- The accreditation exercise has provided a golden opportunity for the whole hospital to work towards a common goal. It was described as a powerful driving force to unite all the staff of the hospital. Better communication, improved sense of belonging and team spirit were seen as evident.

- The scheme also stimulated interaction and promoted understanding between the public and private sectors through venues such as engagement workshops and surveyor training
- All participants acknowledged the important and positive contributions of nurses in the accreditation exercise. They were seen as the key drivers in moving the scheme forward.

Engagement Component

- Majority of the participants were very satisfied with the engagement process. They expressed that the required information was conveyed in a clear and easy to understand format. The engagement workshops were described as very well designed and delivered
- The importance of targeting engagement efforts to the following groups in future accreditation exercises was suggested:
  - Junior frontline medical doctors
  - Allied health staff
  - Patients
  - The public: the what and what not of accreditation.

Readiness Component

- On-site consultant visits and gap analyses were identified as most useful and relevant in getting the hospitals ready for the accreditation exercise.

Surveyor Workforce Component

- All participants stressed that the qualities and standards of surveyors were of prime importance in the whole exercise
- While all participants supported the need to build up a local surveyor team, they also expressed the necessity of involving overseas surveyors in future accreditation exercises. This was seen as a way of upholding the essence of 'external benchmarking' in accreditation
- All participants highly valued the contributions of overseas surveyors. These surveyors were described as experienced, objective and constructive in making suggestions for continuous quality improvement
- Participants strongly recommended the need to continue to develop the experience, knowledge and skills of the local surveyors, particularly in terms of their communication and feedback skills
- When considering recruitment to the future local surveyor team, participants highlighted the importance of having a balance of surveyors with different

professional experience and background (e.g. administrative vs clinical; public vs private).

Standards Component

- All participants believed that the EQuIP standards were appropriate, relevant and clear. Modifications that have taken into considerations Hong Kong's unique local features / context were generally seen as appropriate. The use of these standards for international benchmarking was seen to be very acceptable
- Some participants suggested the need to give differential weighting to the various standards so as to reflect the unique efforts (e.g. interdisciplinary collaboration) that were required for the achievement, especially outstanding achievement, of a particular standard.

Acceptability and Feasibility

- All participants supported the accreditation scheme and expressed that the scheme was acceptable and feasible. The success of this pilot scheme has already stimulated a lot of discussion and informal sharing among other hospitals. This was seen to have set the scene for future implementation of accreditation in Hong Kong.

Most successful aspects of the pilot accreditation scheme

The pilot accreditation scheme was unanimously described by all chief hospital managers as a successful exercise. The following most successful aspects of the scheme were identified:

- The accreditation exercise has provided an opportunity to unite the hospital to move towards a goal. This unity has led to:
    - Improved team spirit and sense of ownership: cultivation of a 'can-do' spirit
    - Increased intra- and inter-unit / departmental collaborations leading to better support and collaboration. This has enabled the hospital to better identify high priority areas that require attention. Clearer delineation of staff responsibilities and accountabilities has also been achieved
    - A positive change in hospital culture: e.g. improved intergroup and interpersonal collaboration and a shift of focus from the individual to the system
- The accreditation exercise has also been successful in:
    - Improving document management and archiving

- Upholding corporate governance
- Promoting the use of a framework for continuous quality improvement.

Least successful aspects of the pilot accreditation scheme

With regard to the least successful aspects of the pilot accreditation scheme, participants commented on the following:

- The need to:
  - Further develop the local surveyors, particularly in terms of their communication and feedback skills
  - Review the criteria for selection of local surveyors to include a balance of surveyors with different professional experience and background (e.g. administrative vs clinical; public vs private).
- The need to review the tight time frame for the whole accreditation exercise.

Future implementation / model of hospital accreditation in Hong Kong

All participants supported a territory-wide implementation of hospital accreditation in Hong Kong. They also supported to continue using the ACHS model as our future accreditation model given that the ACHS model has already been accepted and its feasibility demonstrated in the local context. The ACHS model was further viewed as an appropriate model to work on as Hong Kong moves towards longer term goals in developing a unique local independent accreditation system which would include elements such as an appeal mechanism, credentialing and scope of clinical practice.

In moving towards a territory-wide implementation of the hospital accreditation scheme, participants suggested to:

- Continue to involve overseas surveyors while increased efforts should be given to develop our local surveyors. Training should be targeted to equip local surveyors with the knowledge and skills in protecting confidentiality, maintaining objectivity and developing sensitivity in providing feedbacks
- Promote sharing of the accreditation experiences among different hospitals, both public and private
- Deliberate on the role of the HA Head Office in coordinating core quality management areas such as standards, guidelines and inventory management. This would help to build an appropriate quality management and improvement infrastructure needed for future accreditation exercises
- Consider the implication of resources in the accreditation exercise for individual hospitals. Extra resources, both human and tangible, should be provided to

support the associated work. Some participants pointed out that resources were also required for the hospital to follow up with the recommendations after the accreditation exercise, such as improvements in sterilization and disinfection practices

- Direct more efforts to engaging the patients and the public.

Other issues with regard to hospital accreditation

- Some participants suggested the need to promote a spirit of sharing and learning from the accreditation exercise. It was recommended that the HA could coordinate sharing forums for the pilot hospitals to share their accreditation experiences and ACHS could also videotape their workshops so as to engage staff who have not attended the workshops
- A few participants mentioned the need for more research to document the effects of hospital accreditation, especially on patient safety and clinical outcomes.

SUMMARY

From the perspectives of the chief hospital managers in this study, the pilot hospital accreditation scheme was both acceptable and feasible. The scheme was seen as successful and major positive experiences such as improved team spirit and staff collaboration were noted. In light of the experiences of the pilot scheme, all managers supported the full implementation of a territory-wide accreditation scheme to all hospitals in Hong Kong.

In moving towards a full implementation of the scheme, development of the local surveyor workforce becomes crucial. Managers in this study have made thoughtful suggestions with regard to the selection and training of surveyors. The need to further develop the experience, knowledge and skills of the local surveyors is considered a priority. Provision of extra resources to support the work associated with accreditation is also highly recommended.

B. STUDY ON THE HOSPITAL STAFF PERCEPTIONS OF HOSPITAL ACCREDITATION

AIM AND OBJECTIVES

1. To measure the organizational culture of each sampled hospital
2. To examine the organizational culture of each sampled hospital from staff perspective
3. To examine the perceptions of hospital accreditation of each sampled hospital from staff perspective
4. To examine the relationship between organizational culture and hospital accreditation performance

For the purpose of the evaluation of pilot scheme of hospital accreditation, the following is an extract from the preliminary report of 'Hospital Staff Perceptions of Hospital Accreditation and Organizational Culture" with the objective to examine the perceptions of hospital accreditation of each sampled hospital from staff perspective.

METHODS

The study adopts the qualitative method of focus group interviews to examine experiences of hospital accreditation and organizational culture of each sampled hospital from staff perspective. Different perceptions and experience may exist among different levels of staff who are working in the same hospital (Thomas et al., 2003). In view of this, purposive sampling with three selection criteria was adopted to recruit participants for focus group interviews. The criteria included grade, rank and working experience. Both the highest and lowest ranking staff members from professional, administrative, and supporting grades were recruited for individual focus groups. Participants should have at least one year of experience in the current post of the hospital. Similar social background such as occupation and status can allow more free-flowing conversations among the participants (Morgan, 1997). Six focus group interviews with 6 - 10 participants in each group were conducted in each of the sampled hospitals. The six focus groups in each hospital are as follows:

1. Highest ranking professional staff
2. Lowest ranking professional staff
3. Highest ranking administrative staff
4. Lowest ranking administrative staff
5. Supporting staff from clinical stream
6. Supporting staff from administrative stream

FOCUS GROUP INTERVIEWS

Background characteristics of focus group participants

A total of 44 participants from the professional (n=16), administrative (n=13) and supportive (n=15) grades were recruited to join the six focus groups. Their age ranged from 28 to 59. Sixteen participants (36%) were male.

Table 8 Demographic information of focus group participants

Participant	Focus group[1]	Sex	Educational level	Position[2]	Years of service
1	1	M	Master	Ward Manager	20
2	1	M	Master	DOM	22
3	1	F	Master	Medical Social Worker	20
4	1	F	Bachelor	Ward Manager	28
5	1	F	Bachelor	Consultant (COS)	27
6	1	F	Master	Senior Nursing Officer	30
7	1	M	Bachelor	Consultant (In-charge)	15
8	2	M	Bachelor	Medical Officer	5
9	2	M	Bachelor	Medical Officer	7
10	2	F	Master	Registered Nurse	8
11	2	M	Bachelor	Registered Nurse	16
12	2	F	Bachelor	APN	25
13	2	F	Bachelor	Nursing Officer	30
14	2	M	Bachelor	Pharmacist	14
15	2	F	Bachelor	Registered Nurse	9
16	2	F	Secondary	Enrolled Nurse	10
17	3	F	Master	SHA	17
18	3	M	Bachelor	Manager	15
19	3	M	Secondary	Officer	3
20	3	F	Secondary	Adm.Assistant	25
21	3	M	Master	SHA	21
22	3	F	Master	Manager	16
23	3	F	Secondary	Adm.Assistant	27
24	4	F	Bachelor	TSA	2
25	4	F	Bachelor	TSA	4
26	4	F	Secondary	Clerk III (adm)	9
27	4	F	Secondary	GSA	2
28	4	F	Secondary	Clerk II (adm)	17
29	4	F	Secondary	Clerk I (adm)	32
30	5	F	Secondary	TSA	3
31	5	F	Secondary	Clerk II (clinical)	17
32	5	F	Secondary	TSA	9
33	5	M	Secondary	Foreman	12
34	5	F	Primary	Health Care Assistant	15
35	5	F	Primary	Health Care Assistant	12
36	5	F	Secondary	Health Care Assistant	12
37	5	M	Secondary	GSA	4
38	5	F	Secondary	Ward steward	20
39	5	M	Secondary	Health Care Assistant	17
40	6	M	Secondary	TSA	2
41	6	M	Secondary	Hospital Chef II	12
42	6	F	Secondary	Machinist	16
43	6	M	Secondary	Artisan	17
44	6	F	Primary	Workman II	17

[1]Focus group: 1=Professional high rank; 2=Professional low rank; 3=Administrative high rank; 4=Administrative low rank; 5=Supporting (clinical stream); 6=Supporting (administrative stream).

[2]Position: DOM=Department Operations Manager; COS=Chief of Service of a department; APN=Advanced Practice Nurse, SHA=Senior Hospital Administrator; Manager=Manager of a supporting department; Officer=Officer of a supporting department, Adm =Administrative, TSA=Technical Services Assistant, GSA=General Services Assistant.

Five themes were identified from the focus group data:

1. perceptions of the hospital accreditation,
2. positive experience with hospital accreditation,
3. difficulties encountered with hospital accreditation,
4. perceptions of areas for follow-up or improvement after hospital accreditation.

Details of the themes are reported as follows.

1. PERCEPTIONS OF THE HOSPITAL ACCREDITATION

1.1 The purposes of the accreditation as meaningful

Participants perceived two main purposes: (1) to enhance the quality and safety of patient care, and (2) to brush up the public image of the hospital which was tarnished in the medical blunder happened at the end of 2008. The two purposes were of value to participants, in particular, the second purpose which was perceived as highly worthwhile to put effort on.

1.2 The accreditation process as a formal examination

Participants perceived that the accreditation process was a formal examination process through which the hospital could 'obtain a license' to prove that it was up to international standard. The process was stressful partly because hospital staff from all levels and grades wanted to achieve 'at least a pass'.

1.3 The EQuIP accreditation criteria as abstract

This perception is universal among all levels and grades of hospital staff. The ACHS had organized introductory workshop in July 2009 to provide training on the accreditation standards and EQuIP 4 program to pilot hospital accreditation project teams. The high-ranking staff (administrative and professional) of the hospital perceived that although they had increased the understanding of the concepts of accreditation after receiving the 'very useful' training workshops and support provided by the ACHS (i.e. Introductory Workshop and the Consultancy Gap-Analysis Survey), they were unsure about how to demonstrate the achievement of criteria in the accreditation process due to lack of accreditation experience. The low-ranking staff (administrative and professional) perceived the EQuIP 4 Guide as a useful reference and referred to it as 'the telephone book'. They perceived the interpretation on how to achieve the criteria as 'abstract' and 'depending on individual interpretation'. Uncertainty about how to achieve the criteria was a common perception across all levels and all grades of hospital staff.

Reflecting on the process, participants believed that they had gone through a steep learning curve and that the experience of 'how to demonstrate the achievement of the criteria' could ease the future reaccreditation process. They said that they were sharing this experience with their counterparts in other hospitals who were about to go through the accreditation.

1.4 The accreditation surveyors as official examiners

The surveyors were considered as 'officials' with authority and 'whether the examination was given a pass would depend on these surveyors' decision'. This perception arose from the experience with the two different teams of surveyors who visited the hospital in the Consultancy Gap-Analysis Survey in December 2009 and the OWS in July 2010. Participants, especially supporting staff, perceived that the two teams of surveyors had different focus of attention in terms of what contributed to the achievement in some of the criteria. The high-ranking staff raised a concern on the objectivity of appointing local surveyors.

2. POSITIVE EXPERIENCE WITH HOSPITAL ACCREDITATION

2.1 Achieving a common goal: Enhanced solidarity

Right from the start of preparing for the accreditation, participants perceived that all levels and grades of hospital staff worked together as a family with a strong team spirit to achieve a common goal - to obtain at least a pass in the accreditation. Some participants equated the preparation process to 'the preparation for Chinese New Year, clearing away old things for a new start'. 'Old things' included the issues related to the medical blunder in 2008.

Participants were very pleased that the accreditation had positively impacted on staff morale and performance and the impact continued after the announcement of the accreditation status. Participants took pride on the good accreditation performance despite limited resources, saying that it was partly due to 'the enhanced morale' and 'a heightened sense of solidarity'.

2.2 A timely opportunity: Strengthened service quality and patient safety

The preparation for accreditation was perceived as 'a timely opportunity' to put concerted effort into (1) updating individual unit/department quality assurance

mechanisms such as policies, systems, guidelines, protocols and (2) systematically converting the individual unit/department-based mechanisms into patient-based.

Many participants believed that the accreditation was a good attempt though they were too occupied with routine day-to-day work. Other participants perceived that the hospital accreditation, as ‘a wake-up call’, had developed ‘a new mindset’ about the need to take on ‘an international trend of patient-focused healthcare delivery’. All participants were very pleased with the work thus accomplished, which was believed as beneficial to providing the best possible quality patient care and regaining public confidence on the hospital after the medical blunder.

3. DIFFICULTIES ENCOUNTERED WITH HOSPITAL ACCREDITATION

3.1 Huge workload with limited resources leading to physical exhaustion

Participants felt exhausted because the hospital was under-staffed. There were ‘many backlogs’ to sort out. Coupled with the limitation in material resources, citing the example of lacking computerized facilities, participants said that the hospital managed to sort out backlogs by means of extra manpower, which further added tension to physical exhaustion.

The extra work had to be dealt with after attending to day-to-day routine duties. Professional staff said that ‘clinical care is not to sacrifice’, therefore staying late and bringing home work to finish were common and caused interference with family life. Supporting staff said that they were ‘painful’ because of a few major events happened in a row with the accreditation, citing examples such as ‘decanting’ of a building of the hospital compound, conducting the ‘yearly stocktaking’ and ‘the retirement scheme’ in a department. Some administrative staff said that they went off work at 12 midnight consistently for two weeks to manage the extra work incurred from the accreditation. The work was perceived as ‘tough’ and ‘rush’.

3.2 Lacking experience and a formalized channel to clarify issues leading to uncertainty and anxiety

While the ACHS standards and criteria were perceived as ‘a yardstick for universal measurement of good hospital care’, participants found that they had no previous experience and had to work through a huge amount of written guidelines, i.e. ‘the telephone book’, to identify the right direction to prepare for the accreditation. As reported in the above all participants perceived the accreditation criteria as ‘abstract’.

Some participants perceived that they were ‘close to burn out’ by the end of the accreditation.

Participants in the managerial positions, including administrative and professional staff, were often in high anxiety because they were uncertain about whether their interpretation of the direction to achieve criteria was accurate, but at the same time they needed to convince their colleagues to follow. The anxiety was heightened because all staff expected to obtain a ‘pass’ in the accreditation so as to ‘brush away the tarnished public image of the Hospital’ due to the medical blunder. Although they found the support from the ACHS (i.e. Introductory Workshop and the Consultancy Gap-Analysis Survey) ‘very useful’, they perceived the need to have a two way communication channel with the ACHS to clarify issues relating to achievement of criteria. Participants in the high rank said that the uncertainty and anxiety was relieved only on the day the hospital was awarded the accreditation status.

Participants in middle and first-line managerial positions encountered difficulties in making sense of the written guidelines on achieving the criteria, but found that they had no formalized channel to clarify their interpretations with the ACHS. While they received loads of email messages from the top management on how to prepare for the OWS, they perceived unclear direction. They also perceived the email facilities as inadequate for making discussion to clarify issues with the top management. They managed to circumvent the difficulties by relying on their own judgment about what contributed to best quality, or by informal communication with their counterparts to identify relevant information. Some participants often went on the websites of other pilot hospitals to check out any information or processes that could provide insight.

Supporting staff perceived a tensed atmosphere throughout the hospital. While they wanted to contribute to a good accreditation performance, they perceived the instructions were unclear. Some supporting staff perceived that they were lacking access to the most up-to-date information about preparing for the OWS because they had no access to the email facilities and had to rely on the briefing sessions by their immediate supervisors. Nevertheless, they perceived that they were very willing to ‘follow instructions to do the best’ for the accreditation. What frustrated them most was that the instructions might be changed overnight and they had to put things right again.

4. PERCEPTIONS OF AREAS FOR FOLLOW-UP OR IMPROVEMENT AFTER HOSPITAL ACCREDITATION

Participants perceived that the hospital had made valuable positive changes in response to the hospital accreditation scheme. They suggested follow-up strategies and areas for improvement after hospital accreditation to further sustain the good

practice for continuous quality improvement. These perceptions are grouped under hospital-, HA- and ACHS-specific in the below.

4.1 Hospital-specific

The follow-up strategies included: (1) to consolidate the established mindset of taking on ‘an international trend of patient-focused healthcare delivery’; (2) to consolidate the quality assurance mechanisms established in the accreditation; (3) to maintain the momentum of staying on high alert to look for ways for on-going quality improvement; and (4) to disseminate ACHS feedback on accreditation performance, including strength and weakness of performance in achieving each of the criteria to assist in continuous improvement. Areas for improvement included: (1) To ensure a two way communication channel both within the hospital and with the ACHS for clarifying issues related to accreditation in addition to the useful training from the ACHS (e.g., Introductory Workshop and the Consultancy Gap-Analysis Survey); and (2) to avoid sequencing hospital accreditation with other major hospital events in a row to allow staff a breathing space.

4.2 HA-specific

Participants perceived that follow-up strategies were required (1) to develop an infrastructure for sharing of core data and key processes across HA hospitals to enhance quality assurance and help benchmark good practice; (2) to provide positive reinforcement to hospitals awarded accreditation status; (3) to announce to the public that the hospital has been accredited (to brush away the tarnished public image).
Areas for improvement included: (1) Appropriate allocation of additional resources to cope with the extra workload arising from hospital accreditation; and (2) to further enhance staff’s sense of belonging to the hospital by strengthening the hospital’s culture.

4.3 ACHS-specific

Participants would like (1) to continue to obtain the useful support from the ACHS (e.g., Introductory Workshop and the Consultancy Gap-Analysis Survey); (2) to have a two way communication channel for clarifying issues in addition to the written guidelines; and (3) to enhance the objectivity of accreditation surveyors especially the local ones.

DISCUSSION

This study is the first of its kind to examine hospital staff’s perceptions of hospital accreditation and organizational culture. While findings presented in this preliminary report were limited to those collected from one of the four sampled hospitals, rich data

were obtained with the use of quantitative and qualitative approaches, from which a holistic picture on how hospital staff perceived their accreditation experiences and how they linked the hospital's culture to accreditation performance could be identified. Nevertheless, the data are self-reported and as such is subject to potential bias.

Hospital accreditation was perceived as 'a timely opportunity' for the hospital to provide a proof to the public that the hospital was up to international standard of providing quality and safety in patient care. The whole hospital was committed to making changes to obtain the accreditation status. This perception is in line with the international literature that hospital accreditation impacts on organizational changes (Pomey et al., 2010) and that hospital accreditation leads to better organizational performance in the enhancement of the quality and safety of care (Greenfield & Braithwaite, 2008, Lutfiyya et al., 2009, Sekimoto et al., 2008). Our findings have implications for the HA to adopt hospital accreditation as a quality assurance mechanism for HA hospitals in Hong Kong. Adopting this mechanism will further demonstrate HA's commitment to continuously improve service quality and safety.

Hospital accreditation was perceived by all levels and grades of hospital staff as a stressful 'examination' leading to both physical and emotional exhaustion. The sources of stress included: the lack of any previous experience in the hospital accreditation, the need to have a formalized channel to clarify issues, limited human and material resources, and huge workload. Research shows that during and after hospital accreditation the perceived stress levels of those in managerial positions are high and may negatively impact on their physical and psychological well-being (Elkins et al., 2010). Our findings have implications for the HA to initiate stress management programs to help staff cope with the increased levels of job strain.

The psychological tension arisen from uncertainty and anxiety about the appropriate interpretation and demonstration of the achievement of accreditation criteria was common to all levels and grades of hospital staff. Although participants perceived that the training and support provided by the ACHS had been very useful, they were uncertain and anxious about whether they were on the right track because of lack of accreditation experience. The literature suggests that psychological tension is common among staff members who are new to a hospital accreditation scheme (Ratcliffe, 2009). Participants suggested the establishment of a formalized channel to exchange ideas with ACHS surveyors. They also perceived that whether the accreditation was awarded was dependent on the surveyors' interpretation. Research suggests that differences in what contributes to quality achievement exist among accrediting bodies (Shaw et al., 2010) and hospital staff of different grades (Huang & Li, 2010). Research also shows

that knowledge sharing networks relating to hospital learning curve with hospital accreditation and that this experience would ease future reaccreditation process.

Our findings have implications for the HA to show recognition to its staff and capitalize on their experience by establishing formalized systems such as appointing ‘Hospital Accreditation Advisors’ to encourage experience sharing so as to ease the psychological tension of hospital staff who are about to go through hospital accreditation.

Huge workload incurred from the accreditation but with inadequate resources was another perceived difficulty. Besides, some hospital staff believed that other major events (e.g., decanting) of the hospital occurring right before the accreditation added on extra tension. Indeed, resources must be allocated to priority areas in the era of healthcare cost containment and quality improvement is an area worth investing organizational energy (Ratcliffe, 2009). Research indicates that when examining the quality of healthcare of a hospital, organizational factors such as the size of the hospital, adequacy of workforce and the number of clinical services provided should be considered together with its efficiency (Harrison & Coppola, 2007). Our findings have implications for the HA to ensure commensurate allocation of resources, so that quality assurance mechanisms and processes are in place. It is also suggested that hospitals preparing for accreditation should avoid scheduling major events in a row with hospital accreditation.

Hospital staff identified three elements of the hospital’s culture that were of particular value to achieving good accreditation performance, including (1) strong staff involvement to a common goal, (2) strong leadership of the Hospital Chief Executive, and (3) strong team spirit. These elements coincide with HA’s core values of committed staff and team work. Our findings have implications for the HA hospitals to nurture these good elements of organizational culture so as to enhance organizational performance.

Regarding areas for follow-up or improvement, hospital staff’s perceptions indicate their strong commitment to enhancing quality and safety of services by suggesting follow-up actions to consolidate their learning and good practice from the accreditation exercise.

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附錄 B

醫管局嚴重醫療事件數目
(二零零九年四月一日至二零一一年三月三十一日)

須呈報的嚴重醫療事件		二零零九年四月一日至九月三十日	二零零九年十月一日至二零一零年三月三十一日	二零一零年四月一日至九月三十日	二零一零年十月一日至二零一一年三月三十一日	總計
1	錯誤爲病人或某身體部位進行外科手術／ 介入手術程序	**5**	**3**	**2**	**2**	**12**
2	因手術／介入手術程序後在病人體內遺留工具或其他物料	**6**	**10**	**2**	**9**	**27**
3	進行 **ABO** 血型不配合的輸血	**0**	**0**	**0**	**0**	**0**
4	錯誤處方藥物引致病人永久喪失主要功能或死亡	**0**	**0**	**1**	**0**	**1**
5	因出現血管內氣體栓塞而導致病人死亡或神經損害	**0**	**0**	**1**	**0**	**1**
6	住院病人自殺死亡(包括當時正暫時返家休養的病人)	**4**	**5**	**6**	**11**	**26**
7	在分娩過程或生產時發生嚴重事件引致孕婦死亡	**0**	**2**	**0**	**1**	**3**
8	錯配初生嬰兒或發生擄拐嬰兒事件	**0**	**0**	**0**	**0**	**0**
9	導致病人永久喪失主要功能或死亡的其他嚴重事故	**0**	**0**	**1**	**0**	**1**
	總計	**15**	**20**	**13**	**23**	**71**

資料來源：病人安全及風險管理部擬訂的嚴重醫療事件年報

THE ACHS EQuIP 4 HONG KONG GUIDE

醫院認證計劃
Hospital Accreditation

PART 1
Accreditation, standards, guidelines

衞生署
Department of Health

醫院管理局
HOSPITAL AUTHORITY

香港私家醫院聯會
The Hong Kong Private Hospitals Association

The Australian Council on Healthcare Standards

safety, quality, performance

EQuIP©4


EQuIP

The ACHS EQuIP4 Hong Kong Guide

November 2010

Published under licence from the Australian Council on Healthcare Standards by Steering Committee of Pilot Scheme on Hospital Accreditation

The EQuIP Guide:

First published	1996
Second edition	1998
Second edition revised	1999
Third edition	2002
Fourth edition	2006

The ACHS EQuIP 4 Hong Kong Guide

Part 1 – Accreditation, standards, guidelines

Foreword by Chairperson

Steering Committee on Hospital Accreditation, Hong Kong

The publication of this EQuIP4 Hong Kong Guide means that for the first time, Hong Kong has a set of evaluation criteria for accreditation, adapted from an internationally recognised source, that is suitable for use by all participating hospitals. Indeed, Hong Kong has set herself world best practice level as we pursue to enhance both the quality and safety of our hospitals through introduction of a territory-wide accreditation scheme. We are absolutely determined to bring real differences to the standard of hospital care that our people can expect in the 21st century.

My warmest congratulations go to everyone involved in this project, which is a wonderful illustration of what can be achieved through working in partnership. It embodies many achievements, of which the Steering Committee's Task Force on Standards, comprising members from both the public and private sectors, and patient representatives, can all be rightly proud.

Dr Gloria TAM, JP

Deputy Director of Health, Hong Kong SAR Government and
Chairman, Steering Committee on Hospital Accreditation

Message from Task Force on Standards

In the practice of Quality Management, good standards are extremely important. It is Juran, one of the legendary quality gurus, who stated that “without a standard there is no logical basis for making a decision or taking action.” Thus from the beginning the Task Force understood the importance and gravity of the tasks ahead.

Definitely the Task Force is working on solid foundations laid down by our expert colleagues in Australia. Our raw materials are the EQuIP 4 standards, written and well tested by the Australian Council on Healthcare Standards (ACHS). However, since these standards are to be applied to Hong Kong for hospital accreditation, we must ensure their relevance in the local setting. We are well aware that there can be immense differences between Australia and Hong Kong, not to mention the wide gaps that can exist between a basically western and oriental culture. As we begin, a key word that characterized our work is “meticulous”. Every word in the ACHS EQuIP 4 Guide is reviewed with “meticulous” care to assess its significance indigenously for our hospitals. Fortunately, the Task Force consists of very senior people, representing a wealth of experience in the local healthcare setting. Although appropriate evaluation of each EQuIP 4 standard, criterion and element can often be confidently made by the Task Force, outside experts will be consulted whenever there are questions or doubts. The aim is to be certain that most if not all frontline staff in our hospitals will find the requirements and recommendations in the ACHS standards fully comprehensible and relevant in their practice of caring for the patient.

In the review, the Task Force focused on three aspects, namely legality, adaptability and practicality in applying EQuIP 4 standards in Hong Kong. In terms of legality, great care was taken to ensure that the equivalent law in Hong Kong was included in the standards. Since some of local ordinances may sound alike but are not actual equivalents to those in Australia, meticulous reading was undertaken to ensure that only the relevant legislations were included in the Hong Kong Guide. On adaptability, the Task Force was well aware that the standards must apply to both the public and private sectors and be relevant irrespective of the size of the hospital in Hong Kong. Finally, on practicality, the Task Force had taken great care to eliminate jargons and terms that will be unfamiliar in Hong Kong. Moreover, the Task Force had taken into consideration and integrated local cultural factors, positive elements already existing (such the use of the ID card for identification) and strengths of the local healthcare system into the Hong Kong Guide. The most visible example was writing in the World Health Organization’s First and Second Patient Safety Challenges as actual standards- a first for such Challenges to be integrated into an accreditation system of a territory.

Finally, let me end with another quotation from a Japanese quality guru, Imai of Kaizen fame, who stressed that “There can be no improvements where there are no standards.” We sincerely hope that this EQuIP 4 Hong Kong Guide will serve as the basis for many beneficial quality improvement initiatives in our hospitals in the years ahead.

With the publication of this set Hong Kong Guide, we wish the hospital accreditation project every success!

Dr SETO Wing Hong

Chairman, Task Force on Standards

Contents

1. How to use this EQuIP guide

There is a great deal of information that organisations and individuals need to have about the Evaluation and Quality Improvement Program (EQuIP) of the Australian Council on Healthcare Standards (ACHS), to be able to use the program most effectively to improve care and services in their organisation.

Information needs differ from one group of users to another; for example, clinicians need a different degree of detail and type of information from an organisation's quality manager; EQuIP surveyors need information in a different format from an organisation's chief executive. In order to accommodate the varying information needs of different groups and in response to our members' request ***The ACHS EQuIP 4 Guide,*** is presented in four parts. When distributing the four parts of the guide, the ACHS will provide a magazine holder for appropriate storage.

The content of each part is as follows:

Part 1 Accreditation, standards, guidelines

- introduction to ACHS and EQuIP
- overview of the accreditation process
- overview of the standards review process
- the differences between EQuIP 3 and EQuIP 4 standards
- the full set of EQuIP 4 standards, criteria, elements and guidelines with references and readings
- glossary
- list of acronyms
- acknowledgements

Part 2 Standards

- overview of the intent of each standard
- standards, criteria and elements

Part 2 is a convenient tool for quality coordinators and ACHS surveyors, as it only contains the standards, criteria and elements. The guidelines for each standard are essential reading so that Part 1 is the tool of choice for understanding and implementing the standards.

Part 3 Suggestions for measuring performance

- overview of clinical indicators
- examples of organisational performance indicators for use by organisations in their evaluation efforts (categorised under each criterion).

1. How to use this EQuIP guide

Part 4 Implementing the Evaluation and Quality Improvement Program

- detailed accreditation information and support material to assist organisations in implementing quality systems
- the processes of accreditation

The detailed operating rules and flow charts, that are associated with the processes, will be available on the ACHS website for EQuIP members.

Additional resources will be available for EQuIP members only on the ACHS website – further readings, practical strategies for implementing quality improvement and risk management.

The document you are reading is **PART 1 – Accreditation, standards, guidelines.**

2.1 About the Australian Council on Healthcare Standards

The Australian Council on Healthcare Standards (ACHS) is an independent, not-for-profit organisation, dedicated to improving the quality of health care in Australia through the continual review of performance, assessment and accreditation. The ACHS was established in 1974 and is the leading independent authority on the measurement and implementation of quality improvement systems for Australian health care organisations.

The ACHS mission is to **'improve the quality and safety of health care'** and its vision is **'to be recognised nationally and internationally as the leading Australian organisation that independently assesses performance and promotes and improves the quality and safety of health care.'**

ACHS accreditation programs are based on partnerships and consultations with key stakeholders and participants from within the health care industry so that the standards and accreditation services reflect their needs and encourage ownership of the program.

The ACHS Council is comprised of individuals who represent peak industry bodies in health, professional colleges and associations, governments and consumers. The ACHS is governed by a board of directors elected by and from the Council members and supported by a corporate management structure that oversees the processes of standards development and evaluation of health services against those standards by professionally qualified surveyors.

The principles upon which all ACHS programs are developed and the characteristics displayed by an improving organisation are:

- a customer focus
- strong leadership
- a culture of improving
- evidence of outcomes
- striving for best practice.

These principles can be applied to every aspect of service within an organisation.

A Customer Focus – is an essential component of providing quality care, which:

- provides an ongoing understanding of the needs and expectations of present and potential consumers / patients
- ensures consumers / patients are the priority
- looks at the service from the consumer / patient perspective.

Strong Leadership – demonstrates responsibility and commitment to providing excellent care, quality improvement and performance. Effective leadership:

- provides direction for the organisation / health service
- ensures the creation of strategies, systems and methods for achieving excellence
- inspires and motivates the workforce and encourages employees to contribute, develop, learn, be innovative and creative.

2. Introduction

Continuous Improvement – management and staff continually strive to improve the quality of care. Continuous improvement is used to assist the organisation / health service to:

- understand that looking for ways to improve is an essential part of everyday practice
- achieve and maintain quality care that consistently meets consumer / patient needs
- monitor outcomes for improvement in consumer / patient care.

Outcomes – are identified and used to evaluate the quality of care. Organisations depend on the measurement and analysis of performance. Indicators should:

- provide critical data and information about key processes, outputs and results
- represent the factors that lead to improved health and / or quality of life for consumers / patients and improved operational performance.

Striving for Best Practice – the organisation compares its performance with or learns from others and applies best practice principles. This can lead to:

- discovering new techniques and technologies and using them to achieve world class levels of performance
- learning from others to increase the efficiency and effectiveness of processes
- improved consumer / patient outcomes.

2.2 What is Accreditation?

Accreditation is a formal process to ensure delivery of safe, high quality health care based on standards and processes devised and developed by health care professionals for health care services. It is public recognition of achievement by a health care organisation, of requirements of national health care standards.[1]
Accreditation systems are considered to comprise five key elements:[2]

1. A governance or stewardship function
2. A standards setting process
3. A process of external evaluation of compliance against those standards
4. A remediation or improvement process following the review
5. Promotion of continuous quality improvement

2.3 What is EQuIP?

EQuIP is the Evaluation and Quality Improvement Program developed and conducted by the Australian Council on Healthcare Standards (ACHS). It is a framework for managing health services to ensure quality and safe care and services and for achieving quality improvement. EQuIP was developed for use by Australian health services in 1996.

This Guide contains the standards, criteria, elements and guidelines that constitute the EQuIP 4 quality improvement program.

The ACHS Evaluation and Quality Improvement Program (EQuIP) is a four year quality assessment and improvement program for organisations / health services to work towards excellence in patient care and services. If this is achieved, accreditation will follow. It is designed to assist and support organisations / health services in their quality improvement efforts.

The key components of EQuIP are:

- the standards that organisations work towards achieving
- a yearly Self-Assessment undertaken by organisations to evaluate performance against the standards
- ACHS assistance and guidance of the organisation's Self-Assessment
- biennial onsite surveys by an external, experienced team of accreditation surveyors to provide an independent assessment of the organisation's performance against the standards
- the improvement process undertaken by organisations to address the recommendations from the onsite surveys.

References

1. Australian Council for Safety and Quality in Health Care (ACSQHC), 2006. Shared Meanings, Available at: http://www.safetyand quality.org/definition/smhome.htm
2. Australian Council for Safety and Quality in Health Care (ACSQHC). Standards Setting and Accreditation in Systems in Health, Consultation Paper. 2003.

2. Introduction

2.4 About Adaptation of EQuIP 4 Standards in Hong Kong

2.4.1 Why ACHS EQuIP 4 Guide needs local adaptation

The EQuIP 4 Standards are recognized by the International Society for Quality in Health Care (ISQua) and are used for accreditation in Australia and other countries, such as New Zealand, India, Saudi Arabia, etc. To enhance understanding of quality standards and accreditation process, ACHS has produced the EQuIP 4 Guide which has proven to be useful in Australian hospitals. However, in implementing the pilot scheme of hospital accreditation in Hong Kong (pilot scheme), it is envisaged that there are differences between Australia and Hong Kong as well as limitations and gaps in applying EQuIP 4 standards, criteria, elements and guidelines in the local situation. Hence, to ensure proper interpretation and adaptability of EQuIP 4 with reference to the local context, the Task Force on Standards was established under the Steering Committee on Hospital Accreditation to review all EQuIP 4 standards with a view to formulating the EQuIP 4 Hong Kong Guide for use by different stakeholders, including healthcare workers, hospital managers and surveyors, involved in the pilot scheme.

2.4.2 The Task Force on Standards

The key objective of the Task Force on Standards was to review, harmonize and adapt the EQuIP 4 standards, criteria, elements and guidelines for use in the local context. In brief, the terms of reference of the Task Force are as follows:

i. To assist surveyors in the interpretation of EQuIP 4 in local health care context.

ii. To identify local culture, practices and governing structure which are different to those described in EQuIP 4 standards.

iii. To enhance understanding of healthcare workers on relevance and applicability of EQuIP 4 standards to local hospital systems.

2.4.3 Local Adaptation of EQuIP 4 Standards

The Task Force had reviewed all EQuIP 4 standards, criteria, elements and guidelines focusing on:

i. Legality and practicability of EQuIP 4 in Hong Kong

ii. Relevance and applicability of EQuIP 4 standards, criteria, elements and guideline in both public and private sector hospitals

iii. Implementation details and experience sharing on hospital accreditation.

To uphold the principles of EQuIP 4, the Task Force had adopted the following approach in its review process:

(a) Replace Australian Acts by relevant Hong Kong Ordinances;

(b) Substitute Australian national policies or state-wide regulations by relevant local regulations to ensure adaptability and applicability in both public and private sectors in Hong Kong;

(c) Modify, replace, or list as references statements in the criteria, elements or guidelines that may not be applicable in local hospitals; and

(d) Incorporate strengths in local practices into the EQuIP 4 guidelines as additional statements in the supplementary information of the local guideline.

2.4.4 Review Process and Outcome

From July 2009 to April 2010, the Task Force on Standards had reviewed all the 45 criteria in EQuIP 4, harmonized all differences and reached consensus particularly on issues with major disparities. As a result, the Task Force had succeeded in formulating a full set of Hong Kong Guide.

The Hong Kong Guide has incorporated relevant publications, local guidelines and corporate-based policies in the reference section.

The Task Force had submitted the Hong Kong Guide with all modified criteria to ACHS Council for consideration and endorsement. With the approval by ACHS Council in November 2010, the Hong Kong Guide is now available for use by healthcare workers, hospitals and surveyors in Hong Kong.

2.4.5 How to use the Hong Kong Guide

For detail information on the Hong Kong Guide, please refer to a full copy of the "Guideline for Application of EQuIP 4 Standards in Hong Kong".

The Hong Kong Guide is of relevance to all Hong Kong hospitals intending to adopt the ACHS accreditation model. It can be used by surveyors, hospitals and healthcare workers as an official reference for performing self-assessment and demonstrating evidence of achievements in the accreditation process.

For local hospitals, the Guide serves as the Hong Kong version of EQuIP 4. It contains useful reference on relevant local ordinances, standards or policies and has incorporated practices which are unique in Hong Kong or different to Australia, such as employment, funding model and universal access to public hospitals.

For local and overseas surveyors, the Guide can serve as a reference document to illustrate local differences in law, systems, policies or practices which are acceptable or comparable with requirements set in EQuIP 4. It can facilitate surveyors' assessment and evaluation in the knowledge that the Guide is equally applicable in organizations under the purview of the Hospital Authority (HA), Department of Health (DH) and Private Hospital Association (PHA).

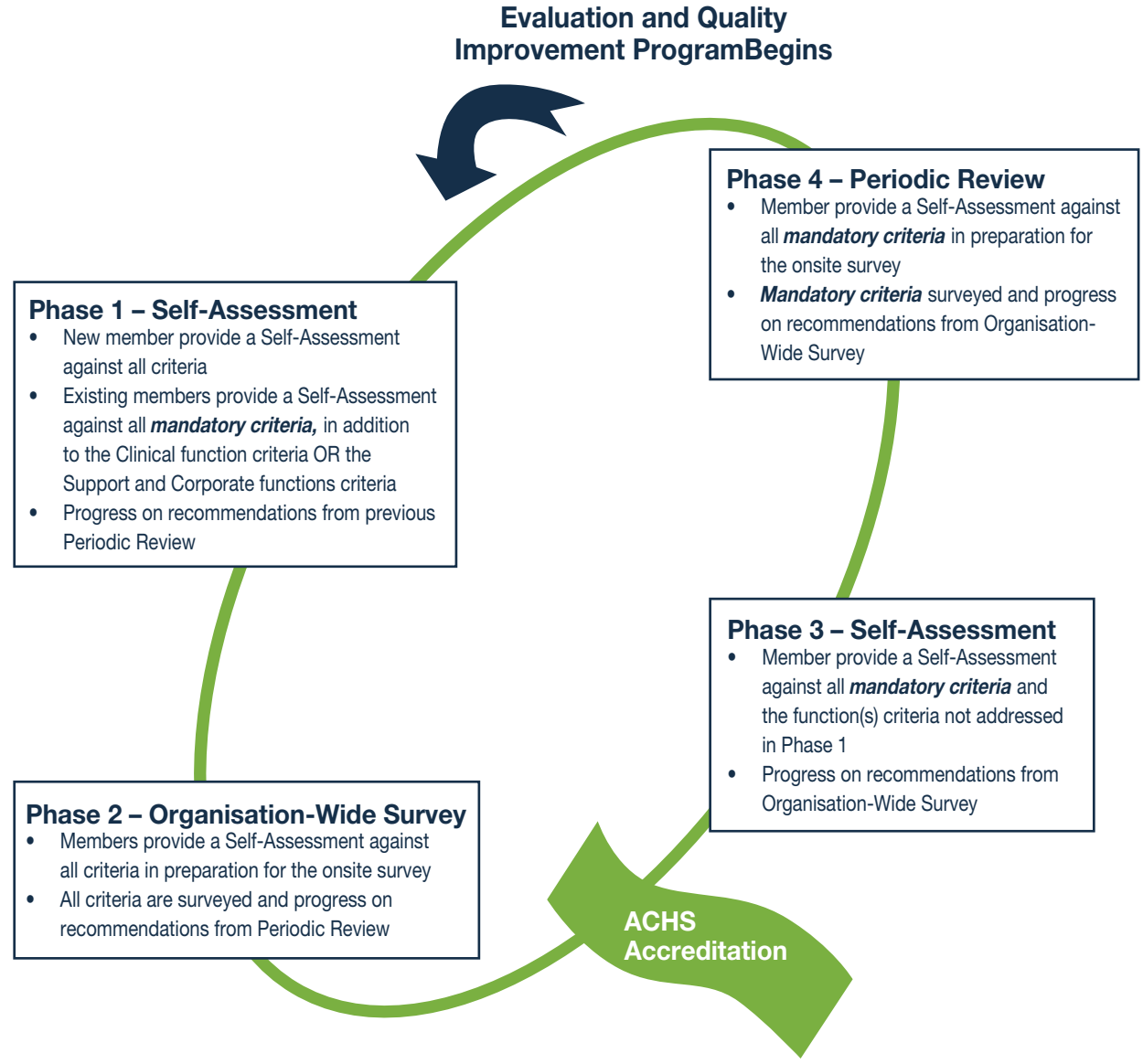
For hospital staff, the Guide provides a comprehensive interpretation of all 45 criteria and related elements and facilitates understanding as to how organisations and surveyors would be rated on the 5 levels of achievement in each criterion based on conditions or evidence required by EQuIP 4. In the approach to accreditation, it is particularly important for staff to understand the description of each criterion or element in the context of local culture, practice and regulation.

3. An overview of the Evaluation and Quality Improvement Program (EQuIP)

The following information provides an outline of the various components of the ACHS EQuIP accreditation processes in which member organisations participate. The full details of the accreditation process and requirements are provided in ***Part 4 of the EQuIP 4 Guide – Implementing the Evaluation and Quality Improvement Program.***

A graphical representation of the cycle of events in which health care organisations participate during a four year ACHS membership period is shown below.

EQuIP Cycle



EQuIP is a four year program with at least one activity per year.

3. An overview of the Evaluation and Quality Improvement Program (EQuIP)

3.1 The Self-Assessment

A **Self-Assessment** using the framework of the EQuIP standards, criteria and elements enables an organisation to identify what they are doing and how well they are doing it. The Self-Assessment provides a gap analysis that the organisation can use as a basis for planning. It also identifies opportunities for improvement and provides the starting point for an organisation to achieve improved practice. In the Self-Assessment, organisations rate each criterion and summarise their evidence to support the rating. This review of the entire organisation's performance provides a baseline upon which the organisation can continue to improve.

The Self-Assessment also provides the foundation of both the Organisation-Wide Survey (OWS) and the Periodic Review (PR). It allows surveyors to gain a good understanding of the organisation's systems before arriving onsite, thereby reducing the time spent on orientation within the organisation. If the documentation is clear and succinct, the verification process is much more efficient for surveyors.

During a four year EQuIP cycle, in addition to the pre-survey Self-Assessments required before the OWS and PR (phases two and four), an organisation will complete two Self-Assessments (phases one and three). These Self-Assessments will address all mandatory criteria and recommendations from the previous survey. In addition, one Self-Assessment will address the Clinical funtion criteria and the alternate Self-Assessment will address the Support and Corporate functions criteria.

3.2 Organisation-Wide Survey (OWS)

Within the four year EQuIP cycle, there are two onsite surveys. The first of these is the Organisation-Wide Survey. The aims of the Organisation-Wide Survey are:

- to verify the Self-Assessment of the organisation
- to conduct an external peer assessment of the organisation
- to review the progress of recommendations given at a previous survey
- to provide feedback and advice to the organisation to assist with improvement implementation
- to award accreditation.

The OWS involves the review of progress and achievement of the organisation against all the EQuIP criteria that have been determined to be relevant to that organisation. (Refer to 4.9 Not Applicable criteria)

3.3 Periodic Review (PR)

The Periodic Review is an onsite survey conducted in the fourth phase of the EQuIP cycle.
The aims of the Periodic Review are:

- to verify maintenance of levels of consumer / patient care
- to ensure that organisations maintain momentum for continuous quality improvement beyond the Organisation-Wide Survey
- to assess progress against recommendations from the previous Organisation-Wide Survey
- to adjust accreditation status if necessary.

At the Periodic Review the organisation is surveyed against all the mandatory criteria and progress of the recommendations from the Organisation-Wide Survey are assessed.

4.1 Review of the Standards

The ACHS Board reviews its programs every four years to ensure that they remain current, evidence based and applicable. The EQuIP 3rd edition was reviewed during 2005 and 2006. EQuIP 4 is the result of that review.

The intent of the review was to:

- identify and respond to the most recent evidence on the best ways to provide and improve health services
- identify and fill any gaps that exist in the standards as a result of the increased awareness, availability of evidence and knowledge of quality systems in recent years
- increase the focus of the EQuIP program on the clinical care that is provided in health services
- enhance attention to consumer participation and acceptability
- improve the readability of the standards, criteria and elements.

The review process involved:

- an extensive review of the relevant literature
- a comparison of the EQuIP standards and criteria with those of the United Kingdom, Canada, the USA, New Zealand, Ireland, France and Japan
- the establishment of working groups, reference groups and expert advisory groups to consult on and determine best practice
- the conduct of focus groups and other consultative forums
- evaluation of the 3rd edition standards
- the development of a number of new standards and criteria
- a field review (invited formal feedback from members and stakeholders)
- a pilot process in 16 health care organisations of various sizes, location (state / territory, metropolitan / rural), role (eg community / acute) and health sector type (public / private).

The review was undertaken with the understanding that the standards and criteria must be as applicable as possible, to all types of health services in Australia. These include day procedure centres, acute care, community health, rehabilitation services, mental health services, metropolitan, rural, remote, public, private, small and large health services.

In order to achieve this, the standards and criteria need to be sufficiently generic to identify what is required but also to allow for interpretation by each health service. In addition, the standards need to be sufficiently detailed to provide guidance to health services and accreditation surveyors about the definitive requirements of the standard. Each organisation will implement the elements in a way that best suits the manner in which they deliver care. What is important is that organisations are able to demonstrate how they have addressed the intent of the element – its aim, its purpose – and that the evidence of this is easily identified.

4. EQuIP standards review

4.2 The Standards Framework

The standards in EQuIP 4 focus on issues considered to be the most important in providing high quality and safe health care.

The ACHS standards are developed in consultation with the health care industry and address all aspects of the health care organisation.

The ACHS standards are structured in a hierarchy, as follows:

- Functions
- Standard
- Criteria
- Elements
- Guidelines.

Function

A ***function*** is a group of standards.

Standard

The ***standard*** describes the overall goal; for example, ***consumers / patients are provided with high quality care throughout the care delivery process.***

Criteria

The criteria describe key components of the goal, that are necessary for meeting the goal; for example, ***planning care with patients, families and carers and working in partnership with them to achieve the best possible results.***

Element

For each criterion there is a series of ***elements.*** Each element identifies what should be in place to at least achieve the criterion at a certain rating level (please refer to rating guidelines later in this section).

Guidelines

The ***guidelines*** give definitions and provide more information and guidance on achieving the standards at the criterion level.

Structure of the standard

Table 4.2 is an example of the structure of a standard. The ACHS standards have a unique format that identifies all the levels of achievement of that criterion. The layout enables the reader to easily visualise the steps required for improvement and a higher level of achievement, as the reader moves from left to right across the page(s).

Standard 1.1. Consumers / patients are provided with high quality care throughout the care delivery process.

Criterion	Little Achievement LA Awareness	Some Achievement SA Implementation	Moderate Achievement MA Evaluation	Extensive Achievement EA Excellence	Outstanding Achievement OA Leadership
1.1.2 Care is planned and delivered in partnership *with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.* This is a mandatory criterion	a) Evidence-based guidelines on care planning and delivery are available. b) Care is provided in response to consumer / patient needs in a timely manner and in accordance with established policies and procedures. c) A comfortable and caring environment is provided for consumers / patients.	a) Care planning and delivery are based on the assessment of the consumer / patient needs and with the consumer / patient and, when relevant, their carer. b) All care planning, decisions, actions and changes are documented in the consumer / patient healthrecord. c) Care is delivered by skilled and trained individuals within a competent multidisciplinary team with an identified team leader. d) A system exists for the effective identification and management of a deteriorating consumer / patient. e) Consumers / patients and carers, when appropriate, are given information that allows them to understand their care. f) There is evidence that the consumer / patient has been provided with information on care delivery options.	a) The care planning and delivery processes are evaluated and improved as required. b) Policies and procedures for care delivery are evaluated against evidence, professional guidelines, codes of practice and medico-legal requirements. c) Multidisciplinary team processes for care delivery are evaluated and improved as required. d) The environment in which care is provided is evaluated and improved as required. e) A system for the effective identification and management of a deteriorating patient is evaluated and improved as required.	a) Care planning and delivery practices, together with data on variances are compared with internal and external systems and improvements are made, to ensure better practice. and / or b) Multidisciplinary team work is compared with other health services and / or industries and improvements are made to ensure better practice. and / or c) The organisation undertakes research relevant to care planning and the delivery of care and acts on results.	a) The organisation demonstrates it is a leader in care planning and delivery practices.

Table 4.2 - Standards structure example – Clinical – Criterion 1.1.2

4. EQuIP standards review

4.3 Criterion Achievement Ratings

4.3.1 Ratings

Each of the 45 EQuIP 4 criteria identifies the five levels of achievement.

Level 1 Little Achievement (LA)

Organisations that achieve an LA rating will have an **awareness** or knowledge of responsibilities and systems that need to be implemented but may have only basic systems in place. At this level there will be compliance with legislation and policy that relates to the criterion.

Level 2 Some Achievement (SA)

An organisation that achieves an SA rating will have achieved all the elements of LA and will have **implemented systems** for the organisation's activities. At this level there is very little or no monitoring of outcomes or efforts at continuous improvement.

Level 3 Moderate Achievement (MA)

An MA rating requires that all the elements of LA and SA have been achieved and that efficient systems in collecting relevant outcome data, monitoring, **evaluation** procedures and methods of improvement are in place.

Level 4 Extensive Achievement (EA)

To achieve a rating of EA in the EQuIP 3rd edition, organisations were required to benchmark their performance against other organisations or internally, in order to demonstrate extensive achievement. In the EQuIP 4 program, **all the elements in LA, SA and MA must be achieved** but in addition EQuIP 4 recognises that extensive achievement can be demonstrated in other ways.

Organisations will be able to demonstrate extensive achievement in a criterion if they satisfy one or more of the following requirements:

- internal or external **benchmarking** and subsequent system improvement, and / or
- the conduct of **research** that relates to that particular criterion, and / or
- the implementation of what would be considered to be **advanced systems** that relate to that criterion, and / or
- proven, **excellent outcomes** in that particular criterion.

Some organisations may be able to demonstrate achievement in more than one of these elements.

Level 5 Outstanding Achievement (OA)

The **elements of LA, SA, MA and EA must be achieved** as well as a demonstration of **leadership** in this criterion. Leadership in a criterion does not necessarily mean that the organisation is the best in Australia. It may mean that the organisation can demonstrate that it is one of the best or is outstanding amongst its peers.

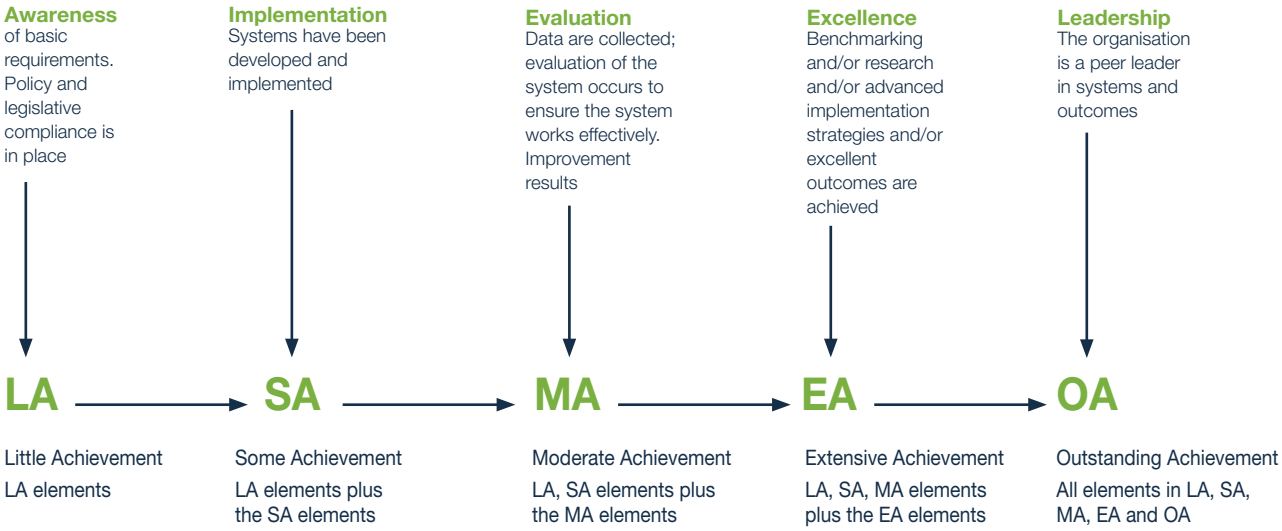
4.3.2 How should organisations and surveyors rate achievement?

Organisations and surveyors will use the elements in each of the criteria to rate the level of the organisation's achievement. The elements are not meant to be an audit checklist; they describe the practices that contribute to the achievement of each level. The manner in which the elements are implemented may differ from organisation to organisation. **What is important is that the organisation can demonstrate that their practices address the intent of the element – its aim, its purpose.**

Elements:

- explain the criteria
- describe some important practices for each level of achievement
- allow an organisation to undertake additional activities and do not limit practices
- are not just a checklist of compliance but prompt the question, **'how good is the practice'?**
- provide direction for improvement activities and for achieving better practice.

The following diagram (4.3.2) will assist organisations to better understand how the elements can assist rating. Surveyors will use this model when assigning ratings for organisations.



4.3.3 Evaluation

The Moderate Achievement (MA) rating in each of the 45 criteria requires that organisations evaluate their systems. The purpose of this is to ensure the system that the organisation has implemented works effectively. This applies not only to the evaluation of clinical systems but also to the evaluation of policy and programs.

Evaluation is judging the value of something by gathering valid information about it in a systematic way and by making a comparison. The purpose of evaluation is to help the user of the evaluation to decide what to do, or to contribute to scientific knowledge.[1]

There are many different methods of evaluation that can be used in health services. The evaluation that is required by health care organisations to achieve an MA rating does not have to involve conventional research processes.

For example, Øvretveit also provides a detailed description of the various methods of evaluation and the steps required for each method. The methods are specifically for use by clinicians, health care professionals and managers in health services.

'Action evaluation'

As the name suggests, action evaluation collects data about an intervention and its effects, and uses comparison to help users to judge the value of the intervention and to decide what future action should be taken. Action evaluation is collaborative, it involves the collection of relevant data, it usually gathers people's opinions, is carried out in a short timeframe and provides useful information upon which action can be taken for improvement.[2]

4.3.4 Benchmarking

Benchmarking is, 'the continuous measurement of a process, product, or service compared to those of the toughest competitor, to those considered industry leaders, or to similar activities in the organisation in order to find and implement ways to improve it. This is one of the foundations of both total quality management and continuous quality improvement. Internal benchmarking occurs when similar processes within the same organisation are compared.'[3]

If an organisation participates in benchmarking activities it is important to complete the requirements of a proper benchmarking exercise; that is, not only to compare processes and outcomes but to institute improvements.

If comparative data are not readily available, organisations can work together to identify definitions for the collection for systems they have in common. Benchmarking partners can be found from organisations that have similar service types, similar casemix or are of a similar size. Improvements from benchmarking result in superior systems being in place.

4.3.5 Advanced implementation strategies

A rating of Some Achievement (SA) requires organisations to have implemented systems for achieving that criterion. The requirement for SA is not complex and the systems required are fundamental. However, if an organisation implements systems that are evidence based and considered to be more than is required for providing quality health services, such achievement will be recognised as being Extensive Achievement (EA). Advanced implementation strategies may include for example, the implementation of an individual consumer / patient supply system in criterion 1.5.1 (medication management) and innovative processes which prepare for any disaster in criterion 3.2.4 (emergency and disaster management).

4.3.6 Research

One of the ways in which it is possible for an organisation to demonstrate Extensive Achievement (EA) in a criterion is to undertake research.

Research is defined as 'diligent and systematic inquiry or investigation into a subject in order to discover facts or principles'.[4]

An organisation will be recognised for its research if that research relates to the criterion. The term 'research' is also used to describe the collection of information about a particular subject. Such activity would not be sufficient for the rating of EA.

4.3.7 How to achieve OA

The requirement for achieving the level Outstanding Achievement (OA) is a demonstration of **leadership** in that criterion. Leadership does not necessarily mean that the organisation is the best in Australia. It may mean that the organisation can demonstrate that it is the best or is outstanding amongst peers. If an organisation believes that it is a leader in a criterion, the organisation provides surveyors with a brief (one page) submission summarising the steps taken to achieve this and proof that the organisation is considered to be a leader. Surveyors will then evaluate the submission and the evidence provided and determine whether an OA can be awarded. Surveyors may also award an OA rating without a self-rating of OA. The surveyors together with the organisation will develop a one page summary describing the leadership status which will be included in the survey report. Such summaries can be used as examples of leadership activities by the organisation and by the ACHS if the organisation agrees. To achieve an OA all the elements in the EA that are applicable need to be met.

4. EQuIP standards review

4.4 Using the Standards to Continually Improve Patient Care

Using the standards and criteria effectively will assist an organisation to:

- evaluate the organisation's performance
- undertake needs analyses
- identify the major areas for achievement of the criterion
- identify gaps in the quality of the care delivered
- identify opportunities for improvement.

4.5 EQuIP 4 Standards

EQuIP 4 edition has 3 functions, 13 standards, and 45 criteria:

Function 1 – Clinical

6 standards

- Continuity of care
- Access
- Appropriateness
- Effectiveness
- Safety
- Consumer focus

Function 2 – Support

5 standards

- Quality improvement and risk management
- Human resources management
- Information management
- Population health
- Research

Function 3 – Corporate

2 standards

- Leadership and management
- Safe practice and environment

Table 4.5 following identifies at a glance, the three functions, the 13 standards (colour highlighted) and each of the 45 criteria.

1. CLINICAL	2. SUPPORT	3. CORPORATE
1.1 Consumers / patients are provided with high quality care throughout the care delivery process	**2.1 The governing body leads the organisation in its commitment to improving performance and ensures the effective management of corporate and clinical risks.**	**3.1 The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services.**
1.1.1 The assessment system ensures current and ongoing needs of the consumer / patient are identified.	*2.1.1 The organisation's continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.*	3.1.1 The organisation provides quality, safe care through strategic and operational planning and development.
1.1.2 Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.	*2.1.2 The integrated organisation-wide risk management policy and system ensure that corporate and clinical risks are identified, minimised and managed.*	3.1.2 Governance is assisted by formal structures and delegation practices within the organisation.
1.1.3 Consumers / patients are informed of the consent process, understand and provide consent for their health care.	*2.1.3 Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.*	*3.1.3 Processes for credentialling and defining the scope of clinical practice support safe, quality health care.*
1.1.4 Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.	**2.2 Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff.**	3.1.4 External service providers are managed to maximise quality care and service delivery.
1.1.5 Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.	2.2.1 Human resources planning supports the organisation's current and future ability to address needs.	*3.1.5 Documented corporate and clinical policies assist the organisation to provide quality care.*
1.1.6 Systems for ongoing care of the consumer / patient are coordinated and effective.	2.2.2 The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation.	**3.2 The organisation maintains a safe environment for employees, consumers / patients and visitors.**
1.1.7 Systems exist to ensure that the care of dying and deceased consumers / patients is managed with dignity and comfort.	2.2.3 The continuing employment and performance development system ensures the competence of staff and volunteers.	*3.2.1 Safety management systems ensure safety and wellbeing for consumers / patients, staff, visitors and contractors.*
1.1.8 The health record ensures comprehensive and accurate information is recorded and used in care delivery.	2.2.4 The learning and development system ensures the skill and competence of staff and volunteers.	3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.
1.2 Consumers / patients / communities have access to health services and care appropriate to their needs.	2.2.5 Employee support systems and workplace relations assist the organisation to achieve its goals.	3.2.3 Waste and environmental management supports safe practice and a safe environment.
1.2.1 The community has information on, and access to, health services and care appropriate to its needs.	**2.3 Information management systems enable the organisation's goals to be met.**	*3.2.4 Emergency and disaster management supports safe practice and a safe environment.*
1.2.2 Access and admission to the system of care is prioritised according to clinical need.	2.3.1 Records management systems support the collection of information and meet the organisation's needs.	3.2.5 Security management supports safe practice and a safe environment.
1.3 Appropriate care and services are provided to consumers / patients.	2.3.2 Information and data management and collection systems are used to assist in meeting the strategic and operational needs of the organisation.	
1.3.1 Health care and services are appropriate and delivered in the most appropriate setting.	2.3.3 Data and information are used effectively to support and improve care and services.	
1.4 The organisation provides care and services that achieve expected outcomes.	2.3.4 The organisation has an integrated approach to the planning, use and management of information and communication technology (I&CT).	
1.4.1 Care and services are planned, developed and delivered based on the best available evidence and in the most effective way.	**2.4 The organisation promotes the health of the population.**	
1.5 The organisation provides safe care and services.	2.4.1 Better health and wellbeing for consumers / patients, staff and the broader community are promoted by the organisation.	
1.5.1 Medications are managed to ensure safe and effective practice.	**2.5 The organisation encourages and adequately governs the conduct of health and medical research to improve the safety and quality of health care.**	
1.5.2 The infection control system supports safe practice and ensures a safe environment for consumers / patients and health care workers.	2.5.1 The organisation's research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research.	
1.5.3 The incidence and impact of pressure ulcers are minimised through a pressure ulcer prevention and management strategy.		
1.5.4 The incidence of falls and fall injuries is minimised through a falls management program.		
1.5.5 The system for prescription, sample collection, storage and transportation and administration of blood and blood components ensures safe and appropriate practice.		
1.5.6 The organisation ensures that the correct patient receives the correct procedure on the correct site.		
1.6 The governing body is committed to consumer participation.		
1.6.1 Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service.		
1.6.2 Consumers / patients are informed of their rights and responsibilities.		
1.6.3 The organisation makes provision for consumers / patients from culturally and linguistically diverse backgrounds and consumers / patients with special needs.		

Key:

	EQuIP 4 standards

Table 4.5

4.6 The Three EQuIP 4 Functions

The purpose of the arrangement of the standards and criteria into the three functions of Clinical, Support and Corporate is to clearly identify the fundamental responsibilities of the key provider groups in health services.

- The Clinical function sets out the standards that are mostly associated with clinical care. Achievement of these standards is mostly the responsibility of clinicians.
- The Corporate function identifies those standards and criteria for which the governors of the organisation are mostly responsible.
- The Support function contains those standards and criteria on which all providers should work together to achieve.

The arrangement of the functions in EQuIP 4 also provides a basic model for understanding corporate and clinical governance. **Corporate governance**[5] is understood to be the system by which organisations are directed and controlled and held to account. **Clinical governance**[5] involves an understanding and acceptance that the governing body has a responsibility for the quality of care delivered by a service and that this accountability is shared equally with the clinicians providing this care.

The two left hand functions (Table 4.5), Clinical and Support, represent clinical governance. The two right hand functions (Table 4.5) of Support and Corporate represent corporate governance.

It is recognised that after 10 years of using EQuIP, organisations may have structured their operations around the previous EQuIP functions. All of the EQuIP 3 functions are still readily identifiable in EQuIP 4. A coloured table showing the relationship between EQuIP 3 and EQuIP 4 functions is available on the ACHS website: www.achs.org.au, Downloads and Publications.

4.7 New Criteria or Elements

New criteria have been introduced to ensure that EQuIP 4:

- incorporates the most recent evidence on the best ways to provide and improve health services
- fills gaps that existed in the standards as a result of the increased awareness, availability of evidence and knowledge of quality systems in recent years
- increases the focus on the clinical care that is provided in health services
- enhances attention to consumer participation and acceptability.

Table 4.7(a) lists the new criteria, some new elements and an explanation of their development for EQuIP 4.

New criterion or element	Comments
1.1.2 SA (d) A system exists for the effective identification and management of a deteriorating consumer / patient.	Research suggests that better outcomes will be achieved if signs of deterioration are recognised and the consumer / patient is treated to reduce the likelihood that an arrest will occur.
1.1.6 Systems for **ongoing care** of the consumer / patient are coordinated and effective.	The continuum has been extended from the immediate post-discharge care and liaison to the ongoing care of consumers / patients particularly those where there are multiple service providers, and those with chronic illnesses. This criterion is particularly relevant to the community setting. *This criterion may not be applicable to some organisations.*
1.1.7 Systems exist to ensure that the **care of dying and deceased** consumers / patients is managed with dignity and comfort.	This addition to continuity of care, where applicable, will ensure quality care and management of consumers / patients and their families / familial group, at the end of life. *This criterion may be not applicable to some organisations.*
1.3.1 Health care and services are **appropriate** and delivered in the most appropriate setting.	Appropriateness is one of the nine dimensions of quality. Appropriateness is the provision of the right treatment, intervention or service in the right way. *This is a developmental criterion and performance will not contribute to the accreditation result for four years from January 2007.*
1.4.1 Care and services are planned, developed and delivered based on the **best available evidence and in the most effective way.**	Effectiveness is one of the nine dimensions of quality. Effectiveness is the extent to which treatments, interventions or services achieve the desired outcomes.
1.5.1 **Medications are managed** to ensure safe and effective practice.	The patient safety agenda has developed significantly in recent years and has grown to encompass many aspects of quality. Standard 1.5 focusses on the five most common causes of harm in western health services. The intent of this criterion is to: • reduce the incidence of error in the prescription and administration of medications to consumers / patients • reduce the level of harm caused to consumers / patients in health care organisations by medication errors. *This criterion may not be applicable to some organisations.*
1.5.3 The incidence and impact of **pressure ulcers** are minimised through a pressure ulcer prevention and management strategy.	The intent of this criterion is to: • minimise the incidence of pressure ulcers • effectively manage pressure ulcers when they do exist. *This criterion may not be applicable to some organisations.*
1.5.4 The incidence of **falls and fall injuries** is minimised through a falls management program.	The intent of this criterion is to: • whenever possible, prevent falls from occurring • when fall prevention is not possible, prevent injury from the fall.
1.5.5 The system for prescription, sample collection, storage and transportation and administration of **blood and blood components** ensures safe and appropriate practice.	The intent of this criterion is to ensure that there is an effective system for ensuring that all aspects of the management of blood are safe and appropriate. *This criterion may be not applicable to some organisations.*
1.5.6 The organisation ensures that the **correct patient** receives the **correct procedure** on the **correct site.**	The intent of this criterion is to ensure that the organisation implements steps to make certain that the indicated procedure is performed on the correct patient and at the correct site and where applicable, with the correct implant. *This criterion may not be applicable to some organisations.*

New criterion or element	Comments
1.6.3 The organisation makes provision for consumers / patients from **culturally and linguistically diverse backgrounds** and consumers / patients with **special needs.**	The EQuIP 3rd edition standard 2.4 in Leadership and Management (Consumer Participation) has been divided into three criteria and moved to the Clinical function. A third criterion has been added to focus on the cultural and special needs of consumers / patients.
2.1.3 Health care **incidents, complaints and feedback** are managed to ensure improvements to the systems of care.	Incidents were previously covered in the EQuIP 3rd edition in the risk management standard 2.2, Leadership and Management. Complaints were part of the criterion that related to consent, rights & responsibilities and complaints, in EQuIP 3rd edition criterion 2.4.2. The content of this criterion therefore is not new but a new criterion has been created combining the management of the three issues.
2.4.1 **Better health and wellbeing** for consumers / patients, staff and the broader community are promoted by the organisation.	This criterion provides a focus on health promotion that was only implied in 'service provision' in EQuIP 3rd edition criterion 1.1.1, Continuum of Care. The intent is to ensure that all health care organisations take responsibility for promoting the health and wellness of their consumers / patients and where relevant, the health of the community they serve.
2.5.1 The organisation's **research program** promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research.	This new criterion has greatly expanded the EQuIP 3rd criterion 2.4.1 MA (d) which stated that research projects needed to be consistent with national guidelines. The intent of the research standard is: • to ensure that if health care organisations engage in clinical or health services research, the research is governed effectively, in accordance with acceptable guidelines and standards • to encourage organisations to participate in research to further the evidence available to health care organisations for providing high quality care. *This criterion would not be applicable to organisations that are not conducting research programs.*
3.1.3 Processes for **credentialling and defining the scope of clinical practice** support safe, quality health care.	Credentialling was an element (3.1.2 LA [d]) in the mandatory criterion on recruitment in EQuIP 3rd edition. The focus on credentialling has been expanded into a stand-alone criterion. It is based on the national credentialling standard. The intent is to ensure that the required structures and processes are in place for effectively managing the credentialling process and for defining the scope of practice. It includes the safe introduction of new interventions.

(Continued)

4.7 New Criteria or Elements

Table 4.7 (b) shows the new criteria in EQuIP 4 and highlights that the majority of standards remain similar to those in EQuIP 3rd edition. Criteria 2.1.3 and 3.1.3 are newly created but the content was part of the EQuIP 3rd edition criteria and elements.

Table 4.7 (c) is a linkage document that shows how the EQuIP 3rd edition criteria link to the EQuIP 4 criteria.

1. CLINICAL	2. SUPPORT	3. CORPORATE
1.1 Consumers / patients are provided with high quality care throughout the care delivery process.	**2.1 The governing body leads the organisation in its commitment to improving performance and ensures the effective management of corporate and clinical risks.**	**3.1 The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services.**
1.1.1 The assessment system ensures current and ongoing needs of the consumer / patient are identified.	*2.1.1 The organisation's continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.*	3.1.1 The organisation provides quality, safe care through strategic and operational planning and development.
1.1.2 Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.	*2.1.2 The integrated organisation-wide risk management policy and system ensure that corporate and clinical risks are identified, minimised and managed.*	3.1.2 Governance is assisted by formal structures and delegation practices within the organisation.
1.1.3 Consumers / patients are informed of the consent process, understand and provide consent for their health care.	*2.1.3 Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.*	*3.1.3 Processes for credentialling and defining the scope of clinical practice support safe, quality health care.*
1.1.4 Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.	**2.2 Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff.**	3.1.4 External service providers are managed to maximise quality care and service delivery.
1.1.5 Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.	2.2.1 Human resources planning supports the organisation's current and future ability to address needs.	*3.1.5 Documented corporate and clinical policies assist the organisation to provide quality care.*
1.1.6 Systems for ongoing care of the consumer / patient are coordinated and effective.	2.2.2 The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation.	**3.2 The organisation maintains a safe environment for employees, consumers / patients and visitors.**
1.1.7 Systems exist to ensure that the care of dying and deceased consumers / patients is managed with dignity and comfort.	2.2.3 The continuing employment and performance development system ensures the competence of staff and volunteers.	*3.2.1 Safety management systems ensure safety and wellbeing for consumers / patients, staff, visitors and contractors.*
1.1.8 The health record ensures comprehensive and accurate information is recorded and used in care delivery.	2.2.4 The learning and development system ensures the skill and competence of staff and volunteers.	3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.
1.2 Consumers / patients / communities have access to health services and care appropriate to their needs.	2.2.5 Employee support systems and workplace relations assist the organisation to achieve its goals.	3.2.3 Waste and environmental management supports safe practice and a safe environment.
1.2.1 The community has information on, and access to, health services and care appropriate to its needs.	**2.3 Information management systems enable the organisation's goals to be met.**	*3.2.4 Emergency and disaster management supports safe practice and a safe environment.*
1.2.2 Access and admission to the system of care is prioritised according to clinical need.	2.3.1 Records management systems support the collection of information and meet the organisation's needs.	3.2.5 Security management supports safe practice and a safe environment.
1.3 Appropriate care and services are provided to consumers / patients.	2.3.2 Information and data management and collection systems are used to assist in meeting the strategic and operational needs of the organisation.	
1.3.1 Health care and services are appropriate and delivered in the most appropriate setting.	2.3.3 Data and information are used effectively to support and improve care and services.	
1.4 The organisation provides care and services that achieve expected outcomes.	2.3.4 The organisation has an integrated approach to the planning, use and management of information and communication technology (I&CT).	
1.4.1 Care and services are planned, developed and delivered based on the best available evidence and in the most effective way.	**2.4 The organisation promotes the health of the population.**	
1.5 The organisation provides safe care and services.	2.4.1 Better health and wellbeing for consumers / patients, staff and the broader community are promoted by the organisation. Table 4.7 (b)	
1.5.1 Medications are managed to ensure safe and effective practice.	**2.5 The organisation encourages and adequately governs the conduct of health and medical research to improve the safety and quality of health care.**	
1.5.2 The infection control system supports safe practice and ensures a safe environment for consumers / patients and health care workers.	2.5.1 The organisation's research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research.	
1.5.3 The incidence and impact of pressure ulcers are minimised through a pressure ulcer prevention and management strategy.		
1.5.4 The incidence of falls and fall injuries is minimised through a falls management program.		
1.5.5 The system for prescription, sample collection, storage and transportation and administration of blood and blood components ensures safe and appropriate practice.		
1.5.6 The organisation ensures that the correct patient receives the correct procedure on the correct site.		
1.6 The governing body is committed to consumer participation.		
1.6.1 Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service.		
1.6.2 Consumers / patients are informed of their rights and responsibilities.		
1.6.3 The organisation makes provision for consumers / patients from culturally and linguistically diverse backgrounds and consumers / patients with		

Key:

	New Criteria

Table 4.7 (b)

4. EQuIP standards review

Table 4.7(c1) Comparative Table – ACHS EQuIP 4th edition to 3rd edition

Standard / Criterion / Topic 4th Edition	4th Edition Criterion Number	3rd Edition Criterion Number
CLINICAL FUNCTION		
CONTINUITY OF CARE	**1.1**	
Assessment system	*1.1.1*	1.2.1
Planned & delivered in partnership with consumer / patient	*1.1.2*	1.3.1
Consent	*1.1.3*	2.4.2
Care evaluation	*1.1.4*	1.3.2
Discharge and transfer of care	*1.1.5*	1.4.1
Ongoing care and management of chronic disease	1.1.6	New
Decision making at end of life	1.1.7	New
Health record	*1.1.8*	4.1.1
ACCESS	**1.2**	
Information about services	1.2.1	1.1.1
Access is appropriate to needs and prioritised according to clinical need	1.2.2	1.1.3
APPROPRIATENESS	**1.3**	
The right care and services are provided in the right setting	1.3.1	New
EFFECTIVENESS	**1.4**	
Care and services are best evidence based and processes are effective	1.4.1	New
PATIENT SAFETY	**1.5**	
Medication safety	1.5.1	New
Infection control	*1.5.2*	5.1.3
Pressure ulcer prevention and management	1.5.3	New
Falls prevention and management	1.5.4	New
Blood management	1.5.5	New
Correct patient, procedure, site	1.5.6	New
CONSUMER FOCUS	**1.6**	
Involvement of consumers	1.6.1	2.4.1
Rights and responsibilities	1.6.2	2.4.2
Cultural and special needs	1.6.3	New
SUPPORT FUNCTION		
QUALITY IMPROVEMENT & RISK MANAGEMENT	**2.1**	
Continuous quality improvement	*2.1.1*	2.3.1
Risk management; corporate and clinical	*2.1.2*	2.2.1 / 2.2.2
Incident and complaints management	*2.1.3*	New / 2.4.2
HUMAN RESOURCES MANAGEMENT	**2.2**	
HR System	2.2.1	3.1.1
Recruitment, selection and appointment	2.2.2	3.1.2
Continuing employment / professional development	2.2.3	3.1.3

Standard / Criterion / Topic 4th Edition	4th Edition Criterion Number	3rd Edition Criterion Number
HUMAN RESOURCES MANAGEMENT	**2.2**	
Learning and development system	2.2.4	3.1.4
Support and workplace relations	2.2.5	3.1.5 / 3.1.6
INFORMATION MANAGEMENT	**2.3**	
Records management	2.3.1	4.1.4 / 4.2.2 / 4.1.2
Information and data management systems	2.3.2	4.1.3 / 4.2.1
Data and information used effectively	2.3.3	4.1.5 / 4.2.3
Information and communications technology	2.3.4	4.3.1 / 4.3.2
POPULATION HEALTH	**2.4**	
Health promotion, health protection and surveillance	2.4.1	New
RESEARCH	**2.5**	
Encouraging and governing research	2.5.1	New
CORPORATE FUNCTION		
LEADERSHIP & MANAGEMENT	**3.1**	
Strategic and operational planning	3.1.1	2.1.1
Governance structures, delegations & financial management	3.1.2	2.1.3 / 2.1.4
Credentialling and scope of clinical practice	3.1.3	New
Non-clinical external services providers	3.1.4	2.1.4
Corporate and clinical policies	*3.1.5*	2.1.5 / 2.1.2
SAFE PRACTICE & ENVIRONMENT	**3.2**	
Workplace Health and Safety (including dangerous goods, hazardous substances and radiation, manual handling)	*3.2.1*	5.1.1 / 5.1.5 / 5.1.7 / 5.1.8
Buildings, plant, equipment, supplies, utilities and consumables	3.2.2	5.1.2 / 1.1.2
Waste and environment	3.2.3	5.1.9
Emergency and disaster management	*3.2.4*	5.1.4
Security management	3.2.5	5.1.6

NB: *Italics* denotes Mandatory Criteria.

4. EQuIP standards review

Standard / Criterion / Topic 3rd Edition	3rd Edition Criterion Number	4th Edition Criterion Number
ACCESS		
Information about services	1.1.1	1.2.1
Signage and disability access	1.1.2	3.2.2
Clinical need	1.1.3	1.2.1 and 1.2.2
Assessment system	*1.2.1*	1.1.1
Care planned & delivered in partnership with consumer / patient	1.3.1	1.1.2
Care evaluation	1.3.2	1.1.4
Discharge	*1.4.1*	1.1.5
LEADERSHIP & MANAGEMENT		
Strategic and operational planning	2.1.1	3.1.1
Legislation	*2.1.2*	3.1.5
Governance structures	2.1.3	3.1.2
Delegations and non-clinical external service providers	2.1.4	3.1.2 / 3.1.4
Corporate and clinical policies and procedures	*2.1.5*	3.1.5
Risk management policy	*2.2.1*	2.1.2
Risk management system	2.2.2	2.1.2
QI system	*2.3.1*	2.1.1
Involvement of consumers	2.4.1	1.6.1
Consumer rights and responsibilities	*2.4.2*	1.6.2 / 1.1.3 / 2.1.3
HUMAN RESOURCES MANAGEMENT		
Human resources planning	3.1.1	2.2.1
Human resource recruitment & continuing employment	*3.1.2*	2.2.2
Performance appraisal	3.1.3	2.2.3
Learning and development system	3.1.4	2.2.4
Workplace relations	3.1.5	2.2.5
Staff support services	3.1.6	2.2.5
INFORMATION MANAGEMENT		
Health record	*4.1.1*	1.1.8
Unique identifier	4.1.2	2.3.1
Non-clinical information	4.1.3	2.3.2
Records management	4.1.4	2.3.1
Research information	4.1.5	2.3.3
Organisation of data	4.2.1	2.3.2
Clinical classification	4.2.2	2.3.1
Analysis of data	4.2.3	2.3.3
IT planning	4.3.1	2.3.4
Risk management IT	4.3.2	2.3.4

Standard / Criterion / Topic 3rd Edition	3rd Edition Criterion Number	4th Edition Criterion Number
SAFE PRACTICE & ENVIRONMENT		
Occupational Health & Safety	*5.1.1*	3.2.1
Buildings, plant, equipment, supplies, utilities and consumables	*5.1.2*	3.2.2
Infection control	*5.1.3*	1.5.2
Emergency and disaster management	*5.1.4*	3.2.4
Manual handling	*5.1.5*	3.2.1
Security management	*5.1.6*	3.2.5
Dangerous goods and hazardous substances	*5.1.7*	3.2.1
Radiation safety	*5.1.8*	3.2.1
Waste and environment	*5.1.9*	3.2.3
IMPROVING PERFORMANCE		
Responsibility & commitment to improving performance in care and service delivery.	6.1.1	2.1.1 New: 1.1.6 1.1.7 1.3.1 1.4.1 1.5.1 1.5.3 1.5.4 1.5.5 1.5.6 1.6.3 2.1.3 2.4.1 2.5.1 3.1.3

NB: *Italics* denotes Mandatory Criteria.

4. EQuIP standards review

4.8 A Developmental Criterion

A developmental criterion is one that the ACHS has introduced to organisations for the purpose of creating awareness and for commencing collaborative national action in a specific area of health care. There is one developmental criterion that has been introduced in EQuIP 4 – **criterion 1.3.1 – Health care and services are appropriate and delivered in the most appropriate setting.**

When a developmental criterion is introduced:

- organisations will work towards achieving the elements of the criterion
- progress towards achievement of the criterion will be discussed during survey but will not be taken into account when determining the accreditation status of the organisation
- a progressive evaluation of the implementation of the standard / criterion will be undertaken by the ACHS.

4.9 Not Applicable (NA) Criteria

There are a few criteria that may be **not applicable** to some organisations because the **topic of the criterion would never occur or would never have the potential to occur in the organisation.**

An organisation will need to discuss and agree with its Customer Services Manager any criteria that are not applicable to their organisation prior to a Self-Assessment or onsite survey being undertaken.

Number	Criterion	Examples where the criterion may be NA
1.1.6	Ongoing care	Day procedure centres, advisory services
1.1.7	Care of dying	Day procedure centres, advisory services
1.5.1	Medication management	Advisory services, equipment services
1.5.3	Pressure ulcers	Advisory services
1.5.5	Blood and blood components	Services that never administer blood or blood products or take pre-transfusion blood samples in any way
1.5.6	Correct patient, procedure, site	Advisory services, services where procedures are never undertaken
2.5.1	Research program	Organisations that never undertake or participate in research of any kind

4. EQuIP standards review

4.10 Mandatory Criteria

Mandatory Criteria are those where a rating of Moderate Achievement (MA) or higher is required to gain or maintain ACHS accreditation. A mandatory criterion is one where it is considered that without evaluation, the quality of care or the safety of people within the organisation could be at risk.

The ACHS Board agreed that throughout the selection process for the EQuIP 4 Mandatory Criteria the following question be used to determine mandatory status:

'Is this ACHS criterion so important, that failure to achieve an MA rating should result in nonaccreditation?'

The process for selecting mandatory criteria for EQuIP 4 was as follows:

- **The ACHS Standards Committee:** selected criteria that were used as the basis for an online survey for members and the industry.
- **ACHS Member and Industry Survey:** The survey was distributed to members, surveyors, councillors, departments of health and corporate offices. 875 responses were received. The survey asked if respondents agreed with the criteria chosen by the Standards Committee and if they thought other current criteria should be included as well as any of the new safety criteria.
- **The ACHS Council Meeting – June 2006:** included a workshop session where councillors (working in groups) were asked to nominate mandatory criteria from a list of 21 (where greater than 50% of respondents to the online survey agreed that the criteria should be mandatory).
- A**greed Mandatory Criteria:** There were 14 criteria that the Standards Committee, survey respondents and councillors all agreed should be mandatory.
- **ACHS Staff:** Following collation of results from all three groups an internal meeting was held with ACHS staff to risk rate the other eight criteria where there was not total agreement.
- **Final Selection Process**

  The rules for selection applied were:

  That the criterion is fundamental:

  - to consumer rights and / or
  - as a core component of safe, quality care and / or
  - to staff, visitor, consumer safety

    and

  - the criterion cannot be adequately covered by an over arching mandatory criterion such as care delivery, quality improvement, risk management.

There are 14 mandatory criteria in EQuIP 4. Table 4.10 lists the mandatory criteria in each of the three functions. The mandatory criteria are easily identified throughout EQuIP 4 by italicised text.

1. CLINICAL	2. SUPPORT	3. CORPORATE
1.1 Consumers / patients are provided with high quality care throughout the care delivery process.	**2.1 The governing body leads the organisation in its commitment to improving performance and ensures the effective management of corporate and clinical risks.**	**3.1 The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services.**
1.1.1 The assessment system ensures current and ongoing needs of the consumer / patient are identified.	*2.1.1 The organisation's continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.*	3.1.1 The organisation provides quality, safe care through strategic and operational planning and development.
1.1.2 Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.	*2.1.2 The integrated organisation-wide risk management policy and system ensure that corporate and clinical risks are identified, minimised and managed.*	3.1.2 Governance is assisted by formal structures and delegation practices within the organisation.
1.1.3 Consumers / patients are informed of the consent process, understand and provide consent for their health care.	*2.1.3 Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.*	*3.1.3 Processes for credentialling and defining the scope of clinical practice support safe, quality health care.*
1.1.4 Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.	**2.2 Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff.**	3.1.4 External service providers are managed to maximise quality care and service delivery.
1.1.5 Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.	2.2.1 Human resources planning supports the organisation's current and future ability to address needs.	*3.1.5 Documented corporate and clinical policies assist the organisation to provide quality care.*
1.1.6 Systems for ongoing care of the consumer / patient are coordinated and effective.	2.2.2 The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation.	**3.2 The organisation maintains a safe environment for employees, consumers / patients and visitors.**
1.1.7 Systems exist to ensure that the care of dying and deceased consumers / patients is managed with dignity and comfort.	2.2.3 The continuing employment and performance development system ensures the competence of staff and volunteers.	*3.2.1 Safety management systems ensure safety and wellbeing for consumers / patients, staff, visitors and contractors.*
1.1.8 The health record ensures comprehensive and accurate information is recorded and used in care delivery.	2.2.4 The learning and development system ensures the skill and competence of staff and volunteers.	3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.
1.2 Consumers / patients / communities have access to health services and care appropriate to their needs.	2.2.5 Employee support systems and workplace relations assist the organisation to achieve its goals.	3.2.3 Waste and environmental management supports safe practice and a safe environment.
1.2.1 The community has information on, and access to, health services and care appropriate to its needs.	**2.3 Information management systems enable the organisation's goals to be met.**	*3.2.4 Emergency and disaster management supports safe practice and a safe environment.*
1.2.2 Access and admission to the system of care is prioritised according to clinical need.	2.3.1 Records management systems support the collection of information and meet the organisation's needs.	3.2.5 Security management supports safe practice and a safe environment.
1.3 Appropriate care and services are provided to consumers / patients.	2.3.2 Information and data management and collection systems are used to assist in meeting the strategic and operational needs of the organisation.	
1.3.1 Health care and services are appropriate and delivered in the most appropriate setting.	2.3.3 Data and information are used effectively to support and improve care and services.	
1.4 The organisation provides care and services that achieve expected outcomes.	2.3.4 The organisation has an integrated approach to the planning, use and management of information and communication technology (I&CT).	
1.4.1 Care and services are planned, developed and delivered based on the best available evidence and in the most effective way.	**2.4 The organisation promotes the health of the population.**	
1.5 The organisation provides safe care and services.	2.4.1 Better health and wellbeing for consumers / patients, staff and the broader community are promoted by the organisation.	
1.5.1 Medications are managed to ensure safe and effective practice.	**2.5 The organisation encourages and adequately governs the conduct of health and medical research to improve the safety and quality of health care.**	
1.5.2 The infection control system supports safe practice and ensures a safe environment for consumers / patients and health care workers.	2.5.1 The organisation's research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research.	
1.5.3 The incidence and impact of pressure ulcers are minimised through a pressure ulcer prevention and management strategy.		
1.5.4 The incidence of falls and fall injuries is minimised through a falls management program.		
1.5.5 The system for prescription, sample collection, storage and transportation and administration of blood and blood components ensures safe and appropriate practice.		
1.5.6 The organisation ensures that the correct patient receives the correct procedure on the correct site.		
1.6 The governing body is committed to consumer participation.		
1.6.1 Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service.		
1.6.2 Consumers / patients are informed of their rights and responsibilities.		
1.6.3 The organisation makes provision for consumers / patients from culturally and linguistically diverse backgrounds and consumers / patients with special needs. Table 4.10 EQuIP 4 Mandatory Criteria		

Key:

	Mandatory Criteria

Table 4.10 EQuIP 4 Mandatory Criteria

4. EQuIP standards review

4.11 Clinical Indicators

The use of clinical indicators (CIs) by health care organisations continues to be an important component of the Evaluation and Quality Improvement Program (EQuIP). The collection of specific Australian Council on Healthcare Standards (ACHS) indicators is not mandatory and organisations may choose to develop their own indicators or use other indicators. Indicators assist health care organisations to identify areas which may benefit from continuous monitoring of clinical activity and performance and to improve the quality of care being delivered.

A clinical indicator is defined simply as a measure of the clinical management and / or outcome of care. A well-designed indicator should 'screen', 'flag' or 'draw attention' to a specific clinical issue. Usually rate based, indicators identify the rate of occurrence of an event. Indicators do not provide definitive answers; rather they are designed to indicate potential problems that might need addressing, usually demonstrated by statistical outliers or variations within data results. They are used to assess, compare and determine the potential to improve care.[6] Indicators are therefore, tools to assist in assessing whether or not a standard in patient care is being met.

Organisations can submit CI data to the ACHS on a six monthly basis. Organisations are then sent the national aggregate data following this submission. Organisations can produce comparative reports for the national data set and for their peer group. Each report provides information to identify statistically significant differences between the individual organisation, all organisations and peer groups. The reports also identify potential gains to be made if an organisation's rate was improved to that of the average and provides information on peer as well as Australian and New Zealand participation.

Further information about the specific clinical indicator sets and the Comparative Report Service are contained in ***Part 3 of the EQuIP 4 Guide – Suggestions for measuring performance.*** Part 3 of the EQuIP 4 Guide can also be downloaded by EQuIP members from the ACHS website www.achs.org.au or contact the ACHS Performance and Outcomes Service email: pos@achs.org.au.

4.12 Performance Indicators

A performance indicator is 'a statistic or other unit of information which reflects, directly or indirectly, the extent to which an anticipated outcome is achieved or the quality of the processes leading to that outcome.'[7]

Performance indicators are most fundamentally evaluative criteria. However, performance monitoring is only a part of evaluation. Performance indicators are one source which informs an evaluation process and may help to identify or flag further issues or questions.

In order to assist health care organisations in the measurement and evaluation of their performance the ACHS has compiled a list of performance indicators. A range of performance indicators has been suggested for each criterion in ***Part 3 of the Guide – Suggestions for measuring performance. The indicators are SUGGESTIONS ONLY.*** Organisations may continue to collect their own suite of performance indicators. There is no expectation that an organisation will collect any of the suggested performance indicators. The indicators suggested in Part 3 are not the only ones available, nor are the lists of indicators all inclusive. The suggestions are designed to provide assistance to organisations.

Not all of the indicators will be suitable for all types of organisations. Organisations may wish to modify the suggested indicators to meet their own needs. We have included indicators that may be useful to a range of health services and indicators that can be adapted to different services. Performance indicators included may be relevant to different types of organisations including day procedure centres, large hospitals, small hospitals, mental health facilities and community centres.

The ACHS will not collect these suggested performance indicators. Organisations will need to determine which indicators they will collect and how they will collect those indicators. An organisation may choose to benchmark particular indicators with other like organisations or with other units / departments within their organisation. The ACHS does not provide any national aggregate rate or benchmarking rates for the suggested indicators. These rates are only provided for the ACHS clinical indicators.

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7. National Health Performance Committee. National Report on Health Sector Performance Indicators 2001: A report to the Australian Health Ministers Conference, April 2002.

CLINICAL FUNCTION

SUPPORT FUNCTION

CORPORATE FUNCTION

5. Standards, Criteria, Elements and Guidelines

1.1 CONTINUITY OF CARE STANDARD

The standard is: **Consumers / patients are provided with high quality care throughout the care delivery process.**

The intent of the Continuity of Care standard is to ensure that organisations provide high quality care and a caring environment to the consumer / patient at all times. They should do this:

- *from* the time that the consumer / patient enters the health care organisation or service
- *through to when* the consumer / patient is discharged or transferred to another organisation / service; and
- *during any ongoing* care they provide after discharge.

The Australian Pharmaceutical Advisory Council (APAC)[1] guiding principles should be read in conjunction with all Continuity of Care criteria.

The *Age-friendly Principles and Practices* should be read in conjunction with all Continuity of Care criteria and referred to when treating older people[2].

There are eight criteria in this standard. They are:

*1.1.1 The **assessment system** ensures current and ongoing needs of the consumer / patient are identified.*

*1.1.2 **Care is planned and delivered** in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.*

*1.1.3 Consumers / patients are informed of the **consent process,** understand and provide consent for their health care.*

*1.1.4 **Care is evaluated** by health care providers and when appropriate with the consumer / patient and carer.*

*1.1.5 Processes for **discharge / transfe**r address the needs of the consumer / patient for ongoing care.*

1.1.6 Systems for **ongoing care** of the consumer / patient are coordinated and effective.

1.1.7 Systems exist to ensure that the **care of dying and deceased** consumers / patients is managed with dignity and comfort.

*1.1.8 The **health record** ensures comprehensive and accurate information is recorded and used in care delivery.*

References

1. Australian Pharmaceutical Advisory Council (APAC). Guidelines, Available at: http://www.health.gov.au/internet/wcms/publishing.nsf/Content/D900D825B95328DACA25705A00181F55/$File/guiding.pdf
2. Australian Health Ministers' Advisory Council (AHMAC). Age-friendly principles and practices. 2004.

CONTINUITY OF CARE:
Standard, Criteria, Elements, Guidelines

Standard 1.1 Consumers / patients are provided with high quality care throughout the care delivery process.

Mandatory Criterion	LA – Awareness	SA – Implementation LA plus the following
1.1.1 *The **assessment system** ensures current and ongoing needs of the consumer / patient are identified.* This is a Mandatory Criterion.	(a) Guidelines are made available for staff to assess physical, psychological and social needs, including the identification of 'at risk' consumers / patients. (b) There is a policy for planning for discharge* at the time of the initial episode of care. (c) Referral systems to other relevant service providers exist.	(a) Assessment is documented and where appropriate is multidisciplinary. (b) Comprehensive assessment guidelines, based on professional standards and evidence are used. (c) The assessment system identifies the physical, psychological and social needs of the consumer / patient. (d) The needs of 'at risk' consumers / patients are identified and managed. (e) The assessment system avoids duplication by multiple providers. (f) A support person / carer is involved in the assessment system where appropriate. (g) Information is provided to the consumer / patient on their health status. (h) Re-assessment of the consumer / patient occurs when there is a change in health or functional status. (i) Planning for discharge / transfer, commences at assessment, is multidisciplinary when appropriate, and coordinated.

These guidelines should be read in conjunction with criterion 1.6.3 cultural and special needs.

The intent of this criterion is to ensure that the assessment system meets all the requirements of the consumer / patient and the organisation.

The assessment system is the process by which the current and ongoing needs of the consumer / patient are identified and documented. To ensure a comprehensive admission and assessment process, the organisation should have guidelines that assess the physical, social and psychological needs of consumers / patients. These guidelines include instruction on the identification of consumers / patients 'at risk' and the requirement to plan separation and discharge at this stage in the episode of care.

Risk is defined as the chance of something happening that will impact on objectives. Risk is often specified in terms of an event or circumstance and the consequences that may flow from that. Risk may have a positive or negative impact.

The **assessment process** should be comprehensive, multidisciplinary and based on

*"Discharge" in Hong Kong means the same as "separation" in Australia

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The assessment process is evaluated and improved, as required. (b) Referral systems are evaluated and improved, as required. (c) Processes for assessing and managing 'at risk' consumers / patients are evaluated and improved as required. (d) Planning for discharge / transfer is evaluated to ensure it: (i) consistently occurs (ii) is multidisciplinary if appropriate (iii) meets consumer / patient and carer needs.	(a) Assessment and discharge planning practices are compared with internal and external systems and improvements are made to ensure better practice.	(a) The organisation demonstrates it is a leader in consumer / patient assessment and discharge planning.

clinical need and priority.[1] **Multidisciplinary** could be as simple as a medical practitioner and a nurse or as complex as several medical practitioners, community health care workers, nurses and several allied health professionals.

A heath care organisation should consider:

- how all relevant information is gathered for a plan of care to be developed (this includes information from the referring specialist, carers, general practitioners [GPs] and other external service providers)
- how additional information should be sourced
- confidentiality, privacy, dignity and consumer / patient expectation
- current health status including physical, mental and emotional
- medical history
- the method of recording the information
- the value of the information currently assessed
- cultural and linguistic backgrounds and special needs as per criterion 1.6.3.

1.1 CONTINUITY OF CARE STANDARD

Criterion 1.1.1 *The **assessment system** ensures current and ongoing needs of the consumer / patient are identified.*

(Continued)

A **comprehensive assessment**, to identify consumers / patients 'at risk' may also include specific assessments, such as:

- aged care assessment
- falls risk assessment
- mental health assessment
- emergency presentation assessment
- pressure ulcers risk assessment
- manual handling risk assessment
- nutritional risk assessment
- anaesthetic risk assessment
- pre-operative assessment
- pain assessment
- discharge planning and separation assessment.

Organisations should have facilities available to assist the administration of specific assessments and the health care professionals completing those assessments.

Consumers / patients conveying personal health information during any assessment should be accommodated in an area where privacy is assured.

Assessment of social and health status and living arrangements of the consumer / patient prior to admission and post-discharge should be taken into account. At the entry and assessment stage of the consumer / patient episode of care, it may be appropriate to initiate a referral to internal or external services. Where appropriate, a carer or support person should be involved in the assessment process.

A comprehensive assessment will be based on organisational policies, evidence and / or standards / guidelines developed by professional bodies and colleges. Where indicated, other health care providers such as GPs and home care services should be involved in the processes of assessment and ongoing care.

The assessment of planning for discharge or transfer is evaluated. The evaluation process could be formal or informal. A support person or carer can refer to relative, friend, domestic helper or old aged home staff.

Organisations may provide evidence of achievement in this criterion through:

- policies and guidelines on assessment, discharge planning, referral systems
- completed assessments in the health record
- the assessment tools and clinician satisfaction with the format
- how information is transferred to other sectors, units or organisations
- how information is transferred into the care planning process
- results of patient surveys on perceived privacy considerations during interviews, examinations and diagnostic procedures
- results of retrospective audits of adverse events / incidents / near misses in the episode of care
- evaluation results of admission waiting times
- the discharge plan.

References

1. Moss, Flower and et al. A multidisciplinary Care Coordination Team improves emergency department discharge planning practice, MJA, 2002; 177(8); 435-439.

2. The Medical Council of Hong Kong. Code of Professional Conduct for the Guidance of Registered Medical Practitioners.

3. The Nursing Council of Hong Kong. Code of Professional Conduct and Code of Ethics for Nurses in Hong Kong.

CONTINUITY OF CARE:
Standard, Criteria, Elements, Guidelines

Standard 1.1 Consumers / patients are provided with high quality care throughout the care delivery process.

Mandatory Criterion	LA – Awareness	SA – Implementation LA plus the following
1.1.2 ***Care is planned and delivered*** *in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.* This is a Mandatory Criterion.	(a) Evidence-based guidelines on care planning and delivery are available. (b) Care is provided in response to consumer / patient needs in a timely manner and in accordance with established policies and procedures. (c) A comfortable and caring environment is provided for consumers / patients.	(a) Care planning and delivery are based on the assessment of the consumer / patient needs and with the consumer / patient and, when relevant, their carer. (b) All care planning, decisions, actions and changes are documented in the consumer / patient health record. (c) Care is delivered by skilled and trained individuals within a competent multidisciplinary team with an identified team leader. (d) A system exists for the effective identification and management of a deteriorating consumer / patient. (e) Consumers / patients and carers, when appropriate, are given information that allows them to understand their care. (f) There is evidence that the consumer / patient has been provided with information on care delivery options.

These guidelines should be read in conjunction with criteria 1.3.1 appropriateness, 1.4.1 effectiveness, 1.6.1 consumer input, 1.6.2 rights and responsibilities and 1.6.3 cultural and special needs.

Planning, delivery and coordination of care are the core business of all health care organisations.

The intent of this criterion is to ensure that care planning and delivery promote a consultative, collaborative approach that actively involves the consumer / patient and carer. This will ensure the best possible outcomes for the consumer / patient. The key considerations are:

- care is planned and documented according to the assessment of the consumer / patient needs
- there is input from the consumer / patient and relevant care providers
- consideration that a second opinion may be sought
- care planning and delivery are based on the best available evidence
- care is delivered by competent individuals and competent multidisciplinary teams
- care is coordinated between all members of the team (including carers)
- the needs of high-risk consumers / patients are identified and managed appropriately
- the environment within which care is provided is comfortable, caring and appropriate to consumer / patient needs.

A **comfortable environment** should be considered in the context of the type of consumer / patient, the setting, the physical environment and the available resources. A caring environment includes

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The care planning and delivery processes are evaluated and improved as required. (b) Policies and procedures for care delivery are evaluated against evidence, professional guidelines, codes of practice and medico-legal requirements. (c) Multidisciplinary team processes for care delivery are evaluated and improved as required. (d) The environment in which care is provided is evaluated and improved as required. (e) A system for the effective identification and management of a deteriorating patient is evaluated and improved as required.	(a) Care planning and delivery practices, together with data on variances are compared with internal and external systems and improvements are made, to ensure better practice. and / or (b) Multidisciplinary team work is compared with other health services and / or industries and improvements are made to ensure better practice. and / or (c) The organisation undertakes research relevant to care planning and the delivery of care and acts on results.	(a) The organisation demonstrates it is a leader in care planning and delivery practices.

the aspects of comfort, respect, dignity and privacy for the consumer / patient and their carer and family / familial group.

Achieving effective planning, delivery and coordination of care may include:

- guidelines developed by professional colleges and / or associations
- clinical pathways / care plans
- legislative requirements, medico-legal requirements, standards, codes of practice, ethics and frameworks
- the organisation's policies and procedures
- guidelines for consumers / patients identified as being at high-risk, such as standard protocols for cardiac arrest or acute psychotic episodes
- organisational strategies to deal with high-risk activities, which will vary within the health sector and be influenced by the consumer / patient. Examples of known high-risk activities include management of blood transfusions or medication management
- strategies to deal with poor nutritional status, delirium, acute psychotic episodes, falls, depression and deterioration in consumer / patient health condition and cardiac arrest
- systems to identify and manage changes in consumer / patient health status including appropriate referral within the organisation or to community services following discharge. Examples include the management of pressure areas, incontinence, post-surgical complications, transfer to an intensive care unit (ICU) and postnatal care.

In the community setting, care may be provided by a number of services. The planning and

1.1 CONTINUITY OF CARE STANDARD

Criterion 1.1.2 *Care is planned and delivered* *in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.*

(Continued)

delivery of care should be well coordinated and communicated and take into account the social and family / familial circumstances of the consumer / patient.

Effective multidisciplinary team work requires the clear delineation of responsibilities of all team members, to ensure comprehensive management without duplication of services, unnecessary services or over servicing. There should be an identified team leader, who is the person responsible for coordinating the care of the consumer / patient.

Explanation should be provided for consumers / patients and carers so that they understand the diagnosis, prognosis, treatment options, and illness prevention strategies. The information should be timely, and the consumer / patient needs to understand their treatment options.

Where appropriate, carers should be made aware of, and referred to, services and support for carers.

Care plans should be documented in the health record.

Care planning and coordination includes ensuring that the outcomes of the care delivered are evaluated. The evaluation could involve:

- processes around care coordination and communication within the organisation and with external providers
- review of the internal referral processes
- review of clinical handover of information
- review of the consumer / patient understanding of their progress
- consumer / patient participation in case conferencing and family / familial discussion.

The care plan or clinical pathway may include:

- goals to be achieved
- tests and investigations to be conducted
- procedures and interventions to be provided
- consumer / patient education strategies to be implemented
- timeframes to be met
- delineation of responsibilities
- discharge plan.

All health care organisations should develop policy and a system for identifying, reporting and managing **deteriorating patients**. In the past, hospitals have focussed on having effective mechanisms in place for resuscitating a consumer / patient after an arrest. Evidence suggests that better outcomes will be achieved if signs of deterioration are recognised and the consumer / patient is treated accordingly. For example, research has shown that very few consumers / patients who suffer a cardiac or respiratory arrest do so very suddenly and without warning. The vast majority of consumers / patients show signs of deterioration for up to eight hours prior to an arrest.[2]

Health care organisations have developed various mechanisms for achieving better outcomes. In a small health care organisation it may be appropriate to call an ambulance or GP to manage the deteriorating patient. In a larger, more complex organisation, the implementation of criteria for recognising patient deterioration and defined response requirements may be a more appropriate strategy. A medical emergency team (MET)[1] and mandatory medical practitioner contact requirements are strategies available to organisations for consideration.

In addition to deterioration of the acute patient, it should be recognised that patients with chronic conditions will also deteriorate. Organisations responsible for consumers / patients with chronic conditions, for example mental health services, should also have policy and systems in place for the management of the deteriorating consumer / patient.

Day procedure centres and community based health centres may more appropriately manage these elements in criterion 3.2.4 emergency and disaster management.

Organisations may provide evidence of achievement in this criterion through:

- relevant documentation of care plan decisions, actions and changes in the health record
- evidence of case conferences in progress notes
- recorded identified goals of treatment
- documented clinical pathway / care plans
- guidelines or policies, linked with relevant college or association guidelines
- evaluation of consumer / patient / carer understanding and involvement in care planning
- evaluation of consumer / patient satisfaction with coordination of multidisciplinary care

References

1. Hillman K, Parr M, Flabouris A, Bishop G, and Stewart A. Redefining in-hospital resuscitation: the concept of the medical emergency team. Resuscitation. 2001; 48:105-110.
2. Schein RM, Pena M, Ruben BH, Spring CL. Clinical antecedents to in-hospital cardiopulmonary arrest. Chest. 1990; 98:1388-1392.
3. Allied Health Professions:- Code of Practice

   Medical Laboratory Technologist: http://www.smp-council.org.hk/mlt/english/index_code.htm

   Occupational Therapist: http://www.smp-council.org.hk/ot/english/index_code.htm

   Optometrists: http://www.smp-council.org.hk/op/english/index_code.htm

   Physiotherapists: http://www.smp-council.org.hk/pt/english/index_code.htm

   Radiographers http://www.smp-council.org.hk/rg/english/index_code.htm

   Social workers http://www.swrb.org.hk/text-eng/draft_cop_e.htm

   Pharmacists: http://www.pshk.hk/DL2/COE.pdf
4. The Nursing Council of Hong Kong: http://www.nchk.org.hk/
5. Hong Kong Academy of Medicine: http://www.hkam.org.hk/

CONTINUITY OF CARE:
Standard, Criteria, Elements, Guidelines

Standard 1.1 Consumers / patients are provided with high quality care throughout the care delivery process.

Mandatory Criterion	LA – Awareness	SA – Implementation LA plus the following
1.1.3 *Consumers / patients are informed of the **consent process**, understand and provide consent for their health care.* This is a Mandatory Criterion.	(a) Consumers / patients are provided with comprehensive and accessible information on recommended investigations, treatment or procedures and costs prior to providing consent for that health care. (b) The investigations, treatment and procedures that require consumer / patient consent are clearly defined. (c) There is a policy on consent that is consistent with Hong Kong legislative requirements. (d) Health care providers are advised of the policy.	(a) Consent is obtained for all investigations, treatment or procedures and costs in accordance with the organisation's policy. (b) There is a process to manage consent where it is unable to be given at the time of entry into the health service.

These guidelines should be read in conjunction with criterion 1.6.2 rights and responsibilities.

The intent of this criterion is to ensure that the process of obtaining consent is managed appropriately.

Consent is a significant aspect of the assessment of consumer / patient needs both from a clinical and non-clinical perspective. Organisations should be aware of any relevant guidelines or legislative requirements and review existing practices.[1] Consent can include financial, procedural, ethics and research consent.

Consent covers a number of different legal requirements:

- the consumer / patient should be informed in broad terms of the nature of any invasive procedure which is performed on the patient. This consent protects the patient and also operates as a defence to legal action
- the consumer / patient should be informed of material risks inherent in the procedure or treatment. This is part of the duty of care owed to the consumer / patient by an appointed medical practitioner who treats the patient
- consent for collection of health information, and to any use of that information and / or disclosure by the organisation to third parties, is required under Hong Kong privacy law requirements[3]
- informed financial consent of the consumer / patient.
- The organisation's consent policy should address the following:
- the organisation's responsibilities in regard to gaining consent
- the procedures, care, treatment and investigation options that require consent
- the process used to obtain consent
- how consent is to be documented in the record
- when a surrogate decision maker, rather than the consumer / patient, may give consent
- the use of interpreters / interpreter services when the consumer / patient is not proficient in the primary language of the organisation's representatives
- when procedures or care and treatment normally requiring consent may be given without consent.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The consent process is evaluated and improved as required. (b) Compliance with the consent process is evaluated and strategies for improvement are implemented as required.	(a) Comparison of documents and practices for consent are compared with internal and external practices and improvements are made to ensure better practice.	(a) The organisation demonstrates it is a leader in its practices for obtaining consent.

Health care providers may be advised of the policy through the credentialling process, minutes of Medical Advisory Committee (MAC) meetings, other group meetings and organisation's newsletters.

A completed **consent process**[2], wherever it occurs, includes a discussion of the following issues:

- the nature of the proposed care, treatment, services, medications, interventions, investigations or procedures
- possible benefits, risks, complications and side effects
- the probability of achieving care and treatment goals
- reasonable alternatives to the proposed care and treatment and the relevant risks, complications and side effects of alternate treatments including the possible results of receiving no treatment or care
- any limitations on the confidentiality of information learned from or about the consumer / patient.

Consent should be obtained and documented in accordance with the organisation's policy. The relationship between a health care organisation and a medical practitioner will impact upon the organisation's responsibilities in the consent process. In the private sector, there are cascading levels of consent; for example, the treating practitioner will usually obtain consent for recommended investigations, treatment or procedures and their costs within their own rooms prior to providing that health care. In these cases, there should be a copy of the documented, signed consent obtained by the treating clinician or an 'acknowledgement of the consent', in the consumer / patient health record. The organisation's policy should be documented to ensure that all relevant parties are aware of the required procedures. The health care organisation is responsible for obtaining consent to the costs of hospitalisation prior to or upon admission and is also responsible for obtaining consent by the consumer / patient, for any invasive procedures that occur after admission, for example catheterisation or invasive radiology.

Consent should also be obtained for any recording or filming of care or treatment. This is considered as relevant consent. Consent for a procedure does not cover consent for filming of that procedure, unless it is stated on the signed consent form, so relevant consent would cover both of these processes. In the case of consent for filming or photography, how these will be used and stored should be discussed

1.1 CONTINUITY OF CARE STANDARD

Criterion 1.1.3 *Consumers / patients are informed of the* ***consent process,*** *understand and provide consent for their health care.*

(Continued)

with the consumer / patient and documented with the consent.

An individual cannot give valid consent if they lack the capacity to make an informed decision. An individual may be unable to give consent for a number of reasons, including because they:

- have limited decision making capacity due to a cognitive impairment, such as dementia or a severe intellectual disability
- are experiencing a temporary incapacity, perhaps during a psychotic episode, due to a temporary psychiatric illness, or because of severe distress
- are a young child; or
- are in an emergency situation and unconscious or in distress.

A lack of decision making capacity should not mean that individuals miss out on necessary health care, support and other services. Most people with disabilities are able to make their own decisions and have the legal right to do so. Health service providers should ensure that health issues are discussed with the individual in a way that is understandable and comprehensible, to the greatest extent possible in the circumstances.

When consent is required, and an individual lacks capacity, a health service provider may be required to identify who can act on the individual's behalf. There may be a range of options and the organisation's policy should have these outlined in accordance with Hong Kong legislation[4, 5]

Organisations may provide evidence of achievement in this criterion through:

- the consumer / patient information brochure
- the organisation's policy on consent including absence of capacity to consent
- health records, including signed consent forms and acknowledgement of consent forms
- retrospective health record review to determine the procedure on the consent form matches the procedure on the operating room count sheet
- audit results on the consent process and consumer / patient understanding
- audit of instances where signed consent forms were not available in the operating room
- evaluation of cancelled or postponed procedures due to lack of consent
- the mechanism for staff education
- evidence of use of interpreters to assist in gaining consent.

References

1. Australian Government, 2006, Health insite; Issues on informed consent, Available at: http://www. healthinsite.gov.au/topics/Informed_Consent
2. Australian Government. National Health and Medical Research Council. Communicating with patients: advice for medical practitioners. 2004.
3. Hong Kong legislation: Cap 486: Personal Data (Privacy) Ordinance
4. Hong Kong legislation : Cap 136D Mental Health (Guardianship) Regulation. Emergency Medical Treatment under Common Law and Part IVC, Mental Health Ordinance (in Appendix 1 of Legal Principles on Informed Consent).
5. Legal Principles on Informed Consent. HAHO Legal Services Section (revised version dated 15/12/03)
6. HAHO operation circular: 2008 Updated Informed Consent Policy
7. Patient information: http://www.ekg.org.hk/pilic/index.jsp
8. Code of Practice for Private Hospitals, Nursing Homes and Maternity Homes.

CONTINUITY OF CARE:
Standard, Criteria, Elements, Guidelines

Standard 1.1 Consumers / patients are provided with high quality care throughout the care delivery process.

Mandatory Criterion	LA – Awareness	SA – Implementation LA plus the following
1.1.4 ***Care is evaluated*** *by health care providers and when appropriate with the consumer / patient and carer.* This is a Mandatory Criterion.	(a) Consumers / patients are encouraged to provide feedback on the care provided.	(a) Formal processes are in place across the organisation for the review of clinical care. (b) Prior to discharge, health care providers discuss the outcomes of care with the consumer / patient and when relevant, the carer, and this is documented.

These guidelines should be read in conjunction with criteria 1.3.1 appropriateness and 1.4.1 effectiveness.

The intent of this criterion is to ensure that organisations evaluate the care and services they provide. Care evaluation should take place to understand if the best possible outcomes have been achieved for the consumer / patient [1]. The care processes provided to and the outcomes achieved for an individual consumer / patient together with the aggregate results of many consumers / patients should be evaluated. For example, not only should the care process and outcome for a consumer / patient having a coronary artery bypass operation be reviewed but also the care and outcomes for all consumers / patients undergoing that procedure in the past (say) six months be reviewed. Another example may be providing additional support in a history of non-compliance with medication and conduct a health record audit of all consumers / patients with a similar history over the past six months.

Evaluation practices should reflect that the outcomes of these reviews are acted upon.

Some important aspects for health care providers to consider include:[2]

- whether the care plan worked
- whether health care providers made a difference in the health status of the consumer / patient
- what the organisation measures to determine if the care made a difference
- collection of various data from clinical pathways and the reliability of the data
- whether the goals of care were met including meeting other organisation's requirements.

Formal processes for reviewing clinical care include ward rounds, clinical audits, clinical indicators, consumer / patient feedback, mortality and morbidity reviews and peer review and should be documented. Organisations which are part of an area / district health service, private

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Individual and group consumer / patient care is evaluated and improved as required. (b) Consumers / patients, and when relevant carers participate in the evaluation of care. (c) Care outcomes for consumers / patients including those identified as 'at risk' are evaluated and improved as required. (d) Indicators, adverse clinical events and mortality are reviewed and documented by relevant clinician groups to evaluate and improve care delivery. (e) Individual and aggregate consumer / patient data are collected and reviewed on care delivery and outcomes.	(a) Performance indicators for process and outcome data are measured and compared with internal and external systems and improvements are made to ensure better practice. and / or (b) The organisation makes references of Hong Kong registries [3] and improvements are made to ensure better practice.	(a) The organisation is a leader in the evaluation of care as demonstrated by its processes and consumer / patient outcomes.

corporation or other group, may develop their own processes.

When considering aggregated outcomes the organisation may identify and monitor variables of care across all of its services and among care pathways. Some organisations may be expected to report data on care delivery to the Hospital Authority, Department of Health, private health insurers or other such bodies. Examples may include:

- clinical process and outcome indicators relevant to the service are collected and reported on demonstrating outcomes achieved
- consumer / patient satisfaction with the expected outcomes as discussed and documented in the health record
- review of effectiveness of clinical pathways and care plans.

These same data could be used internally to evaluate care.

Data collection, reporting and comparisons should be based on Hong Kong definitions where possible, and organisations are encouraged to report to Hong Kong data collections for the purposes of comparison and improvement. Hong Kong data registries include but not limit to the following:

- Hong Kong Renal Registry
- Hong Kong Diabetes Registry
- Liver Transplant Central Registry
- Health Statistics: Notifiable infectious diseases, infectious diseases by voluntary reporting, sentinel surveillance and antibiotic resistance surveillance in: http://www.chp.gov.hk/en/dns_submenu/10/26.html
- Hong Kong Cancer Registry
- HIV Registry
- Territory-wide Obstetrics and Gynaecology Audit

1.1 CONTINUITY OF CARE STANDARD

Criterion 1.1.4 *Care is evaluated* *by health care providers and when appropriate with the consumer / patient and carer..*

(Continued)

Organisations may provide evidence of achievement in this criterion through:

- processes for consumer / patient / carer feedback
- evidence of renewed / updated care plans
- evaluation of care plans and delivery
- clinical outcome reviews
- clinical indicators
- evaluation of instances of untoward events that have occurred in the presence of signs of deterioration
- policies on care evaluation.

References

1. Commonwealth of Australia. Evaluation: A guide for good practice. 2001.
2. North Sydney / Central Coast Area Health Service, 21 October,2005,The Care Plan - A living document, Available at: http://www.archi. net. au/e-library/build/improvement/clinical_sys_ list/ the_care_plan
3. Hong Kong Renal Registry
4. Hong Kong Diabetes Registry
5. Liver Transplant Central Registry
6. Health Statistics: Notifiable infectious diseases, infectious diseases by voluntary reporting, sentinel surveillance and antibiotic resistance surveillance in: http://www.chp.gov.hk/en/dns_ submenu/10/26.html
7. Hong Kong Cancer Registry
8. HIV Registry
9. Territory-wide Obstetrics and Gynaecology Audit

CONTINUITY OF CARE:
Standard, Criteria, Elements, Guidelines

Standard 1.1 Consumers / patients are provided with high quality care throughout the care delivery process.

Mandatory Criterion	LA – Awareness	SA – Implementation LA plus the following
1.1.5 *Processes for **discharge / transfer** address the needs of the consumer / patient for ongoing care.* This is a Mandatory Criterion.	(a) Guidelines for discharge* or, transfer are available. (b) Arrangements with other service providers are made with consumer / patient consent and input and confirmed prior to discharge or transfer.	(a) An effective, system for discharge / transfer is implemented throughout the organisation and ensures continuity of care between referrers and providers. (b) Service providers receive timely notification about consumer / patient discharge to their care. (c) Results of investigations follow the consumer / patient through the referral system. (d) Discharge information is discussed with the consumer / patient and a written discharge summary is provided. (e) Formalised follow-up occurs for 'at risk' consumers / patients.

The intent of this criterion is to ensure that clinical handover is effective and that health care organisations have processes in place to make certain that the consumer / patient has a smooth and safe transition when an episode of care is completed[1].

Clinical handover refers to the transfer of information from one health care provider to another in an organisation / service, when a patient has a change of location of care, and / or when the care of a patient shifts from one provider to another. If communication during the clinical handover is inadequate, delivery of care may be compromised due to failure to understand key aspects of the consumer/ patient condition.[2]

Discharge and transfer should occur effectively from a community service to an acute service, between providers and units in any organisation, from an acute service to the community, and between providers in the community.

There are several circumstances under which **discharge** occur these include:

- death
- self-discharge / discharge at own risk
- one care setting to another
- routine discharge.

There are several circumstances under which **transfer** occur these include:

- improvement in health status
- deterioration in health status
- from one provider to another, such as at change of shift
- from one care setting to another.

In the event of the consumer / patient transfer to either another organisation / service or from one health care provider to another within the organisation, it is important that all necessary health information be forwarded with the consumer / patient to ensure continuity of care.

The key issues to be considered in the discharge or transfer of a consumer / patient are that:

- the discharge or transfer has been appropriately planned with the consumer / patient and / or their carer and the multidisciplinary team

* "Discharge" in Hong Kong means the same as "separation" in Australia

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The processes for discharge / transfer are evaluated and improved as required. (b) Information for consumers / patients, other service providers and the systems for providing the information are evaluated and improved as required.	(a) Performance indicators for discharge / transfer are measured and compared with internal and external systems and improvements are made to ensure better practice. and / or (b) Advanced strategies are in place for notification of ongoing care needs to other service providers.	(a) The organisation demonstrates it is a leader in discharge / transfer systems.

- it is affected in a smooth and timely fashion
- all necessary information about past, present and future care is communicated clearly to the consumer / patient and / or to ongoing care providers
- the consumer / patient and carer understand what is to happen and why.

There is an expectation that:

- the consumer / patient and
- the health care provider to whom the consumer / patient is discharged, and
- the referring health care provider, and
- the health record receive a **discharge summary**.

In some cases, such as in rural / remote areas, the treating health care provider within the organisation may be the same as the health care provider caring for the consumer / patient following discharge from the organisation. Providing the health record is accessible to the health care provider in both the organisation and following discharge, the copy of the discharge summary in the health record is sufficient to satisfy the requirement of the discharging health care provider receiving a copy. The purpose of the discharge summary is that the consumer / patient, the referring health care provider and any other relevant health care providers are aware of and understand ongoing plans and their responsibilities in continuing management.

Organisations should ensure that mechanisms for the transfer of information about the consumer / patient are effective and work for the consumer / patient and the treating medical practitioner.

Different health care organisations will achieve the above in different ways. However achieved, a discharge and transfer policy or guidelines will be needed, as well as a system for implementing the policy or guidelines and a method for evaluating whether it is working.

Written and verbal information should be provided to the consumer / patient on discharge / transfer and should include details on:

- self-care requirements including medications
- investigations / results
- significant complications and precautions
- adverse reactions

1.1 CONTINUITY OF CARE STANDARD

Criterion 1.1.5 *Processes for **discharge / transfer** address the needs of the consumer / patient for ongoing care.*

(Continued)

- plans for ongoing care
- emergency contact details
- information on how to re-enter the health care organisation
- arranged post-discharge services.

Where information has been transferred in and between health care providers, consumer / patient confidentiality and privacy should be maintained.

Formalised follow-up of 'at risk' consumers / patients involves a planned process after the consumer / patient has been discharged or transferred from the treating health service, for example, in some organisations, such as day procedure centres this will be a telephone call to follow up patients, a date for review with a health provider or organisation of a community support visit, and this is documented in the health record prior to discharge or transfer. The patient should be given a copy of this follow-up plan.

'At risk' patients may include elderly, debilitated, intoxicated or paediatric patients or those with a mental disorder

When **evaluating the coordination** of discharge and transfer services the organisation should take the following into consideration:

- consumer / patient satisfaction with the discharge processes
- effectiveness of transfer of information between health care organisations
- effectiveness of transfer of information within the organisation, such as at clinical handover
- effectiveness of arrangements with relevant community health care organisations in a timely manner that ensures that the consumer / patient was aware of the reasons for transfer
- involvement of carers and GPs in the discharge / transfer process
- consumer / patient knowledge of follow-up arrangements.

Organisations may provide evidence of achievement in this criterion through:

- documented processes on discharge or transfer planning
- policies on regular / routine clinical handover
- retrospective health record review to determine variance between the discharge plan and the actual discharge process
- evidence of response to unplanned readmissions
- completed discharge plans
- systems that ensure consumers / patients are transferred appropriately and evaluation of any delays in transfer
- knowledge of admission criteria to the transferring service, for example, rehabilitation, mental health
- home care package liaison such as district nursing services
- instances where consumers / patients phone the organisation post-discharge to determine after care.

References

1. State Government of Victoria, Department of Human Services, November 2003, Good Practice in Discharge Planning: Improving patient transition from hospital to the community, a good practice guide for hospitals, Available at: http:// www.health.vic.gov.au/ discharge/
2. Victorian Quality Council Safety and Quality in Health, 2006, Clinical Handover; A Challenge for Patient Safety, Available at: http://www. health.vic. gov.au/qualitycouncil/downloads/ clinhandover. Pdf
3. Guidelines on Intra-hospital Transfer of Critically Ill Adult Patients.
4. Nursing Standards for Patient Care Section G 1.3 (2002 edition, updated 2009 Feb 10).

MANDATORY CRITERION

CONTINUITY OF CARE:
Standard, Criteria, Elements, Guidelines

Standard 1.1 Consumers / patients are provided with high quality care throughout the care delivery process.

Criterion	LA – Awareness	SA – Implementation LA plus the following
1.1.6 Systems for **ongoing care** of the consumer / patient are coordinated and effective.	(a) There are processes for ongoing care by multiple service providers.	(a) There are documented arrangements for liaison between the organisation and other service providers that outline the coordination of ongoing care. (b) Case management or care coordination is available for appropriate consumers / patients. (c) Consumers / patients with chronic illness are educated in self-management. (d) Triage systems are available to prioritise the admission of consumers / patients with chronic illness when required. (e) Strategies are developed to reduce acute presentations and avoidable admissions of consumers / patients with chronic illness.

These guidelines should be read in conjunction with criteria 1.1.5 discharge and transfer and 2.4.1 population health.

Ongoing care refers to the process of care that follows an admission to a health care organisation.

The intent of this criterion is to ensure that all health care organisations involved in the ongoing care of consumers / patients are responsible for components of this process.

Not all providers in all health care organisations will have a responsibility for the ongoing care of all consumers / patients they treat. Both organisations and individual clinicians should define their role in relation to ongoing care and to ensure that systems are in place to meet their responsibilities. Community and outreach organisations may have more involvement in ongoing care than acute care organisations.

In addition to the ongoing needs of a consumer / patient with an acute condition, this criterion recognises the need to manage the many interventions provided by multiple health care providers for consumers / patients with chronic conditions.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The ongoing care process is evaluated and improvements are made to ensure better practice. (b) The education system for consumers / patients requiring ongoing care is evaluated and improvements are made to ensure better practice. (c) The triage and readmission process for patients with chronic illness is evaluated and improvements are made to ensure better practice.	(a) Performance indicators for ongoing care are measured, compared with internal and external systems and improvements are made to ensure better practice. and / or (b) The education system for consumers / patients requiring ongoing care is compared with other service providers and improvements are made to ensure better practice. and / or (c) The triage and readmission process for patients with chronic illness is compared with other service providers and improvements are made to ensure better practice. and / or (d) The organisation undertakes research into the management of chronic illness and publishes its results in peer reviewed journals.	(a) The organisation is a leader in ongoing care systems that allow consumers / patients to achieve the highest functional level possible. (b) The organisation's ongoing care, consumer / patient education and readmission systems are recognised as best practice by peers.

The public hospitals under Hospital Authority have agreed to work together on certain priority areas such as:

- acute myocardial infarct
- stroke
- cancer treatment
- cardiovascular health
- diabetes mellitus
- fall prevention and control
- mental health
- chronic respiratory disease
- hypertension
- end stage renal failure
- palliative care

Organisations can use the Hospital Authority guidelines that have been established for the management of these diseases.

A coordinated approach for consumers / patients with a chronic condition requires strong links and communication processes within and between service providers in all health care sectors.

1.1 CONTINUITY OF CARE STANDARD

Criterion 1.1.6 *Systems for **ongoing care** of the consumer / patient are coordinated and effective.*

(Continued)

Effective ongoing care requires:

- all team members and the consumer / patient and where appropriate, their carer, to be involved in ongoing care planning
- the consumer / patient to be given information to enable them to understand their condition and to self-manage their illness
- carers to be provided with information on support services for carers
- self-management to be facilitated by allowing consumers / patients access to their health record or a version of their health record for which they are responsible, where appropriate
- education and support programs
- ambulatory care to be encouraged and admission to an acute care organisation to be avoided whenever possible
- discharge summaries to be forwarded to relevant providers.

Consumers / patients with chronic illness who have multiple admissions should not have to be admitted through the emergency departments. Consumers / patients with chronic health conditions should be able to bypass some admission process steps. A fast track admission process should be available to such consumers / patients. The admission process, like all health care processes should be regularly reviewed and improvements made in accordance with the analysis of that review.

Organisations may provide evidence of achievement in this criterion through:

- case management or care coordination system and evaluation
- evaluation of arrangements in place with other providers such as aged care
- evaluation of patient perceptions pertaining to satisfaction with the ongoing care arrangements
- evaluation of clinician satisfaction with ongoing care arrangements
- evaluation of clinician satisfaction with access to health records, including results of investigations from previous admissions
- readmission rates
- evaluation of ongoing education of consumers / patients
- discharge and transfer system – linkages with other care providers, record transfers.

References

1. Department of Health and Ageing, 2002, National Health Priority Areas, Available at: http://www.aihw.gov.au/nhpa/index.cfm
2. Strategic Service Plan, Hospital Authority
3. Smart Patients Websites: http://www21.ha.org.hk/smartpatient/tc/home.html

CONTINUITY OF CARE:
Standard, Criteria, Elements, Guidelines

Standard 1.1 Consumers / patients are provided with high quality care throughout the care delivery process.

Criterion	LA – Awareness	SA – Implementation LA plus the following
1.1.7 Systems exist to ensure that the **care of dying and deceased** consumers / patients is managed with dignity and comfort.	(a) A policy and procedures exist for the management of consumer / patient end-of-life care and are consistent with professional guidelines, common law and policy. (b) A policy exists for mortality management. (c) The organisation has access to palliative care and / or to pain management physicians.	(a) Relevant staff are educated about the policy and procedures for end-of-life management of a consumer / patient. (b) Relevant staff are educated on mortality management procedures. (c) The policy and procedures are implemented throughout the organisation. (d) A support system is used to assist staff, relatives and patients affected by the death. (e) When clinically indicated, consumers / patients are referred to palliative care and / or to pain management physicians.

These guidelines should be read in conjunction with criteria 1.6.2 rights and responsibilities and 1.6.3 cultural and special needs.

The intent of this criterion is to ensure that health care organisations place a high priority on the care and management of patients and their families / familial group, at the end of life. Reference should be made to the Hospital Authority Guideline on Life-sustaining Treatment in the Terminally Ill.[5]

Systems for end-of-life care include:

- decision making guidelines
- recognition of cultural and religious issues
- conflict resolution
- legal requirements
- care of the dying
- referrals to palliative care and / or to pain management physicians
- management of recognised risks.

Established guiding principles for the management of the dying patient should be used in the formulation of the health care organisation's policy and procedures.

They include:[2]

- When life cannot be preserved, the main objective is to provide comfort, respect and dignity for the dying person and their family.
- All patients have a right to be informed of their condition and to make choices about their care and treatment. Care givers have an ethical and legal obligation to honour these choices within established guidelines.
- Withholding and withdrawing life sustaining treatment may be permissible in the best interests of the dying patient. Health care organisations should establish in policy how this is to be managed, according to professional guidelines, in their health care organisation.
- A collaborative approach to decision making between health care providers, the dying patient and their carers should be achieved whenever possible.
- All decisions should be transparent and documented.
- Treatment decisions should be non-discriminatory and based on the patient's medical condition, values and wishes.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Processes surrounding dying and death are evaluated and improved as required. (b) Mortality management processes are evaluated and improved as required. (c) Clinical review committees including morbidity / mortality and case review, evaluate the appropriate referral of end-of-life patients to palliative care and / or to pain management physicians and improvements are made as required.	(a) Staff are provided with advanced training for end-of-life management of consumers / patients. and / or (b) End-of-life care and mortality management processes are compared with internal and external systems and improvements are made to ensure better practice.	(a) The organisation demonstrates that it is a leader in end-of-life care. (b) The organisation demonstrates that it is a leader in mortality management.

- Health care professionals are under no obligation to provide treatments that in the circumstances, offer little benefit to the patient. Patients and providers have the right to receive and provide care in accordance with cultural, religious and spiritual values and beliefs, professional standards and the law.
- The body of the deceased person should be treated with the same respect and dignity as the dying person.

In general terms health care organisations that care for dying and deceased patients should include in their policy and procedures the following:

- How decisions are to be made about the management of a dying patient. This includes whether and how 'Do Not Resuscitate' (DNR) orders are used, and the development and use of advanced care directives.
- The process for identifying and meeting cultural, spiritual and religious values and belief requirements.
- How disagreements within the health care team and / or with the family can best be resolved.
- How to manage difficult issues if they arise, which may include:
  - euthanasia and assisted suicide
  - the management of children and young people
  - artificial hydration and nutrition
  - withholding and withdrawing treatments
  - brain death
  - bereavement support for fellow consumers / patients and staff members.

Advance care planning is a process of preparing for likely scenarios near the end of life. It includes an assessment of, and dialogue about a patient's understanding of their medical history and condition, values, preferences and personal and family / familial resources. Where possible organisations should encourage the use of advance care plans.

The Law Reform Commission of Hong Kong has a Report on Substitute Decision-Making and Advance Directives in Relation to Medical Treatment that relates to decision making at the end of life and matters that relate to these decisions including advance care planning.

1.1 CONTINUITY OF CARE STANDARD

Criterion 1.1.7 *Systems exist to ensure that the* ***care of dying and deceased*** *consumers / patients is managed with dignity and comfort.*

(Continued)

The organisation also should include in its policy and procedures how it will best facilitate organ donation should this be an appropriate action to take.

Mortality management refers to care of the family and the deceased after death. Mortality management should include:

- management of the deceased in regard to notification, infection control, property etc
- referral to the Coroner when and where appropriate[11]
- consideration of relevant cultural and religious issues for the deceased person and their family / familial group
- interaction with the police when appropriate
- consent for post-mortem as appropriate
- consent for organ and tissue donation as appropriate
- interaction with other agencies such as undertakers
- emphasis on documentation of decisions both before and after death.

Organisations may provide evidence of achievement in this criterion through:

- documented policies, including:
  - how issues regarding dying and death are raised with consumers / patients, their carers and staff
  - organ donation, including profile, processes and outcomes
  - staff education policies and evidence of education in mortality management
  - cultural and religious guidelines
  - decision making guidelines
- evidence of mechanisms to deal with family / familial issues
- evidence of compliance with legislative requirements
- palliative care and pain management services, including evidence of staff education in palliative management
- health record review for advanced care plans

References

1. Palliative Care Australia, 2005, Standards for Providing Quality Palliative Care for all Australians. Available at: http://www.pallcare.org.au/Portals/9/ docs/Standards%20 Palliative%20Care.pdf
2. NSW Health, 2005, Guidelines for end-of-life care and decision making. Available at: http:// www. health.nsw.gov.au/pubs/2005/pdf/end_ of_life_ care.pdf
3. Improving Supportive & Palliative Care for Adults with Cancer. National Institutes for Health and Clinical Excellence 2004.
4. Guidelines on Palliative Care, Hospital Authority.
5. Hospital Authority Guidelines on Life Sustaining Treatment in the Terminal Ill 2002.
6. Hospital Authority Guidance on Advance Directives in Adults 2010.
7. Guidelines on Diagnosis of Brain Death Hospital Authority Head Office 2007.
8. Human Organ Transplant Ordinance (Cap 465).
9. Hospital Authority Guidelines for Organ Donation – liver, kidney, cornea, heart, and lung.
10. Report on Substitute Decision-Making and Advance Directives in Relation to Medical Treatment, the Law Reform Commission of Hong Kong.
11. Coroners Ordinance (Cap 504).

CONTINUITY OF CARE:
Standard, Criteria, Elements, Guidelines

Standard 1.1 Consumers / patients are provided with high quality care throughout the care delivery process.

Mandatory Criterion	LA – Awareness	SA – Implementation LA plus the following
1.1.8 *The **health record** ensures comprehensive and accurate information is recorded and used in care delivery.* This is a Mandatory Criterion.	(a) Every consumer / patient has a clinical health record with a unique identifier. (b) Current health record documentation policies and procedures are available for staff and meet relevant professional guidelines. (c) Relevant internal and external health care providers have access to information about the consumer / patient, in accordance with Personal Data (Privacy) Ordinance (Cap486) (d) Documented guidelines are available for consumers / patients on how to access their health records.	(a) Health care providers use the health record to document and communicate all aspects of care delivery in accordance with the organisation's policy. (b) The health record is sufficiently detailed to allow care delivery to be tracked, monitored and evaluated. (c) Cross-references exist between the consumer / patient paper-based health record(s) and any part of the record stored electronically. (d) Hand-written health records are legible. (e) Health care providers are instructed in, and can describe their responsibilities for documentation. (f) Results of reviews and clinical consultations are made available to health care providers.

These guidelines should be read in conjunction with criterion 2.3.1 records management systems.

The intent of this criterion is to ensure that consumer / patient health records are comprehensive, maintained efficiently and that consumer / patient confidentiality is protected.

The **health record** is a legal document that should accurately outline the total needs and the care and management, of consumers / patients. It facilitates communication, decision making and evaluation of care and protects the legal interests of the consumer / patient, clinician and the organisation. For the purpose of this criterion, health records refer to both electronic and paper-based records and should refer to Cap 486 Personal Data (Privacy) Ordinance and Cap 174 Births and Deaths Registration Ordinance[1,2].

A single health record for a consumer / patient assists continuity of care by having all available information in one source. Sections or separate reports should not be kept in different areas / services throughout the organisation as information will not be available to allow informed decision making in the care process and the consumer / patient could be at risk. If the record is required to be separated an organisation should have links and cross-references between the related records. Electronic records (whether complete or partial) should also be linked to the hard copy record.

Despite the availability of many guidelines on the importance of health record documentation, poor documentation continues to be a major factor in medical indemnity claims and adverse events.

Organisations should consider the needs of the consumer / patient, the health care providers and the organisation in developing policies for health record content. A health record should fully document the consumer / patient care and provide any relevant information to ensure the

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Health records are evaluated to ensure they meet medico-legal requirements, professional documentation standards and state / territory health department guidelines. (b) Timeliness of reports and information from investigations are evaluated and improved, as required.	(a) The health record documentation system is compared with internal and external systems and improvements are made to ensure better practice. and / or (b) Results of monitoring of documentation are trended and demonstrate that documentation continuously meets all requirements of external standards and guidelines.	(a) The organisation is a leader in health record documentation. (b) A fully electronic health record exists for each consumer / patient that meets best practice standards.

safe and effective delivery of health care. It should include:[9, 10]

- a unique identifier for health records e.g. Hong Kong identity card number, hospital number, etc.
- a system to alert staff to consumers / patients of the same name
- identification of consumers / patients with challenging behaviours
- the identity of the practitioner who made the record entry, and the consumer / patient it relates to
- complete, legible notes of treatment and care given, medications prescribed and diagnostic tests ordered
- diagnostic test results and a record of when results were received
- accurate statements of fact, or statements of clinical judgment or inquiry, made contemporaneously with consumer / patient consultation
- relevant dates and the content of consultations, discussions and advice or information given to the consumer / patient
- legible entries and no erasures
- diagnosis, details of any treatment plan or ongoing course of care
- operation reports and anaesthetic records if applicable
- details of any allergies, adverse events and relevant consumer / patient history of any of these
- copies or other records of consent to treatment given by the consumer / patient

1.1 CONTINUITY OF CARE STANDARD

Criterion 1.1.8 *The **health record** ensures comprehensive and accurate information is recorded and used in care delivery*

(Continued)

- sufficient information in a form that enables other practitioners to deliver health care safely and promptly, including, if appropriate, the consumer / patient cultural background and / or country of birth and language spoken at home.

Organisations may provide evidence of achievement in this criterion through:

- content of health records, including identification of non-residents from mainland China, Macau and other foreign countries
- evaluation of content of health records by a clinician or nurse, using set agreed criteria
- evidence of strategies for improvement following evaluation, reported back to staff / clinicians
- results of reviews and audits of health records
- evidence of cross-references to other records
- evidence of flags to indicate another record in another format.

References

1. Personal Data (Privacy) Ordinance (Cap 486).
2. Births and Deaths Registration Ordinance (Cap 174).
3. Manual of Good Practices in Medical Records Management.
4. Clinical Data Policy Manual.
5. Guideline on Application of the Data Quality Management Mechanism.
6. Manual on Personal Data (Privacy) Ordinance.
7. Medico-legal Guidelines.
8. A Draft Paper on Disclosure of Patient's Information.
9. NSW Health. A framework for managing the quality of health services in New South Wales. Sydney: NSW Department of Health, 1999.
10. NSW Health Medical Practice Regulation. Regulatory Impact Statement. 2003.
11. United Medical Protection (UMP), Clinical records and your practice. Available at: http://www. unitedmp.com.au/0/0.13/0.13.4/ ClinicalRecords. pdf
12. MDA National Information on Medical Records. Available at: http://www.mdanational.com.au/ risk/strategies_medicalrecords.asp

Further Reading 1.1

ABC Radio National. The Health Report: medical emergency team (MET). 2005. Available at: http://www.abc.net.au/rn/talks/8.30/helthrpt/stories/s1396034.htm

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Cretikos M, Hillman K. The medical emergency team: does it really make a difference? Internal Medicine 2003;33(11): 511-514.

Department of Health and Ageing, Aged care Assessment Information and other health priorities: http://www.health.gov.au/internet/wcms/publishing.nsf/Content/Aged+Care+Assessment+Teams

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Information on health / mental health for consumers and health professionals: http://www.athealth.com/Consumer/newsletter/FPN_4_25.html#4

Institute for Healthcare Improvement,100K Lives Campaign: http://www.ihi.org/IHI/Programs/Campaign/

Lee A, Bishop G, Hillman K, Daffurn K. The medical emergency team. Anaesthesia Intensive Care 1995;23(2):183-186.

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The Office of the Privacy Commissioner; Information for health service providers regarding their obligations under the federal privacy act: http://www.privacy.gov. au/health/index.html

CLINICAL FUNCTION

SUPPORT FUNCTION

CORPORATE FUNCTION

1.2 ACCESS STANDARD

The standard is: **Consumers / patients / communities have access to health services and care appropriate to their needs.**

The intent of the Access standard and criteria is to ensure that communities and consumers / patients have access to necessary health care and services. Health services should ensure that the community has information on available health services and that access is determined by the clinical needs of consumers / patients.

There are two criteria in this standard. They are:

1.2.1 The community **has information on, and access to,** health services and care appropriate to its needs.

1.2.2 Access and admission to the system of care is **prioritised according to clinical need.**

Access is one of the fundamental dimensions of quality in health care. Access refers to the extent to which an individual or population can obtain health care services[1]. There will be different issues about access depending on the service (acute or community) and the sector (public or private). Each organisation should interpret the criteria relevant to their sector and service.

Reference

1. Boyce N, McNeil JJ, Graves D and Dunt D. Quality and outcome indicators for acute healthcare settings. Canberra: Commonwealth Department of Health and Family Services, 1997.

ACCESS:
Standard, Criteria, Elements, Guidelines

Standard 1.2 Consumers / patients / communities have access to health services and care appropriate to their needs.

Criterion	LA – Awareness	SA – Implementation LA plus the following
1.2.1 The community has information on, and access to, health services and care appropriate to its needs.	(a) Information is gathered to define the needs of the community. (b) Information on and access to the organisation's health care services are available to the community and external service providers. (c) When 24 hour emergency services are not available, there is information about the location of the closest emergency service. (d) Relevant external service providers are informed of referral and entry systems.	(a) Consumers / patients have information about the specific service(s) they are using. (b) Health care providers within the organisation have information on relevant external services. (c) There is collaboration between the organisation and external service providers where required.

These guidelines should be read in conjunction with criterion 1.6.3 cultural and special needs.

The intent of this criterion is to ensure that organisations consider the needs of the community for access to, and information on, services provided.

The **community** that the organisation serves may be defined in two ways. Public health care organisations have a responsibility for providing health services to the general broad community, usually defined geographically. A private health care organisation's community however, is described as those consumers / patients who are referred to the health service, by whatever means, for care. Most private health services do not have a responsibility for satisfying the needs of a geographic community.

The **definition of a community** often poses a challenge for a day procedure centre. Their community is often defined through their referral base, which can extend across district, or for some more specialised services, overseas. Generally, the local community will include a defined geographical area as well as a number of distant referral locations – these should be included in references to their community.

It is important that an organisation defines its community, in order to understand the cultural influences or specific requirements within the community, and / or the usual consumers of the service. Public organisations may use demographic data to collect this information. Following definition of its 'community', an organisation will determine the range of services to be provided, and the information that consumers / patients and the community will need in order to access those services. The organisation will then be able to address any special needs of consumers / patients, for example, making Kosher and Halal meals available, or providing a designated play area for children.

The community and the role the organisation has within it, will usually be defined in the organisation's strategic or operational plans. The organisation's definition of their community may depend on the type of service it provides. For example if the organisation is a community centre its community may be young families within the area. If however, the organisation is a private hospital that specialises in ophthalmic surgery then its community will be consumers / patients who are referred to the organisation by (probably) ophthalmic surgeons, as well as the ophthalmic surgeons themselves. Day procedure centres / private organisations should

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The organisation evaluates information on, and access to, services and makes improvements, as required. (b) The methods of communication and providing information to internal and external service providers are evaluated and improved as required.	(a) The organisation compares information on access and access systems, externally and improvements are made to ensure better practice.	(a) The organisation demonstrates it is a leader in information on access and access systems.

include their referring general practitioners (GP) and surgeons as part of their community.

The information that organisations are required to provide to their community may include:

- services available within the organisation, such as pharmacy, outpatient services, cafes, onsite attached accommodation, counselling, surgical services provided
- specific service information for its consumers / patients, such as a list of things to bring on admission, for example medication, street clothes, night attire, x-rays, limited cash and valuables
- financial information relevant to admission
- how the organisation will handle health information, irrespective of whether consent is given. This information should be provided at the earliest opportunity and in line with the Personal Data (Privacy) Ordinance.

Information on health services may be provided in many different formats. These will include:

- directories or lists of organisational and community based services
- brochures and handouts
- websites
- Inquiry hotline
- Public announcement
- other forms of telecommunications.

The organisation should consider its defined community to determine how information may need to be provided to consumers / patients with cultural or special needs. The organization should also develop partnership with local service agencies and organisations, e.g. community centres, elderly centres, schools, patients groups to deliver service information.

External service providers can encompass a wide variety of clinical relationships. These may include visiting medical officers, GP's, allied health practitioners and community pharmacies. A system for communication between the organisation and external providers should be in place to enable appropriate referral and access to the services provided within the organisation.

The community should be made aware of these relationships and how they interact with the health service, particularly in the case of community pharmacies. Organisations that utilise external pharmacies should ensure that their consumers /

1.2 ACCESS STANDARD

Criterion 1.2.1 The community has **information on, and access to** health services and care appropriate to its needs.

(Continued)

patients are informed of details of their medication management prior to distribution by the pharmacy.

The term **normal hours of business** will be interpreted differently by different organisations. It does not mean exclusively, Monday to Friday, 0900 hrs – 1700 hrs.

For example, the service might offer weekend respite or rural area weekend community nurse rounds etc. The concept is that the service is open at predictable hours and these hours may be limited, for example not 24 hours per day or even eight hours per day.

- Operational hours are often based on availability of staff, but whenever possible the specific service hours should reflect community needs. For example, if the organisation offers antenatal classes, consider whether these are held during the day, the evening and / or the weekend. Where day procedure centres are co-located or share premises, consumers / patients should be advised of the times when their service is available at the joint location.
- Operational hours that are reflective of the community's needs and not just the hours that the service is willing to operate, demonstrate a customer focussed approach.
- If 24 hour emergency services are not available onsite, it is essential that there is information on where and how to access emergency services. Day procedure centres should ensure all patients are provided with appropriate follow-up information should an issue arise. These can include after-hours contact phone numbers as well as numbers for the nearest emergency department. Mental health organisations should provide contact details for case managers or mental health crisis teams.

Organisations may provide evidence of achievement in this criterion through:

- information sheets provided for community, including information on:
  - public transport routes and timetables
  - available parking options
  - locations of community or affiliated pharmacies
- media releases / advertising / newsletters / open days / public displays
- results of consumer surveys
- organisational service directory
- evidence of new or extended services provided
- new community groups accessing information
- details of other aligned service providers to assist with postoperative care
- contact number for referrers and processes of referral if requested

Reference

1. Personal Data (Privacy) Ordinance (Cap 486).

ACCESS:
Standard, Criteria, Elements, Guidelines

Standard 1.2 Consumers / patients / communities have access to health services and care appropriate to their needs.

Criterion	LA – Awareness	SA – Implementation LA plus the following
1.2.2 **Access** and admission to the system of care is **prioritised according to clinical need.**	(a) The organisation is aware of the need to prioritise consumer / patient access to services. (b) Guidelines for the admission of consumers / patients to the services are available.	(a) A system exists for prioritising care according to need. (b) Admission / entry processes meet consumer / patient needs and minimise duplication. (c) There is a system to ensure continuity of care between referrers and providers.

The intent of this criterion is to ensure consumer / patient clinical need is considered when prioritising access and admission to an organisation.

There will be different issues about access depending on the service (acute or community) and the sector (public or private). Each organisation should interpret the criterion relevant to their sector and service.

In the public sector, access may be considered by an organisation in relation to transport, money, cultural barriers, availability of appointment times, inadequate numbers of beds and available resources. There should be processes to deal with service provision, meeting consumer / patient needs and prioritisation. Improvements and changes in services may be necessary to continue to meet the needs of the organisation's community.

In the private sector, the clinician usually has the primary role of determining access and prioritisation. In some private health care organisations, bed management issues will still need to be considered where waiting lists are utilised.

Day procedure centres may not have the same issues as other health organisations in relation to 'bed' management, but in areas of high demand, processes need to be developed to ensure that care is provided in a timely fashion. Consumers / patients may be drivers for access where waiting lists are not routinely used, as their procedures tend to be elective in nature. Many day procedure centres have incorporated priority codes for use by the referrer to assist in timely allocation of appointments.

Clinical need will generally be determined with the consumer / patient, by their clinician. Ability to admit to a particular organisation at any time will vary and many factors may need to be considered. Documented selection criteria for treatment / admission / referral to various services should exist.

Day procedure centres should consider the use of admission / selection criteria to assist them in ensuring that consumers / patients are appropriate for the levels of care and types of services offered. This may result in day procedure centres sourcing information on other service providers deemed suitable for care. This in some cases may be the local public hospital.

Admission to a health care organisation may include a determination of who has priority for admission; for example in a mental health service, how operating theatres are accessed and by whom and how intensive care beds are accessed and by whom and what community caseload can be covered. The admission process to any health care organisation should be well documented. Consumers / patients should be informed of the admission process. Staff should be educated about their responsibilities regarding admission, including issues such as privacy and confidentiality and non-discriminatory processes.

In private health organisations, the admission process may also need to incorporate approval from relevant private health insurers and / or the confirmation of alternate payment options. Evidence of how and when this occurs should be available including how issues relating to privacy

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The organisation evaluates the effectiveness of its prioritisation guidelines and these are improved as required. (b) The organisation evaluates the admission process and this is improved as required.	(a) The organisation compares access and admission systems, internally and externally and improvements are made to ensure better practice.	(a) The organisation demonstrates it is a leader in prioritising access for appropriate consumers / patients and for its admission processes.

and confidentiality are dealt with when discussing financial issues with the consumer / patient.

The organisation should **evaluate** the appropriateness of the services it provides to its community to ensure that they continue to be suitable to the needs of the community. This evaluation should include a review of the collaboration, and consultation with consumers / patients, as well as external providers.

Organisations may provide evidence of achievement in this criterion through:

- policies on triage
- admission policy, including the documented selection criteria
- theatre lists
- ICU access policy
- policies on prioritisation
- evaluated data from waiting lists and systems
- results of evaluation of systems
- results of patient satisfaction surveys which have included questions on the admission process
- results of referrer satisfaction surveys on the admission process
- referral information for inappropriate consumers / patients in line with admission criteria.

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CLINICAL FUNCTION

SUPPORT FUNCTION

CORPORATE FUNCTION

1.3 APPROPRIATENESS STANDARD

The standard is: **Appropriate care and services are provided to consumers / patients.**

The intent of the Appropriateness standard and criterion is to ensure that consumers / patients receive appropriate and necessary care, interventions and services.

There is one criterion in this standard. This is:

1.3.1 Health care and services are **appropriate** and delivered in the most appropriate setting.

Appropriateness is doing the right treatment, intervention or service in the right way and effectiveness is the extent to which those treatments, interventions or services achieve the desired outcomes.

This criterion is a 'developmental' criterion. A developmental criterion is one which has been included in EQuIP for the purposes of:

- creating awareness
- encouraging improvement and research
- commencing collaborative national action

in a specific area of quality in health care.

Organisations should work towards achieving performance in this criterion and surveyors will survey against the criterion for the purposes of evaluation. However, for the first four years of implementation of this criterion, the survey result for the criterion will not be considered in determining the accreditation status of the organisation.

Improving the appropriateness of health services and interventions will not be an easy task. There is no one straightforward method for achieving this. Just as several years ago a significant focus was placed on improving patient safety, work should now commence on this very important dimension of quality in health care. Very little was known about the right ways to improve patient safety when action started. Unlike patient safety however, a significant body of evidence exists to provide guidance to health care organisations on how to improve appropriateness.

APPROPRIATENESS:
Standard, Criteria, Elements, Guidelines

Standard 1.3 Appropriate care and services are provided to consumers / patients.

Criterion	LA – Awareness	SA – Implementation LA plus the following
1.3.1 Health care and services are **appropriate** and delivered in the most appropriate setting.	(a) The organisation is aware of the need to provide appropriate care and services in an appropriate environment. (b) A policy exists on how to assess the appropriateness of care and services and the setting in which they are provided. (c) Guidelines are used for ensuring appropriate care delivery.	(a) A strategy is in place to facilitate the appropriate use of: (i) surgical treatment interventions (ii) medical treatment interventions (iii) diagnostic interventions (iv) advice and counselling services (v) referrals and linkages to services. (b) Service planning includes an evaluation of the appropriateness of the services to be provided. (c) The organisation collects a suite of key indicators about appropriateness.

The outcome of appropriate care is the consolidation of a number of other criteria. For organisations to demonstrate appropriate care they can reference activities in other criteria, such as:

- 1.1.1 assessment
- 1.1.2 care planning and delivery
- 1.1.4 care evaluation
- 1.2.1 information on services
- 1.2.2 access to services
- 1.4.1 effectiveness
- 2.1.2 risk management
- 2.1.3 incidents and complaints
- 3.1.1 strategic and operational planning
- 3.1.3 credentialling and defining the scope of clinical practice.

All criteria and dimensions of quality can be linked to appropriateness.

Appropriateness refers to the selection of the intervention that is most likely to produce the desired outcome.[1] Appropriate care is considered to be 'relevant to the client's needs and based on established standards'. The questions to be asked for this dimension could be:

- Is the care / intervention / action provided relevant to consumer / patient needs?
- Is the care / intervention / action based on established standards?

Appropriateness is doing the right thing (in the right setting). It is about doing what is necessary, not doing what is not necessary. Inappropriate care can result from either:

- **underuse**, such as the failure to provide a service which has a benefit that is greater than the risk
- **overuse**, when a health service is provided even though the risk outweighs the benefit.

Appropriateness is one of the nine key dimensions of quality in health care.[2] The other dimensions of quality are effectiveness, efficiency, responsiveness, accessibility, safety, continuity, capability and sustainability. Appropriateness refers to the extent to which services are provided only when they are needed. It requires an assessment of

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The system for assessing the appropriateness of care and services is evaluated by clinicians and management and improved as required. (b) Clinicians and managers are involved in the evaluation of appropriateness.	(a) The system for ensuring appropriateness is compared with external systems and improvements are made to ensure better practice. and / or (b) The organisation publishes comparative data demonstrating improvements in appropriateness. and / or (c) The organisation researches the appropriateness of particular interventions and acts on results.	(a) The organisation demonstrates that it has developed and implemented appropriateness guidelines in an expanding range of services. (b) The organisation demonstrates that it is a leader in providing appropriate care and services in the appropriate setting. (c) The organisation publishes the results of research on appropriateness for broader health system benefit.

value of the service compared to the risk to the consumer / patient in providing or not providing the service. The question of appropriateness of care is seen to be applicable to all health settings and modes of delivery. Many health services already undertake improvement activities that relate to the appropriateness of their services.

There are three levels of appropriateness:

1. the territory level
2. the organisation level
3. the clinician level.

1. **Territory level** – This level encompasses work that has been done by medical colleges, jurisdictions, and other industry bodies in relation to appropriateness. For example, the Hospital Authority has developed guidelines for the appropriate use of blood transfusions which all public hospitals use.

2. **Organisation level** – this level should be the focus of the appropriateness criterion for both organisations and surveyors when assessing and reviewing appropriateness. This criterion focusses on the systems within the organisation that support appropriateness and the evaluation of these systems.

- An organisation is responsible for ensuring that there is a process in place for determining appropriateness.
- Although the size of Hong Kong is small, appropriateness will vary across different health care organisations depending on the local population, the population receiving treatment and consumer needs.
- Systems that may support the assessment and evaluation of appropriateness include the credentialling system and scope of clinical practice system, peer review meetings and / or clinical audit reviews.
- Many services already use criteria for the appropriate admission of consumers / patients to their service such as the admission of patients to a day surgery as outlined by the Hong Kong College of Anaesthesiologists' guidelines.

1.3 APPROPRIATENESS STANDARD

Criterion 1.3.1 Health care and services are **appropriate** and delivered in the most appropriate setting.

(Continued)

- Many organisations review utilisation data for certain interventions and admission categories to determine why their rates are at such variance from other organisations.
- Utilisation rates alone are not a measure of appropriateness. These should be reviewed in consultation with the clinicians and the need of the consumers / patients that an organisation treats. Some other heath services require that their clinicians discuss with their consumers / patients the criteria for the appropriate use of some surgical interventions. These criteria may be documented in the organisation's policies and procedures.
- It is not expected that an organisation has a specific **policy on appropriateness** rather 'appropriateness' of the care and services they provide is reflected throughout more specific organisational and clinical policies.

3. **Clinician level** – The clinician is responsible for determining the most appropriate test, procedure or intervention for a consumer / patient and to discuss the appropriateness with the consumer / patient and document this discussion in the consumer / patient health record.

Doing the right things in the right way will be a multidimensional exercise. There are therefore many components of appropriateness. For the purposes of simplifying this standard and criterion two components of appropriateness have been highlighted for action:

- the appropriateness of care, an intervention or a service
- the appropriateness of the setting in which the care or service is provided.

Many thousands of interventions are provided to consumers / patients every day. These include:

- surgical treatment interventions
- medical treatment interventions
- diagnostic interventions
- advice and counselling services.

The challenge is to ensure that as many of those interventions as possible are needed and are going to provide benefit to the consumer / patient. There is a very strong correlation between the effectiveness and the appropriateness of an intervention.

The appropriateness of an intervention is the effectiveness of that intervention for a particular type of consumer / patient and in certain circumstances. This involves the choice of the service that will most benefit the consumer / patient. For most conditions / diagnoses there are interventions for which there is good evidence.

Appropriate care is also effective care,[2] however the treatment is considered in relation to the patient's particular needs, requests and prognosis. Treatments for similar conditions may vary according to the patient's needs and this may take into account factors such as:

- allergies or adverse reactions
- a person's preference for treatment at home or in a medical facility
- a choice between aggressive treatment versus palliative care
- elective versus emergency procedures
- the stage of the disease process or severity of injury
- cultural influences and religious beliefs.

Appropriate care or treatment should be based on established and accepted standards, such as evidence-based clinical guidelines.

Appropriate may overlap with effective but the main differentiation is that several interventions for a health condition may be effective and available, but one of the treatments may be more relevant or appropriate to the person's needs or community objectives. Furthermore, a particular intervention may be considered to be effective but inappropriate.

Coronary artery bypass grafting (CABG) can also serve as an example of how the effectiveness and appropriateness of a service are related.[3] Clinical trials have shown that CABG is effective in improving survival rates among consumers /

patients with certain indications such as severe angina, positive results on non-invasive tests and 90% narrowing of the left main coronary artery (LMCA). However the same trials show that CABG is ineffective (and thus inappropriate) if it is performed on a consumer / patient with no symptoms and negative results on non-invasive tests and only 30% narrowing of the LMCA. It would therefore be inappropriate to do CABG on these patients.

The appropriateness of the setting in which care is provided is determined by matching consumer / patient needs for treatment with the setting in which it should be provided. This may vary from patient to patient. Appropriate services can be provided in inappropriate settings. For example, a person who has been recently diagnosed with diabetes will require several interventions. In most circumstances it will not be necessary for these services to be provided as an inpatient, but more appropriately, they should be provided as ambulatory services. Consideration should always be given to the most appropriate setting for the provision of care to the elderly, for example, in hospital, a nursing home, hostel or a transitional care facility.

When either the appropriateness of a setting or of the intervention itself is considered, it is assumed that they are provided in a high quality, safe and technically correct manner. Different conclusions can be drawn from the two types of inappropriate health care delivery. A service that is inappropriate for a specific type of consumer / patient should not be provided in any setting. The service is not expected to benefit the consumer / patient and therefore, is not needed. An inappropriate setting means that care could be provided in an alternative setting. It is not possible to identify particular care settings as appropriate or inappropriate. Appropriateness depends on the availability of alternative settings.

Serious issues are also raised about whether organisations should provide services that are considered in the literature to be either of little benefit, unnecessary or inappropriate, simply because the consumer has requested it.

Measuring and managing appropriateness is difficult with the use of a single variable or instrument. Appropriateness of the service can be examined on an individual consumer / patient basis or through an overall approach.

The approach that considers the appropriateness of the care or service provided to an individual underpins clinical peer review activities, where care provided to an individual is compared against a normative standard of care. This may be documented in several ways including a clinical pathway, and / or against a set of intervention / care selection criteria.

Based on the best available evidence a list of criteria can be developed to determine when it is appropriate to use a certain intervention. This will provide more of an assurance to the consumer / patient, the organisation and the funders of health care that interventions that are provided, such as tonsillectomies and hysterectomies in young women are only undertaken in the most appropriate circumstances.

An overall approach for assessing appropriateness examines variations in service provision and draws conclusions from statistical data on the appropriateness or otherwise of services. Review of such data will identify variations in utilisation patterns, but this alone will not allow conclusions to be made regarding the appropriateness of the services. If variations are found, analysis of the reasons should be reviewed.

Evidence of inappropriate care can be seen in data that would indicate either overuse or underuse of services. The ability to determine and identify which care is overused and which is underused is essential.

Examining admission rates for particular conditions and rates of particular interventions (relative utilisation rates) may give an organisation some idea of the appropriateness of those admissions and interventions. Large variations in admission rates or relative utilisation rates are signals of inconsistencies in the factors affecting admission and interventional use. These signals could identify opportunities to achieve better health outcomes for individual consumers / patients through quality improvement processes and adopting best practice. Where variations are seen, the health care organisation has a responsibility for examining

1.3 APPROPRIATENESS STANDARD

Criterion 1.3.1 Health care and services are **appropriate** and delivered in the most appropriate setting.

(Continued)

the reasons for the variation and improving where necessary.

Health services will need to identify **a suite of indicators** that are relevant to the services they provide, establish a mechanism for comparison with other similar health services and establish a system for analysis and improvement.

There are several well documented methods available for examining and improving appropriateness. The RAND Corporation and the University of California, Los Angeles (UCLA)[4] have developed an explicit method for determining the criteria for the appropriate use of medical and surgical interventions. The method begins with a literature analysis that summarises what is known about the efficacy of a procedure, its effectiveness, and indications for its use. The next step is to develop a list of specific clinical indications based on that review. Using the list of indications and a literature review, peers can rate the appropriateness on a scale of one to nine. On the basis of these ratings and clinical data collected from health records, appropriateness in actual practice can be measured.[5]

Clinical information in the health record can be reviewed to determine the indications for the services and any relevant risk factors or co-existing illnesses. To assess the appropriateness of the setting, the medical record may be reviewed to determine the severity of the illnesses and the intensity of services needed to care for the patient.

In using admission rates to improve the appropriateness of care it should be borne in mind that:

- the rates need to be focussed on a specific admission type or procedure group
- determining the 'right rate' is extremely complex and is not necessary to improve the appropriateness of care
- there may be advantages in comparing data with 'high rate', 'median rate' and 'low rate' organisations
- active participation by clinicians at the local level in identifying relevant local factors and implementing strategies is essential. The importance of involving at least one locally recognised leading clinician cannot be overemphasised
- no single technique will be effective in all instances and often, a combination will be required.

In summary, there are different expectations for managing appropriateness at different levels; territory, organisational, clinical unit and individual clinician level. Health care funders will also have an interest and responsibility for facilitating the use of appropriate interventions and care and the decrease in the use of inappropriate interventions and care. The continuous evaluation of the implementation of this criterion in health services will contribute to the evidence required to ensure that action at the various levels of organisation is effective.

Organisations may provide evidence of achievement in this criterion through:

- policies, procedures and guidelines
- evidence of the use of criteria of appropriateness, such as the Interhospital Multidisciplinary Programme on Antimicrobial Chemotherapy (IMPACT) guideline
- evidence of the use of analysis of indicators of appropriateness
- adherence to by-laws
- clinical service plans
- demographics, population, studies, demographic data
- organisational profile
- clinical pathways / patient care plans
- contracts with other service providers such as Radiology Service or satellite Haemodialysis Service
- operational plan
- new interventions policy
- staffing levels and skill mix

- education
- clinical audit
- review of clinical indicators
- credentialling of staff
- patient selection and admission
- incident data
- ulilisation data.

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7. National Institute for Clinical Excellence (NICE) guideline.
8. Cochrane database.
9. Guidelines for Day Case Surgery, The Hong Kong College of Anaesthesiologists http://www.hkca.edu.hk/ANS/standard_publications/guidep05.pdf
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CLINICAL FUNCTION

SUPPORT FUNCTION

CORPORATE FUNCTION

1.4 EFFECTIVENESS STANDARD

The standard is: **The organisation provides care and services that achieve expected outcomes.**

The intent of the Effectiveness standard and criterion is three fold. It is to ensure that:

- health care organisations use interventions that have been proven to be effective
- all other care, services and interventions are based on the best available evidence
- care is provided in the most effective way possible.

There is one criterion in this standard. This is:

1.4.1 Care and services are planned, developed and delivered based on the **best available evidence** and in the **most effective way.**

Appropriateness is doing the right treatment, intervention or service in the right way and **effectiveness** is the extent to which those treatments, interventions or services achieve the desired outcomes.

EFFECTIVENESS:
Standard, Criteria, Elements, Guidelines

Standard 1.4 The organisation provides care and services that achieve expected outcomes.

Criterion	LA – Awareness	SA – Implementation LA plus the following
1.4.1 Care and services are planned, developed and delivered based on the **best available evidence** and in the **most effective way.**	(a) Health care professionals know how to access sources of evidence for the care and services the organisation provides. (b) A policy exists for implementing best available evidence into clinical practice. (c) The organisation is aware that consumers / patients accommodated outside the specialty ward area may be 'at risk'.	(a) A system exists for appraising the best available evidence and determining the practice that will be implemented in the organisation. (b) The organisation supports health care providers in the implementation of evidence-based care. (c) The organisation identifies, maps and documents its key care processes. (d) Care process mapping is undertaken by a multidisciplinary team where applicable. (e) A policy and system exist for the management of consumers / patients accommodated outside the specialty ward area to ensure care is safe and effective.

These guidelines should be read in conjunction with criteria 1.1.2 care planning and delivery, 1.3.1 appropriateness, 2.4.1 population health and 3.1.5 corporate and clinical policies.

The effectiveness of health care relates to 'the extent to which a treatment, intervention or service achieves the desired outcome'.[1] Organisations should consider these questions:[2]

- What is the right thing to do?
- Did we do the right thing? (appropriateness)
- Did we do it right? (effectiveness)

There is evidence available to inform health care organisations of the strategies and methods that can be used to provide the most effective care, services and interventions.

This standard and criterion require health care organisations to focus on three key strategies for which there is evidence of a contribution to providing more effective care and services. They are:

- using interventions / treatments that are determined to be most effective
- using evidence in the development and delivery of care and services and in the development and implementation of policy and other practices
- mapping and documenting key processes to ensure they will be undertaken in a consistent manner to minimise variation.

All health care organisations need to have systems in place that ensure as much as possible that available evidence is considered and used to determine what clinical practices will be used in that setting, and that the systems used to ensure evidence-based practice are well developed and work well.

Clinical practice guidelines should be used whenever available. A system should be developed to ensure that evidence is used in the development of these guidelines.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Indicators are used to evaluate the use of evidence-based care which is improved as required. (b) The system for ensuring the use of effective care, services and practice is evaluated and improved as required. (c) Key care processes are evaluated and improved as required. (d) The system for managing consumers / patients accommodated outside the specialty ward area is evaluated and improved as required.	(a) The system for ensuring the use of effective practice is compared externally and improvements are made to ensure better practice. and / or (b) The organisation benchmarks identified key care processes with like organisations and improvements are made to ensure better practice. and / or (c) The organisation undertakes research into the effectiveness of interventions and services and on the adoption of evidence into practice.	(a) The organisation demonstrates that it is a leader in the practice of evidence-based health care. (b) The organisation demonstrates that it is a leader in its identified key care processes.

Evidence may change and practices that are considered to be best practice now may change with time and the accumulation of more evidence. Best practices can only be based on the best, currently available evidence.

In the current health care environment clinicians and managers can no longer rely solely on experience, rationale and opinion-based processes. Health care organisations need to be sure that all **policy development**, care processes and services are based on the **best available** evidence, considering all other interventions provided in health care.

Organisations need to be assured that clinical teams are examining the evidence available when determining care plans and clinical pathways. It is recognised that some proven interventions may be cost prohibitive and perhaps that not all proven interventions will be able to be used in all appropriate circumstances, such as new drugs that are not yet on the Hospital Authority Drug Formulary. It is recognised that implementation may be dependent on many external factors, for example, government purchasing policies and practices, corporate office policies.

The best way for health care organisations to ensure that they **provide care and services in the most effective way**, is to:

- understand their most common care processes including the admission and pre-operative processes
- document the best way to carry out those processes
- put mechanisms in place to ensure that all who are involved, understand and carry out the process in this expected way.

It is not expected that a care map or process flow chart will be exactly correct for all patients with a particular condition. It can be expected however, that approximately 80% of patients with a particular condition will require the same components of care. Examination of the variation from this pathway should lead to improvements.

1.4 EFFECTIVENESS STANDARD

Criterion 1.4.1 Care and services are planned, developed and delivered based on the **best available evidence and in the most effective way.**

(Continued)

In larger organisations, the purpose of **process redesign** is to achieve effective care from a consumer / patient perspective, identifying where delays, unnecessary steps or potential threats are built into the process, and then redesign the process to remove them and improve the quality of care. Typical steps in such a process might include:

- mapping the existing care process (sometimes described as the 'as is' stage)
- analysing where problems exist in that process and questioning why each step is done, by whom, where, in what sequence, and whether there is a better way
- imagining what 'an ideal' process might look like
- identifying practical changes to the current process to make it closer to the ideal process
- testing these changes and evaluating whether they result in improvement.[3]

This process of review or redesign may result in a clinical pathway or care pathway, however named. Such documents ensure that all steps in the process that are undertaken are necessary, all multidisciplinary care providers are aware of all necessary steps and no essential steps are forgotten.

A consumer / patient accommodated outside the specialty ward area, is one who is being treated in an area of the health service that normally treats a different casemix. A consumer / patient accommodated outside the speciality ward area may also be known as a **'home-ward outlier'**. For example, a consumer / patient with a medical condition such as diabetes may be admitted to a surgical ward because of a lack of available medical beds, or a child may be admitted to a non-paediatric ward. A consumer / patient who suffers from dementia could be considered to be a 'home-ward outlier' in any environment, especially if they are the only consumer / patient in that area suffering from dementia. In a day procedure centre a patient undergoing an orthopaedic procedure and is added to the end of an ophthalmic surgical list is a 'home-ward outlier' patient.

Consumers / patients accommodated outside the specialty ward area are at greater risk of being forgotten, receiving the wrong treatment and / or medications, increased length of stay and increased morbidity.

The National Institute of Clinical Studies (NICS) in Australia has published two reports which document 23 interventions for which there is evidence that there is a gap between what we know works and what is used in practice.[4, 5] The listing of these interventions is not meant to suggest that all health services need to provide all these interventions. Different interventions are more relevant in different health care settings.

Health services need to assess which of these and any other proven interventions are appropriate to their case mix and how they will ensure their use. Just as important as increasing the uptake of beneficial forms of care is the removal of harmful or ineffective practices. The following list is the evidence-practice gaps list developed by the National Institute of Clinical Studies.[4, 5] The list is a guide only.

The NICS interventions are as follows:

1. Advising on smoking cessation

Giving a consumer / patient brief advice on smoking cessation can influence their decision to quit. Pharmacotherapies such as nicotine replacement and buproprion can enhance the impact of the advice.

2. Advising on smoking cessation in pregnancy

Smoking cessation programs, mostly involving psychosocial interventions can be effective in reducing smoking rates in pregnant women.

3. Screening for lung cancer with chest X-rays

Current evidence does not support annual chest X-ray screening of current or former smokers to detect lung cancer.

4. Preventing stroke in patients with atrial fibrillation

For every 1,000 people with atrial fibrillation, by taking oral anticoagulants, about 25 will avoid experiencing a stroke and 12 will avoid dying from a stroke.

5. ***Using ACE inhibitor and beta-blocker therapies in heart failure***

Some heart failure morbidity and mortality could be prevented through the more widespread use of ACE inhibitor and beta-blocker therapies.

6. ***Measuring glycated haemoglobin in diabetes management***

HbA1c testing at appropriate time intervals is effective for achieving target blood glucose control.

7. ***Reducing the use of antibiotics for common cold and acute bronchitis***

There is no mandatory need for early routine prescription of antibiotics for colds or acute bronchitis.

8. ***Preventing venous thromboembolism in hospitalised patients***

Various pharmacological and mechanical methods have proven effectiveness in preventing VTE.

9. ***Preparing for elective colorectal surgery***

Nine out of ten patients having elective colorectal surgery receive some form of bowel preparation, yet there is no evidence it improves consumer / patient outcomes.

10. ***Reducing the use of colonoscopy in colorectal surgery follow-up***

Evidence shows that colonoscopic follow-up examinations are being done too frequently.

11. ***Managing acute and cancer pain in hospitalised patients***

Many patients continue to suffer unnecessarily.

12. ***Encouraging periconceptional use of folic acid supplements***

An adequate intake of folate in the periconceptional period has the capacity to prevent 70% of all cases of Neural Tube Defects.

13. ***Promoting and supporting breast feeding***

Breastfeeding offers substantial benefits to both babies and mother. Exclusive breastfeeding is recommended for the first six months in order to fully recognise the benefits.

14. ***Placing infants to sleep on their back to reduce the risk of SIDS***

There is a need for educational and public awareness campaigns to emphasise the safety of the back sleeping position rather than an avoidance of the stomach position.

15. ***Promoting the use of preventers in people with chronic asthma***

Half the people with asthma for whom preventers would be beneficial are not taking them regularly.

16. ***Managing acute mild asthma in the Emergency Department***

There is substantial evidence that ipratropium bromide is of limited usefulness in acute episodes of mild to moderate asthma.

17. ***Recognising and managing panic disorder and agoraphobia***

Effective treatments include cognitive behavioural therapy and antidepressants. Only cognitive behavioural therapy has been shown to have a lasting effect after short term treatment has finished and should be offered as first-line therapy.

18. ***Vaccinating against influenza in at risk groups***

Annual influenza vaccination has been shown to reduce illness, hospitalisation and death.

19. ***Commencing haemodialysis with appropriate vascular access***

New patients commencing haemodialysis with a catheter have a two to three-fold increased risk of death compared with those with an A-V fistula.

20. ***Achieving optimal control of blood pressure***

Many patients with hypertension are either not being prescribed or are not taking medication that is necessary to get their blood pressure under control.

1.4 EFFECTIVENESS STANDARD

Criterion 1.4.1 Care and services are planned, developed and delivered based on the **best available evidence and in the most effective way.**

(Continued)

21. Optimising care for stroke patients

Patients managed in a stroke unit are more likely to survive, regain independence and return home than those receiving conventional care.

22. Preventing osteoporosis-related fractures from happening again

Effective and well tolerated therapies are available, and can be strongly recommended in appropriate individuals at higher risk of osteoporotic fracture.

23. Applying compression therapy to treat chronic venous leg ulcers

Evidence shows that pressure therapy is the most effective treatment for diagnosed venous leg ulcers.

24. Preventing Surgical site infection

Locally the Hospital Authority identified surgical site infection as the second most common healthcare associated infection. Applying strategies for the prevention of surgical site infection help reduce surgical patients' morbidity, mortality and length of stay, and save cost for the healthcare institutions.

The list above is not exhaustive. The Agency for Healthcare Research and Quality (AHRQ)[6] in the United States has also undertaken a substantial body of work to identify effective interventions.

Organisations may provide evidence of achievement in this criterion through:

- collection of clinical indicator data
- changes in clinical indicators collected
- evidence-based policies, clinical practice guidelines
- identification of common care processes of principal conditions treated
- process to access information on non-principal conditions treated
- consumer / patient feedback
- information available on the use of clinical pathways / care maps
- audits of clinical pathways / care maps
- review of unplanned readmissions.

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1.5 SAFETY STANDARD

The standard is: **The organisation provides safe care and services.**

This standard should be read in conjunction with criteria 1.1.5 discharge / transfer, 2.1.2 risk management, 2.1.3 incident and complaints management and 3.2.5 security management.

A degree of flexibility is provided in this standard. Some of the criteria contained in this standard will be more relevant to some health care organisations than to others. The flexibility in these criteria is explained in the guidelines under each criterion. Organisations should determine the level of achievement required in each of these criteria.

Further, organisations should determine those issues that do pose the biggest safety risks in their organisations. These should be managed effectively under an alternative criterion, for example the risk management criterion or the security management criterion for the management of aggression in mental health services.

The intent of this standard is to ensure that health care organisations focus efforts on reducing harm to consumers / patients and staff. This standard expects that organisations will develop a system for reducing the incidence of harm, and specifically, the five most common causes of harm in Western health systems. They are:

- medication errors
- health care acquired infections
- pressure ulcers
- falls
- errors in the management of blood products.

In addition to these five common causes of harm the safety standard requires organisations to have systems in place for ensuring that the correct procedure is undertaken on the correct patient, at the correct site.

There are six criteria in this standard. They are:

1.5.1 **Medications are managed** to ensure safe and effective practice.

*1.5.2 The **infection control system** supports safe practice and ensures a safe environment for consumers / patients and health care workers.*

1.5.3 The incidence and impact of **pressure ulcers** are minimised through a pressure ulcer prevention and management strategy.

1.5.4 The incidence of **falls and fall injuries** is minimised through a falls management program.

1.5.5 The system for prescription, sample collection, storage and transportation and administration of **blood and blood components** ensures safe and appropriate practice.

1.5.6 The organisation ensures that the **correct patient** receives the **correct procedure** on the **correct site.**

Health care organisations should recognise that ensuring safety for both consumers / patients and all staff requires a far broader focus than on just the six issues covered by this standard, and that efforts to improve safety within an organisation should therefore not stop at action to achieve these six criteria. All opportunities for consumer / patient harm should be identified and prevented with barriers built into the system, making it resilient to the impact of errors[1, 2]. Opportunities for staff harm should be treated in the same way.

Several aspects of safety are dealt with in other EQuIP standards and criteria. These include:

- standard 1.1 continuity of care
- criterion 2.1.2 the risk management criterion, which provides the basis of an effective safety system
- criterion 2.1.3 the incident management criterion which provides the cornerstone to any good consumer / patient safety system
- criterion 2.2.3 performance review
- criterion 2.2.4 staff education
- criterion 2.3.3 data and information use
- criterion 3.1.3 credentialling and defining the scope of clinical practice
- criterion 3.1.4 external service providers.

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SAFETY:
Standard, Criteria, Elements, Guidelines

Standard 1.5 The organisation provides safe care and services.

Criterion	LA – Awareness	SA – Implementation LA plus the following
1.5.1 **Medications are managed** to ensure safe and effective practice.	(a) There is a policy on medication management that is consistent with Dangerous Drugs Ordinance(Cap134), Antibiotics Ordinance (Cap 137), Pharmacy and Poisons Ordinance (Cap 138). (b) Health care providers have access to published guidelines for medication management. (c) A standardised list of approved abbreviations for medications is used throughout the organisation. (d) Potential medication risks are identified, evaluated and acted upon. (e) A multidisciplinary body oversees the management of medication safety.	(a) Procedures are in place to reduce the risk and number of medication errors. (b) There is a system to report medication errors, near misses and adverse drug reactions and this is linked to the incident management system. (c) Clinical staff are provided with orientation and ongoing education on the policies and procedures of safe medication management. (d) The orientation system is updated when new risks are identified. (e) There is standardisation of medication charting across the organisation. (f) There is pharmacy involvement in the distribution system. (g) Consumers / patients are educated about their medications. (h) A system is in place to ensure medication review of individual consumers / patients.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The system for safe medication management is evaluated and improved as required. (b) Medication charts are reviewed and both the chart and the medication management system are improved as required. (c) Medication errors, near misses and adverse drug reactions are analysed and trended and further strategies to reduce medication incidents are implemented. (d) Distribution managed by pharmacy is evaluated and improved as required.	(a) The organisation conducts research and develops innovative methods to improve medication management. and / or (b) The organisation implements evidence-based advanced systems for medication management. and / or (c) The organisation compares medication management systems and medication error data internally and externally and improvements are made to ensure better practice. and / or (d) An individual consumer / patient supply system is in place. and / or (e) Individual staff skills and competence are defined, assessed, evaluated and improvements made to ensure better practice. and / or (f) The system for medication review is compared with internal and external systems and improvements are made to ensure better practice.	(a) The organisation is recognised as a leader in safe medication management.

1.5 SAFETY STANDARD

Criterion 1.5.1 Medications are managed to ensure safe and effective practice.

The intent of this criterion is two fold. The criterion is designed to:

- reduce the incidence of error in the prescription and administration of medications to consumers / patients
- reduce the level of harm caused to consumers / patients in health care organisations by medication errors.

This criterion relates to all health care organisations that prescribe and / or administer drugs.

The use of medication remains the most common intervention in health care. Medicine misuse, underuse, overuse and adverse reactions annually result in an estimated 140,000 hospital admissions in Australia; most of these adverse drug events are preventable.[1]

There are several ways organisations can achieve safe use of medicines, one of which is described in the Report on Drug Administration Procedures & Practices in Public Hospitals 2005.

The **quality use of medicines** is defined as 'the judicious, appropriate, safe and effective use of medicines',[4] and should be the aim of every health service that has any role to play in the administration of medications.

A **medication error** may be defined as '…any preventable event that may cause or lead to inappropriate medication use or consumer / patient harm, while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures and systems including: prescribing, order communication, product labelling, packaging and nomenclature, compounding, dispensing, distribution, method of administration – such as IV or oral, education, monitoring and use'.[5]

All strategies aimed at reducing medication errors and the harm caused by medication errors should be focussed on reducing the complexity of processes by reducing the number of steps and promoting standardisation. Some of these strategies include:

- the introduction of standardised medication charting across the organisation
- the removal of high-risk medicines from patient areas
- the introduction of medication review.

A medication management system should:

- address medication safety, medication adherence and adverse drug events/reactions across the continuum of care; from the community into the acute service and on return to the community
- cover all drugs, drug delivery devices, including infusion pumps with safety features, labelling processes and information transfer processes relating to drug therapy
- consider the choice of the drug distribution system, such as ward stock and supply system, bedside lockers, individually dispensed medicines or automated dispensing devises
- include a link to the risk management system and specifically the incident management system
- refer to the local guidelines e.g., Report on Drug Administration Procedures & Practices in Public Hospitals 2005[9], Guidelines and Safety Solutions from Hospital Authority

Health care organisations are encouraged to implement a common chart (e.g. Medication Administration Record) in their health care organisation when possible.

High-risk medicines are those which if prescribed and administered incorrectly cause morbidity and mortality. They often have a small therapeutic range, for example, anticoagulants, intravenous potassium and insulin. Other medications can pose a high risk due to the possibility of them being prescribed incorrectly such as sound alike names or multiple strengths. Hospital Authority alerts have been issued for some high-risk medicines with recommendations for actions. [8, 9] A systems approach (e.g. Safety Solutions issued by Hospital Authority Head Office[10])should be used to identify high-risk medicines within an organisation and strategies developed to reduce the impact.[3]

Health care organisations that prescribe and administer drugs should undertake **medication review**. This does not necessarily mean that a pharmacist must carry out this process, but that an individual consumer's / patient's medications are reviewed. In some organisations this will be carried out by a pharmacist and in others this will be carried out by the medical practitioner.

It is not expected that all organisations will have access to a **clinical pharmacist**, however, the clinical pharmacist applies specific pharmaceutical expertise to help to maximise medicine efficacy and minimise medicine's toxicity in individual patients. It allows pharmacists to become part of the clinical team and to anticipate medication errors. One of the pharmacist's traditional roles is of quality control, monitoring and reporting on errors only retrospectively. Clinical pharmacy is a move away from reactive quality control towards proactive involvement in direct consumer / patient care and the anticipation of errors, thereby reducing the incidence of harm to patients. Medication review on admission to a service can also identify whether an admission is due to prescribing errors or to adverse reactions to medicines in the community. Medication review on admission can help to identify such problems and report back to GPs. Medication review at discharge is key to providing accurate, complete and comprehensive medicines information to consumers / patients and to their community providers / GPs so that care may be continued.

Australian clinical pharmacy practice standards describe goals and procedures for ten activities aimed at optimising the use of medicines and patient outcomes. The three priority clinical pharmacy services are:[10]

- accurate medication history, including medication reconciliation on admission
- assessment of current medication management, including medication reconciliation at discharge
- provision of medicines information to consumers / patients.

A health care organisation is responsible for ensuring that the culture exists for **medication management and reporting systems** within the organisation that enables the identification and notification of as many medication errors, near misses and adverse drug events and adverse drug reactions as possible. This is essential if potential risks are to be identified, evaluated and acted upon. Incident reports provide valuable information about incidents and near misses however; systems other than the incident information system should be in place to gather information about adverse drug events. These include health record reviews, audits, reviews of the literature and various reports.

In the future, electronic medication management systems that include decision support should sustain the safer use of medicines, along all steps of the medicines management pathway. In the interim, where appropriate, organisations may use currently available technology to reduce risk, such as use of bar codes and scanning devices with 'smart' safety features.

Organisations may provide evidence of achievement in this criterion through:

- audits of:
  - medication error rates
  - adverse reaction rates
  - prescriptions
  - compliance with medications
- policies, e.g. reference to Report on Drug Administration Procedures & Practices in Public Hospitals 2005[9].
- medication chart review
- standard list of abbreviations
- evidence of pharmacy or pharmacist involvement in the distribution system
- health record review.

1.5 SAFETY STANDARD

Criterion 1.5.1 Medications are managed to ensure safe and effective practice.

(Continued)

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SAFETY:
Standard, Criteria, Elements, Guidelines

Standard 1.5 The organisation provides safe care and services.

Mandatory Criterion	LA – Awareness	SA – Implementation LA plus the following
1.5.2 *The **infection control system** supports safe practice and ensures a safe environment for consumers / patients and health care workers.* This is a Mandatory Criterion.	(a) There is an infection control policy, including sterilization and reprocessing where applicable, that is referenced to: (i) Center for Health Protection, Scientific Committee of Infection Control, Hospital Authority Hong Kong standards (ii) local legislation (iii) codes of practice (iv) WHO and CDC (USA) guidelines (v) industry guidelines. (b) The infection control management plan is approved, supported and resourced by the organisation's executive. (c) Designated personnel with skills, training and experience are responsible for the practical operation of the infection control program. (d) Health care providers are educated and information is available on the risks of infection and their responsibilities in preventing infection. (e) Notifiable diseases are identified in accordance with legislative requirements and responsibilities for notification are met. (f) Health care providers are supplied with equipment and an environment that enables them to implement the infection control policies. (g) External service providers, students, carers and visitors are advised of the organisation's infection control requirements.	(a) There is a system in place which implements the infection control policy. (b) The infection control system includes isolation and containment of infections when required. (c) The infection control system ensures effective communication of information relating to infection risks. (d) There is a documented program of continuous education for staff about infection control issues. (e) Health services planning includes infection control management strategies. (f) Implementation of a hand hygiene program in accordance with the WHO First Global Patient Safety Challenge *

*** Adding Hand Hygiene as a new element**

These guidelines should be read in conjunction with criteria 2.1.2 risk management, 2.1.3 incident management, 2.4.1 population health and 3.2 the safe practice and environment standard.

The intent of this criterion is to ensure whenever possible that infections are prevented from occurring in health services and where prevention is not possible infections are managed effectively.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The infection control system is evaluated and improved as required. (b) Process indicators focusing on compliance with infection management practices are collected, reviewed and improved as required. (c) Outcome indicators for infection control are measured, reviewed and improved as required.	(a) Performance indicators for the infection control system are compared with internal and external systems and improvements are made to ensure better practice. and / or (b) The organisation communicates results of its performance in its infection control to inform consumers / patients, colleagues and peers. and / or (c) The organisation undertakes research into infection control and acts on results.	(a) The organisation is recognised as a leader in infection control systems.

Infection control in health care organisations is one of the key areas of safety. Because of the nature of health care, consumers / patients and staff can both be sources and recipients of infection. Infections can be transmitted between people including staff, consumers / patients and visitors, from the environment, or from equipment. Adopting good quality infection control measures can minimise the risk of these infections.

1.5 SAFETY STANDARD

Criterion 1.5.2 *The* **infection control system** *supports safe practice and ensures a safe environment for consumers / patients and health care workers.*

(Continued)

Infection control in a health care setting has seven elements. These are:[1,2]

- surveillance of infections
- Infrastructure of ICT
- principles of infection control
- quality management
- effective patient care practices and procedures
- managing infectious diseases in the health care setting
- infection control in specific health care settings.

An outline of the **overall strategy** should be documented in an infection control manual. The strategy should identify:

- who is at risk and from what
- the hazards involved
- the procedures for minimising risk
- the basic measures for infection control, including standard precautions and additional precautions.

Organisations should have an infection control policy and manual that is relevant to that organisation. These policies and procedures will be based on existing jurisdictional directives, guidelines of the Centre for Health Protection (CHP) the Hospital Authority (HA) and the Centre for Disease Control and Prevention (CDC). Policies should address the specific infection risks for that organisation, covering all aspects of infection control, including surveillance, isolation precautions, use of PPE, outbreak management, control of multi-drug resistant organisms (MDRO), environmental cleaning, single-use items and reprocessing of sterile instruments. Policies should be endorsed by the organisation's executive. CHP and HA guidelines on *cleaning, disinfecting and sterilising reusable medical and surgical instruments and equipment, and maintenance of associated environments in health care facilities* should be referred to when developing policies and the infection control management plan. Policies should also cover employees' health, such as immunisations offered and levels of immunity to some specific diseases and education and training.

Standard precautions are based on the principle that all blood, body fluids, excretions, secretions except sweat, non-intact skin, mucous membranes may contain transmissible infectious agents. Standard precautions include a group of precautions applied to all patients regardless of suspected or confirmed infection status in any setting in which healthcare is delivered. These include hand hygiene, prevention of sharps injuries and mucosal exposures, use of masks, gloves, gowns, eye protection and face shields depending on the anticipated exposure and safe injection practices. Reusable equipment should be cleaned, disinfected or sterilized before used on other patients.[3,4,5,6]

Other infection control practices can include:

- aseptic technique, including appropriate use of skin disinfectants
- personal hygiene practices, particularly hand washing before and after all consumer / patient contacts
- use of personal protective equipment, which may include gloves, impermeable gowns, plastic aprons, masks / face shields and eye protection
- handling and disposal of sharps and other clinical waste
- use of single-use equipment
- reprocessing of reusable equipment and instruments, including use of disinfectants
- environment controls, including design and maintenance of premises, cleaning, pest control and spills management
- provision of support services, such as laundry and food services.[2]

Additional precautions apply when standard precautions may not be sufficient, such as in suspected or confirmed cases of tuberculosis, measles or Creutzfeldt-Jakob disease. Additional precautions are tailored to a specific infectious agent, whether airborne, or through droplet or contact transmission. Organisations should be aware of state guidelines or policy directives for isolation and containment of particular infectious diseases.

Surveillance of infection is a major component in infection control. Program includes, but is not limited to, laboratory based surveillance on Multiple Drug Resistance Organisms (MDRO), surgical site infection and device related infections e.g. Ventilator Associated Pneumonia (VAP), Catheter Associated Bloodstream Infection (CABSI), Catheter Associated Urinary Tract Infection (CAUTI).

Infrastructure of infection control team includes adequate ICN to bed ratio, laboratory support in accordance with the acuity of patients and intensity of surveillance program, continuous education program for ICT and platform for research and development.

Quality management relates to the implementation of an infection control program and development of a quality improvement program that encompasses all the components of the quality improvement cycle. Depending on the size of the organisation, an infection control committee or responsible person should be appointed to ensure compliance with ethical and legal standards, as well as accreditation standards. Policies should prove to be supported by the organisation's executive and be developed following consultation with employees. Quality management of infection control should be organisation-wide. This involves an ordered, systematic approach to a range of activities and processes to implement procedures and protocols. Key performance indicators to identify any breaches in the infection control system should be monitored.

Immunisations such as for Hepatitis B and flu; and MMR vaccine should be offered to relevant staff and documented in staff records.

Staff education and training, both internal and external to the organisation should be relevant, current and documented.

The **effective patient care practices** and procedures component of infection control covers the procedures of the organisation to address infection control, such as:

- standard precautions, as identified above
- the design and maintenance of the facility
- monitoring the compliance of patient care practice e.g., hand hygiene, wound care, bundled care for CABSI, CAUTI, VAP; and the corresponding rate of infections
- environmental, waste and spills management
- spills of blood or body fluid that may involve sharps and mucosal exposure to infection
- monitoring all environmental facilities, including water towers, pools, ventilation systems and air conditioners
- handling of blood and blood products
- use of therapeutic devices
- health care establishment support services, such as linen, laundry processes and food services, including storage, preparation and handling of food.

Organisations should be aware of relevant standards in regard to food safety, cleaning and laundry and how those service providers may enter patient areas.

All areas of the physical environment should be monitored and maintained to ensure the organisation meets current standards, codes and regulations. There should be:

- dedicated work areas with easy to clean surfaces
- separate procedural areas from cleaning areas
- workflow from clean to dirty areas
- ventilation, air conditioners, cooling towers and water systems that comply with Australian standards
- hand basins, with non-touch taps where indicated
- liquid soap
- disposable or single-use cloth towels, both for clinicians, other staff and visitors to the organisation.

Where indicated, the use of antimicrobial, non-antimicrobial or alcoholic hand rub is advised[1].

1.5 SAFETY STANDARD

Criterion 1.5.2 *The* **infection control system** *supports safe practice and ensures a safe environment for consumers / patients and health care workers.*

(Continued)

Consumers / patients with infectious conditions in waiting rooms or other shared areas should be triaged and isolated as required.

Managing infectious diseases in the health care setting involves surveillance, the identification of major risk factors and the recommendations for management procedures for consumers / patients, health care providers, instruments and the health care environment. Short descriptions of the management of viral, bacterial, antibiotic resistant and other similar diseases which are important in the health care setting should be documented.

Managing major risk factors involves identifying the risk and documenting the activities and tasks that put consumers / patients and staff at risk.

Communicable diseases should be reported to the relevant department in each state / territory. Information should be readily available to staff on what diseases to report and where and how they should be reported.

Infection control in specific health care settings involves the identification of the major risk factors and management procedures for specialized health care settings, including operating rooms, midwifery and obstetrics, intensive care units, home and community and long-term care.

Staff working in informal settings or a setting that may be considered to be low risk, such as office-based practices, community settings or long-term care establishments with a home-like atmosphere, should be provided with the same hand washing facilities, protective clothing and protective equipment as staff working in larger health care settings. Consideration of infection control issues should be made where visiting hairdressers, podiatrists and companion animals etc may also be an issue. Waste should be disposed of in accordance with Australian standards in any health care setting.

Organisations may provide evidence of achievement in this criterion through:

- infection control policies
- infection control systems
- sterilising process monitoring
- minutes of meetings
- support services
- evidence of staff immunisation
- sterilisation tracking systems
- evidence of advice given to external service providers, students, carers and visitors
- staff training
- risk assessment audits.

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1.5 SAFETY STANDARD

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SAFETY:
Standard, Criteria, Elements, Guidelines

Standard 1.5 The organisation provides safe care and services.

Criterion	LA – Awareness	SA – Implementation LA plus the following
1.5.3 The incidence and impact of **pressure ulcers** are minimised through a pressure ulcer prevention and management strategy.	(a) A policy exists for the prevention and management of pressure ulcers. (b) Health care providers use a pressure ulcer risk assessment tool to assess consumers / patients. (c) Pressure ulcer prevention and management plans reflect organisational guidelines.	(a) The pressure ulcer prevention and management strategy is implemented and adapted to local needs and health care settings. (b) The management strategy includes management for surgical procedures expected to last more than three hours and for high-risk patients prior to and following discharge. (c) Relevant staff are educated in pressure ulcer prevention and management. (d) Information and education on pressure ulcer prevention and management is available to consumers / patients and health care providers.

The intent of this criterion is two fold. The criterion is designed to:

- minimise the incidence of pressure ulcers
- effectively manage pressure ulcers when they do exist.

The presence or absence of pressure ulcers is often seen as an indicator of quality of care as they are one of the most common causes of harm to consumers / patients in health services.

Pressure ulcers are defined as any lesion caused by unrelieved pressure resulting in damage of the skin and underlying tissue.[1] Policies on pressure ulcer prevention and management should be applied across all populations including:

- neonates
- people with spinal cord injury
- frail aged
- people undergoing lengthy procedures and across all settings, including:
- emergency departments
- transport vehicles such as ambulances
- operating theatres
- community nursing.

The major risk factors for developing pressure ulcers are:[2]

- immobility
- sensory loss

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Pressure ulcer data are trended over time and improvements are made to the prevention and management strategy as required. (b) Pressure ulcer management is evaluated and improved as required. (c) Education programs on pressure ulcer prevention and management are evaluated and improved as required.	(a) Pressure ulcer data are compared with internal and external systems and improvements are made to ensure better practice. and / or (b) Pressure ulcer prevention and management programs are compared with internal and external systems and improvements are made to ensure better practice. and / or (c) Pressure ulcer prevention and management programs are communicated to and implemented in other health care organisations. and / or (d) The organisation undertakes research into pressure ulcer prevention.	(a) The organisation is recognised as a leader in strategies for pressure ulcer prevention and management.

- impaired cognitive state
- urinary and faecal incontinence
- age over 65 years
- male sex
- chronic illness
- poor nutritional status
- impaired oxygen delivery to tissues
- raised skin temperature
- skin dryness
- presence of pressure, shear or friction forces.

The primary focus of this criterion is on prevention. However if consumers / patients enter a health care organisation with a pressure ulcer or one subsequently occurs, it should be managed in the most effective way.

Guidelines for the treatment of pressure ulcers are available from many sources, and organisations should provide access for all health care providers to these guidelines and protocols. The National Institute of Clinical Studies (NICS) has developed a Pressure Ulcer Resource Guide. It contains examples and links to a range of other resources that have been developed.[3]

A pressure ulcer **prevention and management strategy** is a systematic approach adopted by all sections of an organisation to ensure appropriate identification and actions for consumers / patients at risk. A systematic approach should include:

1.5 SAFETY STANDARD

Criterion 1.5.3 The incidence and impact of **pressure ulcers** are minimised through a pressure ulcer prevention and management strategy.

(Continued)

- risk assessment
- documented care plan
- pressure relief
- appropriate care and equipment
- multidisciplinary staff education
- consumer and family education
- audit and reporting
- appropriate referral to medical, nursing and allied health professionals.

All staff should recognise that monitoring and surveillance should be undertaken on all consumers / patients identified at risk of developing pressure ulcers. Organisations should ensure that staff have access to clinical expertise in pressure ulcer wound management and ongoing education where applicable.

Risk assessment processes can include a range of screening and assessment tools that assist in identifying the level of risk for the development of pressure ulcers. Some tools available are the Norton Risk Assessment Score[4], the Braden Scale[5] and the Waterlow Risk Assessment card[6]. The same tool should be used across the organisation. Documentation outlining the risk assessment process should also cover the timing and frequency of administration of the tool. Equipment should be congruent with the level of agreed risk of pressure ulcers and be readily accessible. Expenditure on appropriate equipment can generate potential cost savings in improved patient outcomes, decreased length of stay, reduced back strain injuries, improved utilisation of staff time and treatment.

Education programs and information should be developed and evaluated by a multidisciplinary team including consumers / patients. Education should include use of the agreed screening and assessment tool and identifying the different stages as pressure ulcer classification can be unreliable between clinicians.

Pressure ulcer data can be derived from prevalence and incidence surveys and adverse event and incident reports. A clinical audit of health records or risk assessments can also be used. Organisations should collect clinical indicator data that enables them to benchmark against other organisations with similar populations. Mechanisms for evaluation of implementation of the policy include data and compliance with guidelines by direct and indirect monitoring of staff and education.

The prevention and management of pressure ulcers should be maintained across the care continuum. For instance, pressure ulcer wound management regimes should be maintained across interservice transfers. Effective and successful discharge will depend upon appropriate measures and equipment being in place together with written and verbal information for consumers / patients and carers about assessment and prevention.

Organisations may provide evidence of achievement in this criterion through:

- policies on admission of patients with pressure ulcers
- policy on management of patients during surgical procedures
- pressure ulcer management systems
- pressure area assessment tools, including the use of these in all areas of care such as: paediatrics, ICU, general surgical, medical wards
- health record audits
- education / information for staff and consumers / patients
- equipment register.

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SAFETY:
Standard, Criteria, Elements, Guidelines

Standard 1.5 The organisation provides safe care and services.

Criterion	LA – Awareness	SA – Implementation LA plus the following
1.5.4 The incidence of **falls and fall injuries** is minimised through a falls management program.	(a) A policy and guideline exist for falls management. (b) Consumers / patients are assessed for risk of falls: (i) on admission (ii) following a change of health status (iii) after a fall. (c) Falls prevention information is provided to staff, consumers / patients and carers. (d) Appropriate falls reduction strategies are implemented according to identified risk factors. (e) The organisation uses a validated risk assessment tool to identify consumers / patients at risk of falls. (f) Consumers / patients are involved in their falls prevention / management plan.	(a) The falls policy is implemented across the organisation. (b) An individual falls management plan addresses the falls risk factors identified in the assessment. (c) Falls and fall injury prevention equipment is accessible for consumers / patients following appropriate education and training for use. (d) Falls risk is considered as part of discharge planning for high-risk consumers / patients. (e) Staff are educated on falls and falls injury risk assessment, prevention and management.

These guidelines should be read in conjunction with criterion 3.2.1 safety management systems.

The intent of this criterion is two fold. The criterion is designed to:

- whenever possible, prevent falls from occurring
- when fall prevention is not possible, prevent injury from the fall.

Fall-related injury is one of the leading causes of morbidity and mortality in older Australians and the single biggest reason for hospital admissions and emergency department presentations in people over 65 years of age.[1]

The risk of patients having a fall and therefore requiring assistance post-fall occurs in every health care organisation, including day procedure centres and community health centres. The use of anaesthesia increases the risk of a fall occurring and appropriate risk management strategies should be employed to minimise identified risk. Occupational Safety and Health (OSH) procedures should be in place to protect staff from injury where they may be required to lift a patient that has fallen. There should also be strategies to deal with staff who have fallen.

Policies and guidelines for falls prevention, for use by the whole organisation could include:

- roles and responsibilities
- education to consumers / patients and staff
- available equipment
- risk assessment of consumers / patients on admission or when changes occur in the consumer / patient health status
- environmental hazards

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Falls and fall injury data are analysed and improved as required. (b) The falls and falls injury prevention and management education program is evaluated and improved as required.	(a) Falls data management programs are compared with internal and external systems and improvements are made to ensure better practice. and / or (b) The falls management program is communicated and implemented in other health care organisations. and / or (c) The organisation undertakes research into falls and falls injury prevention. and / or (d) The organisation demonstrates development of partnerships with other stakeholders to facilitate falls prevention across the continuum of care.	(a) The organisation is recognised a leader in the areas of falls prevention and management.

- post-falls strategies and management
- reduction strategies
- standard reporting systems
- data management
- monitoring.

Falls prevention includes standard strategies such as:

- screening or assessing all older people for risk of falling
- physical assistance when a person is transferring or mobilising
- educating older people, their carers and staff about falls prevention
- providing information to consumers / patients and carers
- encouraging exercise
- optimising nutritional status
- maintaining bladder and bowel function
- monitoring medication
- ensuring a safe environment.

Some older people continue to have falls despite efforts to reduce this risk. Injury prevention interventions include hip protectors, Vitamin D and calcium supplementation, osteoporosis management and arrangement of continence control.

Risk factors for falling include:[2]

- *Intrinsic:* poor nutritional status, weakness, poor grip, balance disorders, functional and cognitive impairment and visual deficits.

1.5 SAFETY STANDARD

Criterion 1.5.4 The incidence of **falls and fall injuries** is minimised through a falls management program.

(Continued)

- *Extrinsic:* polypharmacy, and certain types of medications particularly psychotropics, some anti-arrhythmic medications and diuretics.
- *Environmental:* poor lighting, loose carpets and lack of bathroom safety equipment, out- of-reach assistive devices or assistive devices used incorrectly.

Effective and successful discharge may also be dependent on appropriate equipment and measures being in place and information provided to consumers / patients and carers about how to prevent falls in a community setting.[3]

Organisations may provide evidence of achievement in this criterion through:

- falls prevention and management policies
- health record audits
- falls risk assessments and action plans
- evaluated falls data
- signage for example, for parents in paediatric wards
- consumer / patient information sheets.

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SAFETY:
Standard, Criteria, Elements, Guidelines

Standard 1.5 The organisation provides safe care and services.

Criterion	LA – Awareness	SA – Implementation LA plus the following
1.5.5 The system for prescription, sample collection, storage and transportation and administration of **blood and blood components** ensures safe and appropriate practice.	(a) A policy exists for: (i) the safe collection and identification of the pre-transfusion patient blood sample (ii) prescription and documentation of blood component therapy (iii) the timely availability and safe administration of blood component therapy (iv) monitoring the appropriateness of blood component therapy (v) ensuring written consent is obtained (vi) a process for refusal of transfusion. (b) A policy exists for the transportation and storage conditions of blood components including: (i) removal from any blood fridge (ii) a documented audit trail. (c) The blood management policy is compliant with local or international guideline as appropriate.	(a) The blood component management system ensures: (i) verification of the correct patient and blood component (ii) timely and safe collection of blood samples (iii) documented indication and prescription for blood transfusions. (b) The system for the safe transportation and storage of blood and blood components includes: (i) a blood components inventory register (ii) allocated responsibilities for responding to storage alarms and taking corrective action (iii) documentation accompanying blood components (iv) labels being checked each time the product is handled. (c) Appropriate staff are trained and credentialled in: (i) blood sample collection (ii) blood component therapy prescription and administration (iii) the storage and transportation of blood components. (d) The consumer / patient is made aware of the risks associated with blood component therapy.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The blood management systems including: (i) patient blood sample collection (ii) prescription, documentation (iii) the safety and appropriateness of blood component therapy (iv) analysis and reporting on disposal rates of blood products are monitored and evaluated and improvements made to ensure better practice. (b) The staff training and credentialling program is evaluated. (c) The competence of individual staff members to collect blood and to administer blood component therapy is regularly reviewed. (d) The system for transportation and storage of blood components is evaluated and improvements made to ensure better practice. (e) The blood components inventory register system is evaluated and improvements made to ensure better practice.	(a) The blood management system is compared with internal and external systems and improvements are made to ensure better practice. and / or (b) The system for transportation and storage of blood components is compared with internal and external systems and improvements are made to ensure better practice. and / or (c) The organisation undertakes research into blood management practices.	(a) The organisation demonstrates that it is a leader in blood management systems and blood component therapy practices. (b) The organisation demonstrates that it is a leader in blood component transportation and storage practices.

1.5 SAFETY STANDARD

Criterion 1.5.5 The system for prescription, sample collection, storage and transportation and administration of **blood and blood components** ensures safe and appropriate practice.

These guidelines should be read in conjunction with criteria 1.1.3 consent and 3.1.4 external providers.

The intent of this criterion is that if a health care organisation uses blood components in any way, there is an effective system for ensuring that all aspects of the management of that blood are safe and appropriate.

This criterion will not be applicable to organisations that do not store, transport or administer blood and blood components.

When considering the 'vein to vein' blood transfusion process, only the laboratory processes are presently accredited in any detail. This is undertaken by the National Pathology Accreditation Advisory Council (NPAAC) and the National Association of Testing Authorities (NATA).

The management of blood and blood components beyond the laboratory relates to:

- consumer / patient identification at all points along the process
- correct labelling of the pre-transfusion blood sample
- storage and transportation of blood and blood products
- appropriateness of blood transfusions
- documentation of all aspects of the transfusion process including the reason for transfusion
- appropriate training for the administration of transfusion
- credentialling of staff for blood and blood product administration
- consent for transfusion
- governance and staff responsibility.

This criterion is based on the many evidence-based standards, guidelines and circulars that have been developed in recent years by individuals, organisations and associations, expert in the field of blood management and blood transfusion therapy. These include:

- The Australian and New Zealand Society for Blood Transfusion (ANZSBT)
- The Australian Red Cross Blood Service (ARCBS)
- The Royal College of Nursing Australia (RCNA)
- The National Health and Medical Research Council (NHMRC).

Where a health care organisation has a remote blood refrigerator which is not one situated within the transfusion laboratory, the hospital is responsible for ensuring that a **maintenance and quality control program** for the refrigerator is in place for the storage of blood and blood products. Risk management should include authorised access for collection, transport and delivery of blood to a responsible health professional.

The National Health and Medical Research Council has defined the appropriate use of red blood cells. Transfusion should be based on clinical judgement and the latest scientific evidence and transfusion of red blood cells is likely to be appropriate when Hb<70g/L. In some consumers / patients who are asymptomatic and / or where specific therapy is available, lower threshold levels may be acceptable. Consideration should be given to consumer / patient factors, signs and symptoms of hypoxia, ongoing blood loss and the risk to the consumer / patient of anaemia.

As a general principle, every effort should be used to conserve blood.

Complete documentation of transfusions is required to be kept in the consumer / patient health record. This includes the blood transfusion compatibility report, sheets used for prescription and nurse observations, documentation of the transfusion, management and adverse events and a record of the component or donation numbers transfused.

Policies and procedures should be available to all staff involved in the prescribing, collection, transporting, administration of blood products and management of adverse reactions including medical, nursing, midwifery and laboratory staff. Policies and procedures should include pre-transfusion sample collection and labelling, timeliness, including urgent requests and

procedures in the event of refusal to blood transfusions and equipment use.

Training in blood policies and procedures should be in place for new staff and regular updates Training and competence assessment records should be retained. Staff should be assessed as being competent to carry out the tasks they are performing.

Credentialling is carried out to ensure the formal qualifications, training, experience and clinical competence of non-medical clinicians providing health services. There are numerous internet sites that offer training in blood transfusion, an example of which is http://www. learnbloodtransfusion.org.uk/.[3]

The Australian and New Zealand Society of Blood Transfusion[2] currently recommends that 'two members of staff shall be responsible for carrying out the **identity check** of the consumer / patient and the blood component at the consumer / patient bedside. The members of staff shall be doctors or nurses holding current registration. The consumer / patient is requested to state their name . All consumers / patients should have a completed identification band attached at all times'.[3]

Consent should be documented on a consent form or by documenting the discussed information in the consumer / patient health record. Where a consumer / patient gives verbal consent, this should be documented by the treating physician. If a consumer / patient is unable to give consent the local policy regarding consent for a medical procedure should apply. Refusal of consent should also be documented, whether refusal is for religious or personal reasons.[6]

Transfusion information leaflet should be available.[7]

The **governing body** shall be **responsible** for ensuring that health care professionals are informed of and follow policies on blood transfusion. An appointed staff member is responsible for setting local policies and organising training. All incidents and near misses relating to blood administration should be reported to and monitored by the executive committee / hospital transfusion committee.

Organisations may provide evidence of achievement in this criterion through:

- policies and procedures
- consent processes
- evidence of handling refusal to consent
- evaluation of systems
- staff training
- KPI / audit data

References

1. Transfusion Guideline for Hospital Authority Hospitals.

2. Nursing Standards for Patient Care, Hospital Authority.

3. National Health Service (NHS) and Scottish National Blood Tranfusion Service. Learn Blood Transfusion, Available at: http://www.learnbloodtransfusion.org.uk/

4. Australian and New Zealand Society of Blood Transfusion Inc. Guidelines for the administration of blood components. Sydney: ANZSBT, 2004.

5. Transfusion information leaflet.

6. Authorised site of the Office of Public Information of Jehovah's Witnesses Health and Medicine, Available at: http://www.jw-media.org/medical/index.htm

7. Better Health Channel, Consumer Information on Blood Transfusions, Available at: http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Blood_transfusion?open

Further Reading

Australian and New Zealand Society of Blood Transfusion Inc. Guidelines for pretransfusion.

1.5 SAFETY STANDARD

Criterion 1.5.5 The system for prescription, sample collection, storage and transportation and administration of **blood and blood components** ensures safe and appropriate practice.

(Continued)

testing. Sydney: Australian and New Zealand Society of Blood Transfusion Inc, 2002.

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Australian Council on Safety and Quality in Health Care. Towards better, safer blood transfusion. Canberra: Boyce N, Brook C, 2005.

Bouton F. Transfusion guidelines for neonates and older children. British Journal of Haemotology 2004; 124:433-453.

Department of Health. Health service circular. Better blood transfusion. London: Department of Health, 2002.

Gray A, Howell C, Pirie E. Improving blood transfusion: a patient-centred approach. Nursing Standard 2005; 19(26):38-42.

National Health Service. Newsletter. Blood matters. London: National Health Service, 2004.

NSW Department of Health. Guideline for the management of fresh blood components. Sydney: NSW Department of Health, 2003.

Royal College of Nursing. Right blood, right patient, right time. London: Royal College of Nursing, 2004.

SAFETY:
Standard, Criteria, Elements, Guidelines

Standard 1.5 The organisation provides safe care and services.

Criterion	LA – Awareness	SA – Implementation LA plus the following
1.5.6 The organisation ensures that the **correct patient** receives the **correct procedure** on the **correct site**.	(a) A policy and protocol exist for ensuring correct patient, correct procedure and correct site that is consistent with WHO Guidelines for Safe Surgery 2009. (b) Correct patient, correct procedure and correct site information is provided to staff, consumers / patients and carers.	(a) The policy is implemented by all surgical / procedural teams in the organisation. (b) Staff are educated on the policy and protocol. (c) Consumers / patients are involved in ensuring correct patient, correct procedure and correct site. (d) There is a system to report near misses and errors and this is linked to the incident management system.

These guidelines should be read in conjunction with criteria 1.5.5 blood management and 2.1.3 incident management.

This criterion relates to all organisations that undertake surgical and / or interventional procedures. This criterion is applicable to all operative and other invasive procedures that potentially expose patients to harm, including procedures performed in settings other than the operating room, e.g. endoscopy, interventional radiology, fine needle aspiration cytology etc.

The intent of this criterion is to ensure that the organisation implements steps to make certain that the indicated procedure is performed on the correct patient and at the correct site and with the correct implant where applicable. An example would be verification of the correct patient and the correct blood component.

This criterion is referenced by material produced by the US Veterans Affairs (VA) policy and Australian guidelines.[1,2] Reference can also be made to the WHO Surgical Safety Checklist.[3,4,5]

The WHO Surgical Safety Checklist 2009 specifies the following stages:

1. Before induction of anaesthesia (confirm patient identity, site, procedure and consent, site marked)
2. Before skin incision (team time-out, imaging displayed)
3. Before patient leaves operating room (instrument, sponge and needle counts, specimen labeling)

Local policies may differ slightly in the order in which they place these steps. Organisations are required to comply with jurisdictional policy.

Organisational policy and associated protocols and procedures should include:

- to whom the policy pertains
- the procedural steps to be taken
- actions to be taken when there are discrepancies or disagreements in variation at the time of 'time-out'
- actions to be taken in the event of a wrong patient, wrong procedure, wrong site incident
- any exceptions to the use of the policy
- dispute resolution procedures.

Responsibility for ensuring correct patient, correct procedure and correct site verification rests with all team members. However, the person in charge of the interventional procedure carries ultimate responsibility.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Compliance with the policy and protocol is evaluated and improved as required. (b) Any confirmed incidence of wrong patient, wrong procedure or wrong site is investigated.	(a) The organisation achieves total compliance with the protocol for all procedures. and / or (b) Evaluation demonstrates that there is no incidence of wrong patient, wrong procedure or wrong site within the organisation.	(a) The organisation is recognised as a leader for ensuring correct patient, correct procedure and correct site.

Organisations may provide evidence of achievement in this criterion through:

- pre-operative policies and compliance with national protocol
- staff education
- evidence of compliance with policies
- information provided to staff and consumers / patients
- results of review of near misses and errors.
- Participation in WHO Second Global Patient Safety Challenge – Safe Surgery

References

1. Australian Council for Safety and Quality in Healthcare (ACSQHC), 2004. Ensuring Correct Patient, Correct Site and Correct Procedure, Available at: www.safetyandquality.org.au

2. Royal Australasian College of Surgeons, Implementation guidelines for ensuring correct patient, correct side and correct site surgery, Available at: http://www.surgeions.org/AM/Template.cfm?Section=Search&section=Professio nal_Standards2&template=/CM/ContentDisplay. cfm&ContentFileID=2452

3. WHO Second Global Patient Safety Challenge http://www.who.int/patientsafety/safesurgery/en/

4. Haynes AB, Weiser TC, Berry WR, Lipsitz, SR et al. A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population. N Engl J Med 2009; 360:491-9.

5. Hospital Authority Surgical Safety Policy 2009. HAHO Operations Circular no. 10/2009.

Further Reading:

Leape LL, Berwick DM. Five years after to err is human. Journal of the American Medical Association 2005; 293(19):2384-2390.

Leape LL, Woods DD, Hatlie MJ, Kizer KW, Schroeder SA, Lundber GD. Promoting patient safety by preventing medical error. Journal of the American Medical Association 1998; 280(16):1444-1447.

Tamuz M, Thomas EJ, Franchois KE. Defining and classifying medical error: lessons for patient safety reporting systems. Quality and Safety in Health Care 2004; 13:13-20.

Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L, Hamilton JD. The quality in Australian health care study. Medical Journal of Australia 1995; 163(9):458-471.

CLINICAL FUNCTION

SUPPORT FUNCTION

CORPORATE FUNCTION

1.6 CONSUMER FOCUS STANDARD

The standard is: **The governing body is committed to consumer participation.**

The intent of this standard and criteria is to promote consumer participation and the need to involve consumers / patients in their health care and ensure their rights, responsibilities and needs are met.

This standard has three criteria. They are:

1.6.1 **Input is sought from consumers, carers and the community** in planning, delivery and evaluation of the health service.

1.6.2 Consumers / patients are informed of their r**ights and responsibilities.**

1.6.3 The organisation makes provision for consumers / patients from **culturally and linguistically diverse backgrounds** and consumers / patients with **special needs.**

Consumers are people who are potential users of health services, including their family and carers or a representative of organisations of consumers[1, 2]. Draper describes consumers '...as diverse as the full range of people living in contemporary Australian society'. Any definition of consumer must incorporate women, men, people from diverse cultural experiences, including Aboriginal and Torres Strait Islander people, class positions and social circumstances, sexual orientations, health and illness conditions[3].

References

1. NSW Department of Health. Partners in Health: Report of the consumer and community participation and implementation group. Sydney: NSW Department of Health, 2001.
2. Queensland Health. Consumer and community participation toolkit. Brisbane: Queensland Health, 2002.
3. Draper M. Involving consumers in improving hospital care: lessons from Australian hospitals. Canberra: Commonwealth Department of Health and Family Services, 1997.

CONSUMER FOCUS:
Standard, Criteria, Elements, Guidelines

Standard 1.6 The governing body is committed to consumer participation.

Criterion	LA – Awareness	SA – Implementation LA plus the following
1.6.1 **Input is sought from consumers, carers and the community** in planning, delivery and evaluation of the health service.	(a) Management is committed to consumer participation. (b) The organisation has a policy that promotes consumer participation. (c) The organisation works with relevant consumers and consumer groups. (d) Consumers are advised of the organisation's code of conduct.	(a) Consumers and consumer groups are consulted about effective ways of participating. (b) Partnerships are established between consumer / carer / community groups and the organisation. (c) The organisation implements training for interested consumers. (d) Consumers are involved in policy development and health services planning. (e) Written guidelines on consumer participation are developed in partnership with consumers. (f) Consumers sign confidentiality agreements when appointed to committees, and as otherwise appropriate. (g) There is recognition for consumer participation.

These guidelines should be read in conjunction with criteria 1.1.2 care planning and delivery and 1.2.1 community access.

The intent of this criterion is to ensure that an organisation recognises the importance of consumer and community involvement in health care. This ranges from inclusion in their own care and decision making through to involvement in policy decisions.

The term **community** is used to describe the broad range of stakeholders with an interest in health services. While some communities may connect through a local or regional interest in health, others may share a cultural background, religion or language. This includes individual consumers, organisations and groups, health professionals and specific population groups. These may include youth, families with young children, veterans, aged persons, children, single adults, people from culturally and linguistically diverse backgrounds (CALD)[1, 2], gay, lesbian, bisexual, transgender and intersex (GLBTI) backgrounds, and people with mental health problems.

Input may mean as little as asking a consumer(s) for their opinion and experiences about how to improve services and then to plan and implement improvements accordingly. It should be noted that for private health services, their consumers / patients and visiting medical officers (VMOs) and not the broader community, are their community. The organisation should identify who their consumers are. There will be no requirement for organisations to engage consumers in any particular way. Focus groups or advisory committees are just two of many possibilities. The organisation will be responsible for determining the most effective way of achieving consumer input.

Consumer participation is the process of involving health consumers in decision making about their own health care and in health service planning, policy development, priority setting and addressing quality issues in the delivery of health services. The process of participation enables consumers to be involved with health service providers in problem solving for areas of mutual concern.[1, 2]

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Data on consumer participation are evaluated and improved, as required. (b) Consumers are involved in the evaluation of their participation. (c) Consumers are involved to ensure issues are acted upon and improved as required. (d) Feedback on consumer participation is provided to the community and the organisation. (e) Data on consumer / patient / carer participation in care, are collected and evaluated.	(a) Consumers participate in the development and evaluation of services and the development of new services. and / or (b) Consumer participation is compared with other organisations and improvements are made, to ensure better practice. and / or (c) Staff are trained in how to implement and evaluate consumer participation strategies.	(a) The organisation demonstrates leadership and innovation in involving consumers in the planning, delivery and evaluation of health services.

For consumer and community participation to be effective, not only majority groups but also diverse groups within the community need to be heard. Strategies should be employed for different groups so that as many people as possible can participate. Consumers should be consulted as to how they wish to participate.

There are four reasons why health care organisations should have a strong consumer focus and be involved in enhancing and responding to consumer participation: [3]

- participation is an ethical and democratic right
- participation improves health outcomes through improved compliance
- participation improves service quality and safety
- participation makes services more responsive to the needs of consumers, for example through the modification of treatment regimes.

Structures for consumer participation may be formal or informal depending on the type and size of the organisation. There are some legislated responsibilities to involve consumers in health services planning and it is important that organisations are aware of and comply with these responsibilities in accordance with any state / territory legislation. The basic framework for community participation includes:

- informing
- listening to
- responding to
- involving the consumer / community group.

There are a number of strategies used to involve **consumers** in health service decision making, including:

- ongoing structures for participation, for example Hospital Governing Committees with members from patients, carers and community.

1.6 CONSUMER FOCUS STANDARD

Criterion 1.6.1 *Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service.*

(Continued)

- focus groups, consultations, surveys on satisfaction, improving or changing services, or other appropriate channels, for examples: email, regular meeting with disease based specialty groups.

There are a number of strategies used to involve the **community** in health service decision making, including:

- ongoing structures for participation, for example medical advisory committees and quality councils
- focus groups, consultations, surveys on satisfaction, improving or changing services
- partnerships, working with local service organizations, rehabilitation service organizations, and patients' groups.

Resources of time and money are crucial in enabling or holding back participation. Organisations can do a number of things to reduce the costs or compensate for costs incurred:

- assist with transport costs or provide transport
- provide participants with some office space and use of a phone and photocopier
- reimburse expenses incurred
- consider a fee for participants[3]
- provision of meals and parking.

Training programs should be provided to support consumer, carer and community representatives where appropriate. Training may be as simple as informing the consumers what is required of them to effectively participate. Training programs may also be provided to staff on consumer / community participation and consultation. Training or education programs for staff and management are critical to highlight the importance of participation, the potential benefits and how to involve the community.

Information should be provided to consumers and the community in a manner that is easy to understand. Communication should be transparent, honest and frequent and summarise changes made as a result of consumer participation.

Evaluation will help the organisation to identify what does and does not work and allows the organisation to shape future participation. Consumer feedback and data should be gathered on an ongoing basis. It is understood that some agreement or memorandum of understanding between the organisation and consumers or consumer groups may have been arranged at an area, district or corporate level and this agreement is not the direct responsibility of the organisation. A range of methods can be used to gain consumer feedback, including:

- surveys
- interviews
- focus groups
- suggestion boxes.

There may be potential issues that the organisation has not considered in regard to **consumer involvement in clinical ethical issues** but are raised in another situation, for example organ transplantation on overseas residents. There is a need that management considers and addresses the action it would take if it decided to undertake practices outside its usual service options. Management should have a framework in place that protects consumer rights.

Organisations may provide evidence of achievement in this criterion through:

- inclusion in the strategic plan
- terms of reference and minutes of relevant committees
- policies regarding consumer participation
- evidence of consumer training
- evidence of consumer participation on committees
- evidence to show patient consultation and feedback

References

1. NSW Department of Health. Partners in Health: Report of the consumer and community participation and implementation group. Sydney: NSW Department of Health, 2001.
2. Queensland Health. Consumer and community participation toolkit. Brisbane: Queensland Health, 2002.
3. Department of Public Health and Flinders University/South Australian Community Health Research Unit. Improving health services through consumer participation: a resource guide for organisations. Canberra: Department of Health and Ageing, 2000.

CONSUMER FOCUS:
Standard, Criteria, Elements, Guidelines

Standard 1.6 The governing body is committed to consumer participation.

Criterion	LA – Awareness	SA – Implementation LA plus the following
1.6.2 Consumers / patients are informed of their **rights and responsibilities.**	(a) A consumer / patient rights and responsibilities document exists. (b) A confidentiality and privacy policy is in place. (c) The procedure for consumer access to their health records is documented and communicated to consumers / patients.	(a) All consumers / patients receive a copy of the rights and responsibilities document. (b) Staff discuss rights and responsibilities with the consumer / patient. (c) All staff sign confidentiality agreements.

These guidelines should be read in conjunction with criteria 1.1.2 planning and delivery of care, 1.1.3 consent, 2.1.2 risk management and 2.1.3 health care incidents, complaints and feedback.

The intent of this criterion is to ensure that the rights and responsibilities that consumers have in health care delivery are recognised by the organisation, and communicated to consumers.

The organisation should provide information to consumers / patients in appropriate ways and through various channels, e.g. designated staff, enquiry station, notice board, pamphlet, website. This means that information should accommodate special needs such as a visual or hearing impairment or the need for cultural and linguistic relevance.

Information will include:

- consumer / patient rights and responsibilities
- complaints mechanisms
- confidentiality
- privacy
- procedure for access to records
- full disclosure of costs.

The rights and responsibilities of consumers / patients should be respected and promoted within the organisation.

The organisation should have a confidentiality and privacy policy in accordance with the values of the organisation, relevant legislative requirements, professional codes of ethics and accepted standards. All staff should be educated about the policy and should sign confidentiality agreements on commencement of employment.

Consumers / patients should be involved in developing rights and responsibilities documentation wherever possible to ensure it covers all relevant issues and is understandable. It is understood that the development of some patient charters may occur at a state or corporate level, although it is still likely that consumers are involved in their development.

Consumer / patient **responsibilities** involve at a minimum, informing staff about their special needs. This responsibility should be explained in the information given out at the time of booking in or at a pre-admission clinic.

Consumers have the right to trained and competent interpreters.[1] Interpreters should be used when required. Organisations should comply with health department and any other relevant guidelines, on the use of interpreters. All staff should have information on how to access interpreters. In Hong Kong, it is culturally acceptable to use family members as interpreters unless otherwise requested by patients or the families.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The system to inform consumer / patient rights and responsibilities is evaluated and improvements to documents and practices are made as required.	(a) Comparison of documents and practices for consumer / patient rights and responsibilities occurs with external systems and improvements are made to ensure better practice. and / or (b) The organisation can demonstrate that consumers / patients exercise their rights and know their responsibilities.	(a) The organisation is a leader in its systems for ensuring consumers / patients are informed about their rights and responsibilities.

Professional interpreters: [2]

- interpret information accurately and honestly without adding or omitting anything being said
- maintain absolute confidentiality
- are impartial and objective.

Rights and responsibilities documents can be guided by the following guidelines:

- Personal Data (Privacy) Ordinance (Cap 486)
- Mental Health Ordinance (Cap 136)
- Disability Discrimination Ordinance (Cap 487)
- Race Discrimination Ordinance (Cap 602)
- Hospital Authority Patients' Charter

Amendment should be made later according to socially recognised documents.

Organisations should consider providing materials to assist people to become more actively involved in their health care. It explains how and why things can go wrong, and how working in partnership with health care professionals leads to the best possible care.

Organisations may provide evidence of achievement in this criterion through:

- patient rights and responsibilities document / pamphlet
- evaluation of relevant processes informing consumers / patients about their rights and responsibilities
- policies on consumer engagement and participation
- staff education and training programs
- admission procedures.

References

1. National Health and Medical Research Council, July 2005, Making Decisions about tests and Treatment, A Guide to Better Communication Between Patients and Health Professionals. Consultation Draft. Available at: http://www.7.health.gov.au/nhmrc/publications/_files/toolkitdraft.pdf
2. Department of Immigration and Multicultural Affairs, Translating and Interpreter Services, Available at: http://www.immi.gov.au/tis/index.htm
3. Australian Council for Safety and Quality in Health Care (ACSQHC), 10 tips for Safer Healthcare Booklet, Available at: http://www.safetyandquality. org/index.cfm?page=publications#10tips
4. Personal Data (Privacy) Ordinance (Cap 486).

1.6 CONSUMER FOCUS STANDARD

Criterion 1.6.2 *Consumers / patients are informed of their rights and responsibilities.*

(Continued)

5. Mental Health Ordinance (Cap 136).
6. Disability Discrimination Ordinance (Cap 487).
7. Race Discrimination Ordinance (Cap 602).
8. Hospital Authority Patients' Charter.
9. Smart Patient Web-site.

CONSUMER FOCUS:
Standard, Criteria, Elements, Guidelines

Standard 1.6 The governing body is committed to consumer participation.

Criterion	LA – Awareness	SA – Implementation LA plus the following
1.6.3 The organisation makes provision for consumers / patients from **culturally and linguistically diverse backgrounds** and consumers / patients with **special needs.**	(a) The organisation meets legislative requirements relevant to culturally and linguistically diverse backgrounds and special needs. (b) The organisation identifies consumers / patients with special needs. (c) Policies are written to ensure that services are provided appropriate to consumers / patients from culturally and linguistically diverse backgrounds and consumers / patients with special needs.	(a) Translated information is developed appropriate to cultural and special needs. (b) Staff are informed about and have access to information regarding cultural diversity and special needs. (c) The organisation collects demographic, linguistic, cultural and epidemiological data about the culturally and linguistically diverse population it serves. (d) Trained interpreters are available and staff / consumers / patients are informed of the availability. (e) Staff are trained in areas of special needs.

These guidelines should be read in conjunction with criteria 1.2.1 community information and access and 3.2.2 buildings and signage.

The intent of this criterion is to ensure that the needs of the many and diverse groups and individuals that comprise the Hong Kong population are adequately addressed when accessing health care.

Individuals from **culturally and linguistically diverse backgrounds** and those with special needs are spread widely across all socio-economic levels and may be encountered in all health services. Organisations should accommodate the needs of these people when they are consumers / patients of their health service. This may mean as little as providing a nutritionally balanced vegetarian meal for a vegetarian patient through to providing information brochures in several languages.

Understanding cultural, religious and language needs is an important part of providing responsive health care. In addition to such considerations, it is important to acknowledge a person's individual situation and the potential impact this has on how the person will perceive, access and use a health care organisation. As consumer / patient group expectations vary, organisations should guide practices that increase responsiveness to individual health care needs within the resources available. By addressing these needs, barriers to accessing health care for culturally and linguistically diverse / non-Chinese speaking consumer / patient groups can be reduced and overall health outcomes improved.

Organisations should develop policies and systems to address:

- understanding people and their needs
- systems to understand and analyse changing demographics
- encouraging participation in decision making
- providing relevant and accessible information
- an appropriately trained workforce
- meeting the specific needs of different communities.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Food, services and care are provided in a manner that is appropriate to consumer / patient cultural and special needs. (b) The organisation evaluates whether consumer / patient cultural and special needs are met and strategies for improvement are implemented as required. (c) Staff have access to training and resources to enhance their skills in delivery of culturally appropriate care and services. (d) Data on utilisation of the service by people from culturally and linguistically diverse backgrounds are collected and maintained to monitor access which is improved as required.	(a) Performance indicators for culturally and linguistically diverse backgrounds and special needs are measured and compared internally and externally, and improvements are made to ensure better practice.	(a) The organisation demonstrates leadership in its systems for ensuring consumers / patients from culturally and linguistically diverse backgrounds and with special needs are met.

Diversity is a broad concept that includes all Hong Kong people. Recognising that each person is a unique and complex being is integral to understanding and responding effectively to health care needs at an individual, family or community level. Diversity[1] extends to age, personal and corporate background, education, function and personality. It includes lifestyle, sexual preference, ethnicity and status within the general community. Facilitating access for these often marginalised groups and individuals should occur across all areas of health care.

In the Hong Kong context , individuals with culturally and linguistically diversity include: ethnic minorities, foreign domestic helpers, dialect speaking Chinese, cross border consumers, and religions.

Guidelines for legislature requirements are Codes of Practice made by the Equal Opportunities Commission in accordance with Disability Discrimination Ordinance (Cap 487) and Race Discrimination Ordinance (Cap 602), or code of service developed with consumers / patients from culturally and linguistically diverse backgrounds. Example of suggestions include: accessible service location, translation service, multi-language information.

Barriers faced by culturally and linguistically diverse communities generally do not apply to other Hong Kong people. These barriers include:[3]

- different culturally based concepts of health and illness which may affect the understanding of treatment and impact on compliance.
- lack of familiarity with the local health system which may be very different from health services in their home country
- lack of proficiency in the Chinese / English language which impacts on the ability to access and communicate with health service providers
- lack of understanding of consumer rights and responsibilities
- language and cultural barriers to adequately understand information in order to be able to consent to medical / surgical procedures. This has serious medico-legal implications

1.6 CONSUMER FOCUS STANDARD

Criterion 1.6.3 *The organisation makes provision for consumers / patients from* ***culturally and linguistically diverse backgrounds*** *and consumers / patients with* ***special needs****.*

(Continued)

- lack of confidence to enable effective participation as consumers in health care planning and evaluation
- issues for consumers from refugee backgrounds who have experienced trauma and often torture and who continue to suffer severe health consequences as a result of their refugee experience or the years of subsequent deprivation in refugee camps.

Special needs refers to a personal condition or situation that could make it difficult for a consumer / patient to participate fully in their health care. The personal condition or situation could include:

- poor literacy, whether from English as a second language or not
- affected by age, either elderly or very young
- affected by trauma
- affected by medications / drugs
- a disability.

Some of the key areas that organisations should address for people with special needs and their parents, families and carers include:

- enabling support to be provided early and to respond better to people's individual needs, as well as to the needs of their families and carers
- ensuring that care and services enable and empower people with special needs, so that they can participate in their health care and make informed choices
- valuing families, carers and volunteers for the contribution they make towards meeting the support needs of children and adults with special needs
- The preference of patient with special needswhich is reasonable should be taken into consideration
- strengthening rural, regional and urban communities (as applicable), so that they are more accessible and more inclusive of people with special needs
- developing more effective strategies to respond to the increasing demand for special needs in health care services
- improving access to physical environments within the organisation
- creating more opportunities for education of persons with special needs and training for staff working with people who have special needs.
- The preference of patient with special needs which are reasonable should be taken into consideration

There are many different types of disability. A disability can be caused by a genetic condition, an illness or an accident.[4] If a person has a disability they will most probably have special needs. Disability may include:

- intellectual disability
- physical disability
- sensory disability
- acquired brain injury
- neurological impairment
- mental illness
- dual disability / co-morbidity (one of the above and a psychiatric disability), also known as dual diagnosis, often refers to a person with a mental illness and a drug or alcohol addiction
- disabilities that are unrelated to ageing
- any combination of these.

Communication with people with some disabilities may be difficult. Alternative modes of communication may need to be sought for those with vision, speech, language, hearing and cognitive impairments. Care should be taken to focus on the patient's overall health rather than just factors relating to their disability.

The preferred approach to managing the frail aged is a focus on maintaining, improving and preventing deterioration in the health and quality of life. Screening will identify those who require a comprehensive multidisciplinary assessment and

care plan. Organisations should refer to the Aged-friendly Principles and Practices when treating older people. [5]

Older people with complex co-morbidities may require additional time having their conditions and treatments explained to them, and developing effective strategies for self-management. The treatment and care of people with complex needs will improve if it is coordinated from one point.

Organisations may provide evidence of achievement in this criterion through:

- policies in line with legislative requirements
- staff training programs
- pre-admission information
- disability and cultural signage
- availability of information in other languages
- use of interpreters
- evaluation of demographic information.

References

1. Teichner J, Holland P, Gough R. Employee Relations Management: Australia in a Global Context. Sydney: Prentice Hall, 2002.
2. Disability Discrimination Ordinance (Cap 487).
3. Australian Government Department of Health and Community Services, Continuous Improvement Handbook, version 2, Section D: Special Considerations, Available at: http://www.facs.gov.au/disability/ci_handbook/section_D.html
4. Department of Human Services. Victorian state disability plan 2002-2012. Melbourne: Department of Human Services, 2002.
5. Department of Health and Ageing. Aged friendly principles and practices. Canberra: Department of Health and Ageing, 2004.
6. Race Discrimination Ordinance (Cap 602).
7. Code of Practice by the Equal Opportunities Commission.

Further Reading

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1.6 CONSUMER FOCUS STANDARD

Criterion 1.6.3 *The organisation makes provision for consumers / patients from* ***culturally and linguistically diverse backgrounds*** *and consumers / patients with* ***special needs****.*

(Continued)

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CLINICAL FUNCTION

SUPPORT FUNCTION

CORPORATE FUNCTION

2.1 QUALITY IMPROVEMENT AND RISK MANAGEMENT STANDARD

The standard is: **The governing body leads the organisation in its commitment to improving performance and ensures the effective management of corporate and clinical risks.**

The intent of this standard is to ensure that the organisation:

- effectively manages all corporate and clinical risks in an integrated way
- continuously improves all aspects of the organisation and the services the organisation provides.

There are three criteria in this standard. They are:

*2.1.1 The organisation's **continuous quality improvement system** demonstrates its commitment to improving the outcomes of care and service delivery.*

*2.1.2 The integrated organisation-wide **risk management policy and syste**m ensure that **corporate and clinical risks** are identified, minimised and managed.*

*2.1.3 Health care **incidents, complaints and feedback** are managed to ensure improvements to the systems of care.*

Risk management is intended to reduce the threat of activities and processes going wrong, **quality improvement** is the action taken throughout the organisation to increase the effectiveness of activities and processes to provide added benefits to the organisation and consumers / patients. While risk management and quality management are distinct functions a quality and risk management continuum exists. Quality and risk management programs must work together to achieve organisational goals and quality outcomes. **Incident and complaints management** is one strategy available to health care organisations for identifying, analysing and treating risks.

QUALITY IMPROVEMENT AND RISK MANAGEMENT: Standard, Criteria, Elements, Guidelines

Standard 2.1 The governing body leads the organisation in its commitment to improving performance and ensures the effective management of corporate and clinical risks.

Mandatory Criterion	LA – Awareness	SA – Implementation LA plus the following
2.1.1 *The organisation's **continuous quality improvement system** demonstrates its commitment to improving the outcomes of care and service delivery.* This is a Mandatory Criterion.	(a) The governing body is committed to continuous quality improvement. (b) A framework for continuous quality improvement exists.	(a) Improving performance is a planned and continuous process. (b) Leaders in quality improvement are recognised across the organisation and supported as drivers for improvement. (c) Management identifies and promotes organisational performance improvement targets. (d) There is a system for prioritisation of necessary improvements and such improvements are adequately resourced. (e) Staff are supported and engage in ongoing improvement in care and service delivery.

This criterion is relevant to all other criteria.

The intent of this criterion is to ensure that all health care organisations understand the importance of the development of an improvement culture and system. **A continuous quality improvement** culture will not exist in an organisation without effective leadership for quality from the top of the organisation.

The governing body, clinicians and managers are responsible for promoting a culture of continuous improvement that is consistent with the goals of the organisation and is integrated into the organisation. It enables all stakeholders to contribute to better health outcomes for consumers / patients. Together the governing body, clinicians and managers are responsible for implementing a comprehensive quality improvement program throughout the organisation. They are also responsible for the appropriate delegation of its day-to-day management.

Quality improvement goes by various names and acronyms. These include Continuous Quality Improvement (CQI), Clinical Practice Improvement (CPI) Total Quality Management (TQM) and Quality Assurance (QA).

The foundation of any improvement culture and process is to continually ask and answer the following three questions:

1. What are we trying to achieve? (the aim statement)
2. How will we know that change is an improvement? (the measures used)
3. What change can we make that will result in an improvement? (strategies or tools adopted)[1]

The characteristics of an **improving organisation** include:

- customer focus – consumer / patient needs are recognised

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The effectiveness of the improvement framework and its component activities is evaluated and improved as required. (b) Qualitative and quantitative data are collected, analysed and used to drive improvement. (c) Involvement in organisational quality improvement is evaluated and improved as required. (d) Results from performance targets and improving performance activities are communicated across the organisation and to the governing body. (e) Quality improvement is linked to the risk management system, education, and strategic plan.	(a) Comparison occurs with internal and external systems and improvements to practices and systems are made to ensure better practice. and / or (b) The evaluation of the effectiveness of improvement activities demonstrates excellence in improvement processes. and / or (c) A cultural assessment is undertaken and improvements to the organisation's culture are made to ensure better practice.	(a) The organisation demonstrates that it is a leader in continuous quality improvement.

- strong leadership – responsibility and commitment to improving performance is demonstrated
- a culture of improving – management and staff continually strive for improvement
- evidence of outcomes – outcome data are used for evaluation
- striving for best practice – the organisation compares its performance with others and improves as a result of that comparison.

There are five recognised steps in an improvement process: [2]

1. *The Development stage:* Identify the component or process to be improved, who would be involved in the process and identify what is to be achieved.
2. *Diagnostic stage:* Establish through the use of various tools, the reason that the problem exists or the component that needs to be improved, what changes should be made that will produce an improvement, and how any resulting improvement will be measured.
3. *Intervention stage:* Identify the interventions that could address the causes found through the diagnostic phase, test the effect of each intervention through Plan, Do, Check, Act (PDCA) cycles and implement the effective intervention(s).
4. *Impact and functioning stage:* Evaluate and document the effect of the changes, making amendments to any policies or procedures pertaining to this component of the organisation.
5. *Sustaining improvement stage:* Continue monitoring any changes to your systems and planning for future improvement in this area and any others. This stage requires mechanisms to ensure sustainability. This should involve:
   - *Standardisation* of existing systems and procedures for achieving work activities.

2.1 QUALITY IMPROVEMENT AND RISK MANAGEMENT STANDARD

Criterion 2.1.1 *The organisation's* ***continuous quality improvement system*** *demonstrates its commitment to improving the outcomes of care and service delivery.*

(Continued)

- *Documentation* of all associated policies, procedures, guidelines and protocols.
- *Training and education* of staff on the new policy.
- *Measurement and review* to ensure that the change becomes part of the regular practice.

Organisations may provide evidence of achievement in this criterion through:

- Quality Council / Committees / improvement teams membership that includes governing body leadership and participation
- governing body agenda and minutes with reports of improvements, clinical and non-clinical performance, sponsoring of key improvement activities
- strategic and operational plans, budgets that include quality improvement
- governing body endorsement of framework for quality improvement
- continuous quality improvement plans, framework such as philosophy, policy, improvement processes, performance targets, links to incidents, complaints, risks, education, planning
- strategies for supporting staff to be leaders / participants in improvement activities
- by-laws, appointment criteria, position descriptions that include quality improvement responsibilities
- system for prioritising improvements to address high-risk, high volume issues
- reports of quantitative and qualitative performance data, clinical and non-clinical and communication and distribution channels
- minutes of meetings that discuss and action data
- a list of improvements, clinical and non-clinical
- evaluation of the improvement activities
  - impact on the consumer / patient, organisation performance targets, cost versus benefit
- evaluation of governing body, management and staff participation such as membership of project teams, number of activities
- evaluation of continuous quality improvement framework such as understanding and knowledge of the philosophy, policy, improvement processes, performance targets; improvements addressing high-risk, high volume services; costs versus benefits
- benchmarking activities – improved practices and systems
- assessment of organisational culture for quality improvement.

References

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QUALITY IMPROVEMENT AND RISK MANAGEMENT: Standard, Criteria, Elements, Guidelines

Standard 2.1 The governing body leads the organisation in its commitment to improving performance and ensures the effective management of corporate and clinical risks.

Mandatory Criterion	LA – Awareness	SA – Implementation LA plus the following
2.1.2 *The integrated organisation-wide **risk management policy and system** ensure that **corporate and clinical risks** are identified, minimised and managed.* This is a Mandatory Criterion.	(a) Clinicians, managers and other staff are made aware of their responsibilities for managing risks through consultation and communication. (b) There is an organisation-wide risk management policy for corporate and clinical risks which has been endorsed by the governing body and is available to clinicians, managers and other staff. (c) The risk management policy identifies specific strategies for managing both corporate and clinical risks.	(a) A coordinated, organisation-wide risk management system, including corporate and clinical risks is developed, documented and implemented. (b) Management has allocated resources to risk management. (c) Systems are in place to ensure clinicians / managers / staff can initiate action to prevent and / or reduce the impact of risks. (d) A risk management approach is used when considering and developing new and modified services. (e) Clinicians / managers / staff demonstrate their understanding and knowledge of the risk management system. (f) Integration between the quality improvement systems and risk management exists within the organisation.

This criterion should be read in conjunction with all other criteria.

The intent of this criterion is to ensure that health care organisations understand the importance of the development and implementation of an integrated risk management framework for corporate and clinical services.

Risk Management is defined as 'a logical and systematic method of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risks associated with any activity, function or process in a way that will enable organisations to minimise losses and maximise opportunities'.[1]

An integrated risk management strategy will include corporate and clinical areas including patient and staff related clinical risks, financial, human resources, occupational safety and health, environmental and asset related risks and will be integrated with the quality improvement system.

Risk management systems aim to support:

- achievement of an organisation's strategic goals
- protection of organisational assets (financial and physical)
- protection of human, and intangible resources and property
- prevention of injury to consumers / patients, employees and visitors
- reduction or mitigation of loss.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Risk identification and risk analysis are undertaken using qualitative and quantitative data. (b) The corporate and clinical risk management system is evaluated and improved as required. (c) Data from risk management processes are provided to clinicians, managers and other staff and improvements to care and services occur.	(a) Components of the risk management system are compared with internal and external systems and improvements are made to ensure better practice. and / or (b) Evaluation of the risk management system demonstrates that risk management is effective and risks are minimised.	(a) The organisation demonstrates that it is a leader in its approach to risk management.

As part of the risk management process, organisations should establish a policy and a system that:

- identifies
- analyses
- evaluates
- treats
- continuously monitors and reviews, and
- communicates

all corporate and clinical risks that occur, or have the potential to occur in a health care organisation.[1]

The strategies used to identify risks can be prospective, as they occur, or retrospective.[2]

Analysing risks involves determining the consequences of the risk and the likelihood that it will occur or reoccur. It should also involve the determination of the potential consequences of the risk as opposed to the actual outcome.

The **evaluation** of the risk involves a determination of the best intervention to be undertaken in order to manage or treat the risk. In this evaluation there should be a consideration of whether the risk can be:

- eliminated, that is, is there an intervention that is likely to remove the risk? Such methods will include ceasing a service or process, architectural / physical plant changes or engineering controls, such as safety engineered medical devices

2.1 QUALITY IMPROVEMENT AND RISK MANAGEMENT STANDARD

Criterion 2.1.2 *The integrated organisation-wide risk management policy and system ensure that corporate and clinical risks are identified, minimised and managed.*

(Continued)

- mitigated through reducing the likelihood of the risk occurring or consequences in the event of occurrence, when a risk cannot be eliminated. This will be achieved through methods such as process redesign, checklists and cognitive aids, documentation, policy implementation, software enhancements or modifications

- accepted, when neither elimination nor risk reduction can be achieved or falls within the organisation's approved criteria for risk acceptance. Where risk acceptance is identified as the treatment option, documented processes supporting this decision should be evidenced.

Treatment of risk will involve implementing the strategies identified in the evaluation phase.

All health care organisations should establish processes to ensure effective prioritisation and timely treatment of risks. **A risk register** is a tool that can be used to support the prioritisation of risks and the allocation of appropriate resources. A risk register assists to identify, analyse and document potential risks in a consistent manner. A risk register should be a dynamic tool that is regularly reviewed and amended to support decision making about risk management. Risks assessed and documented should be organisation-wide and include clinical, financial, human resources and information technology considerations.

A system for **monitoring and reviewing** risks should be established to ensure that treatment strategies are effective and continue to minimise risk.

Prevention is a foundation for the management of potential risks. Through effective communication, sound management of organisational systems, committee infrastructure and thorough documentation, significant progress can be made in improving the quality of consumer / patient care.

A governing body endorsed policy should be implemented that defines the organisation's **risk management** framework, with evidence that the governing body regularly reviews risk issues and the risk management framework is as reflected in the minutes. The risk management framework should link to strategic and business planning and support assessment of new services and / or altered services.

Consultation with stakeholders is a key requirement for effective management of risks. Mechanisms for achieving this may include the organisation's committee structure or department meetings, depending on the size of the organisation, focus groups, for example information technology, human resources, finance or clinical to identify risk issues and meetings of the governing body that reflect that risk issues are discussed and actioned.

Clinician engagement is critical to effective clinical risk management programs and may be supported through a clinically oriented Risk Management Committee / Medical Advisory Committee, speciality groups with provision of speciality specific data, or an organisation's medical by-laws for credentialling and scope of clinical practice. Identification of clinical 'champions' may also provide a means of engaging clinicians in the organisation's risk management program.

Staff, management and governing body training and education should be provided as relevant to the person's role in risk management. Evaluation of understanding of the risk management process and organisational framework should be undertaken.

Integration between quality and risk should be evident with issues being identified that may be raised as a risk issue but that have lead to improvement activities or enhanced patient outcomes.

Examples of strategies that may be included in a risk management program are shown below.

Corporate risk management strategies, such as:

- audit processes
- human resources planning
- political risk management
- implementation of financial management systems

- fraud minimisation schemes
- occupational health and safety strategies
- implementation of an incident management system including sentinel events
- education and training programs for all staff
- recruitment and retention strategies
- effective use of complaints and feedback from consumers, patients and staff
- staff performance review and development
- Input from local and foreign experts.

Clinical risk management strategies, such as:

- clinical audit processes
- superior review, peer review and peer supervision
- retrospective patient record review
- implementation of an incident management system including sentinel events
- conduct of mortality and morbidity reviews
- effective use of clinical indicators
- effective credentialling and defining the scope of clinical practices for all clinicians
- performance review and development.

No one strategy is ideal for managing all risks. Organisations should undertake to implement a 'suite' of the above mentioned risk management strategies in accordance with the size of the organisation and scope of services provided, in order to be effective.

Organisations may provide evidence of achievement in this criterion through:

- education / communications / meetings for staff on risk management
- organisation-wide risk management policy and procedures (endorsed by the governing body) for staff to manage and prevent corporate and clinical risks and that links with the quality improvement system
- strategic, operational and business plans that consider risks
- budget allocation for risk management
- tools for identifying and analysing risks
- quantitative and qualitative data on identified risks such as incidents, root cause analysis findings, clinical outcomes, staff injury, budget variance
- reports of the data on risks and the communication and distribution channels
- minutes of governing body, committees, medical staff councils, staff meetings where risk issues are reported and actioned
- by-laws, appointment criteria, position descriptions that include risk management responsibilities
- improvements resulting from the analyses of risks
- evaluation of clinician, management and staff understanding of the risk management system
- evaluation of risk management system – policy, risk identification, system for managing and preventing risks, communication of data on risks, use of data; high-risk, high volume activities identified and improved; cost versus benefit.

References

1. Standards Australia. AS/NZS 4360-2004. Risk Management.
2. Langley G, Nolan T, Norman C, Provost P. The improvement guide: A practical approach to enhancing organizational performance. San Francisco: Jossey Bass, 1996.
3. Code of Practice for Private Hospitals, Nursing Homes and Maternity Homes.
4. Medical Device Control Office: http://www.mdco.gov.hk/

QUALITY IMPROVEMENT AND RISK MANAGEMENT: Standard, Criteria, Elements, Guidelines

Standard 2.1 The governing body leads the organisation in its commitment to improving performance and ensures the effective management of corporate and clinical risks.

Mandatory Criterion	LA – Awareness	SA – Implementation LA plus the following
2.1.3 Health care **incidents, complaints and feedback** are managed to ensure improvements to the systems of care. This is a Mandatory Criterion.	(a) The organisation is aware of the need to effectively identify and manage incidents and complaints in an integrated manner. (b) Incident, complaint and feedback management policies exist and are communicated to staff and consumers / patients. (c) The organisation is aware of the principles for open disclosure. (d) Consumers / patients are provided with information about complaint, feedback and incident management processes.	(a) Incidents, complaints and feedback are managed in accordance with hospital policies, the code of practice for Private Hospitals, Nursing Homes and Maternity Homes, and Personal Data (Privacy) Ordinance[8] (Cap 486) (b) The incident management system includes: (i) identification (ii) review (iii) action on incidents (iv) levels of responsibility for incident management (v) support for consumers / patients and staff involved in incidents and complaints. (c) A system exists for testing and implementing the recommendations from the reviews of serious incidents. (d) The organisation recognises and manages both the systemic and individual staff member contributions to an incident. (e) Positive feedback about care and service is communicated to staff and management. (f) Clinicians / managers / staff are orientated in incident and complaint management and open disclosure.

These guidelines should be read in conjunction with standard 1.5 safety and criterion 1.6.3 rights and responsibilities.

The intent of this criterion is to ensure that health care organisations have effective mechanisms in place for managing health care incidents as and when they occur, and for preventing their recurrence. Incidents, complaints and feedback should be managed with due regard to privacy and confidentiality for the consumer / patient and any other persons involved.

Comprehensive incident management involves: [1]

- identification of an incident or near miss
- notification of identified incidents or near misses into the reporting system
- prioritisation to ensure that a standardised, objective measure of severity is allocated to each incident or near miss
- investigation of the incident; an important component of any patient safety program

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Incidents are trended and risk rated and improvements are made as required. (b) Improvement strategies are evaluated to ensure the organisation is providing a safe environment. (c) The incident and complaint management system is evaluated and improved as required. (d) The support provided for consumers / patients and staff involved in incidents and complaints is evaluated, and improved as required. (e) The principles of open disclosure of an adverse event are evident in the system to manage incidents and complaints. (f) Consumers are involved in the incident and complaint management processes.	(a) Incident and complaint data are compared internally and externally and improvements are made to ensure better practice. and / or (b) The incident, complaint and feedback management system is compared with external systems and improvements are made to ensure better practice. and / or (c) The organisation undertakes research into incident and complaint management and acts on results. and / or (d) Consumers / patients have access to a system of direct notification of incidents and complaints. and / or (e) Frontline staff are trained in methods of conflict and complaint resolution. and / or (f) A national open disclosure standard is fully implemented in the organisation.	(a) The organisation is recognised as a leader in incident and complaint management systems and processes. (b) The organisation publicly reports on incidents and complaints and the improvements implemented.

- classification, the process of capturing relevant information to ensure that the complete nature of the incident is documented and understood
- analysis and action to understand how and why the incident occurred and to identify ways of preventing a recurrence
- feedback; should include the changes made and improvements achieved as a result of changes made.

An incident is an unplanned event resulting in or having the potential for injury, ill–health, damage or other loss.[2] Any event that could have had an adverse consequence but did not, and is indistinguishable from fully fledged adverse events in all but outcome should also be considered to be an incident. These are known as near misses.[3] Adverse events and sentinel events are a subset of incidents.

2.1 QUALITY IMPROVEMENT AND RISK MANAGEMENT STANDARD

Criterion 2.1.3 *Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.*

(Continued)

A complaint is defined to include expressions of dissatisfaction or concern about a health care service made by consumers / patients, their carers or others. All complaints are included, whether they are formal written complaints, a concern expressed during discussions with a health care professional, or views expressed as part of a consumer feedback survey. [4]

A sentinel event is 'an event in which death or serious harm to a patient has occurred. An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. An incident with actual or potential serious harm, or death'. [4] A sentinel event can be further described as an event that happens rarely or one which represents an adverse outcome of such significance that it warrants individual investigation.

Health care organisations should manage all incidents, sentinel events and near misses in line with hospital policies and the Code of Practice for Private Hospitals, Nursing Homes, Maternity Homes and Department of Health policies. However, each category should be managed in a different way. As described, sentinel events are by definition serious, and therefore require a thorough investigation, for example, in the form of a root cause analysis (RCA). There are other well researched approaches to incident investigation that can be applied, providing the required outcome of system changes is met.

Incidents and near misses, which by definition are more common and less serious, should be aggregated and investigated either through a RCA or through a clinical practice improvement method to ensure that the real causes are identified and action is taken to prevent recurrence.

Organisations should understand the contribution that both 'the system' and 'the individual' makes to an incident. The incident management system should have two completely separate investigative processes. The first of these processes should be aimed at an objective review of 'the system' issues that contributed to the incident. The other process is aimed at reviewing an incident to determine whether an individual health care provider's actions contributed to the incident. Organisational policy should identify the circumstances under which each type of investigation should take place.

An incident Information Technology (IT) system, if implemented, should support, capture and analyse the data from the incident management process.

Few individual incidents are identified by more than one method; the use of multiple evaluation methods will increase the total number of events identified. Incident, complaint and feedback mechanisms should be used.

Feedback to staff and management is a communication from a consumer / patient relaying how delivered products, services and messages compare with consumer / patient expectations.

Feedback is important because consumers / patients evaluate the care experience they receive at a health care organisation on criteria that health care professionals may not have considered or acknowledged. Consumer / patient feedback can also alert the organisation to incidents or near misses that might normally have gone undetected.

Consumer / patient complaints can arise from their perceptions. Often, investigations reveal the consumer / patient perceptions are indeed, misperceptions. However, these misperceptions are the consumer / patient view of reality.

How the organisation communicates with the consumer / patient to correct misperceptions is crucial for successful complaint resolution. Complaints may be expressed orally or in writing and may be made through a complaints process or as part of other consumer feedback mechanisms such as consumer surveys or focus groups.

The Better Practice Guidelines on Complaints Management for Health Care Services document [5] outlines procedures to assist health care organisations to develop or improve their complaints management systems. The application of the better practice guidelines will vary according to the size and nature of the organisation. These guidelines consider applicable laws and policies of professional indemnity organisations and professional standards. The guidelines set out better practice indicators by which organisations

can demonstrate their complaints management system and identify where they should improve. The Australian Standard AS ISO 10002, *Customer satisfaction – Guidelines for complaints handling in organisations, AS 4608, Dispute management systems* and the Good practice guide for effective complaint handling, are intended to assist those involved in complaints handling and should be referred to when developing or reviewing complaints management systems. [6]

Consumers / patients, visitors and the community need to be aware of the procedures to make a complaint and be provided with suitable means for reporting grievances. Consumers / patients should be given reminders periodically of their right to complain.

As a reference, the Open Disclosure Standard: a national standard for open communication in public and private hospitals, following an adverse event in health care[7] was published by the Australian Council for Safety and Quality in Health Care in 2003. The principles of open disclosure are:

1. openness and timeliness of communication
2. acknowledgement of the event
3. an expression of regret
4. recognition of the reasonable expectations of patients and their support persons
5. staff support
6. integrated risk management and systems improvement
7. good governance
8. confidentiality.

Presently Hong Kong has not yet developed a local open disclosure policy but it is in the process.

The open disclosure standard aims to promote a clear and consistent approach by health care organisations to open communication with consumers / patients and their carers following an adverse event. All health care organisations will be required to work towards the implementation of this standard.

The elements relating to open disclosure in EQuIP 4 are:

LA (c) The organisation is aware of the principles of open disclosure.

SA (f) Clinicians / managers / staff are orientated in incident and complaint management and open disclosure.

MA (e) The principles of open disclosure of an adverse event are evident in the system to manage incidents and complaints.

and do not require full implementation of this standard at this stage. Organisations should refer to the 'open disclosure standard' when reviewing their policies.

Organisations may provide evidence of achievement in this criterion through:

- incidents and complaints management systems
- policies and procedures, including:
  - incidents and complaints
  - open disclosure
  - how incidents and complaint management is addressed in the orientation system
- information available to consumers / patients and staff on how to lodge complaints
- clinical and non-clinical routine audits such as death audits, environmental audits
- participation in programs such as the Advanced Incident Reporting System (AIRS) and the Sentinel Event Reporting System for Private Hospitals.
- integration of complaints and feedback to the incident reporting system
- evidence of staff training.

2.1 QUALITY IMPROVEMENT AND RISK MANAGEMENT STANDARD

Criterion 2.1.3 *Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.*

(Continued)

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7. Australian Council for Safety and Quality in Health Care (ACSQHC). Open disclosure standard: a national standard for open communication in public and private hospitals following an adverse event in health care. Canberra: Australian Council for Safety and Quality in Health Care, 2003.
8. Personal Data (Privacy) Ordinance (Cap 486).

Relevant Standards

- Standards Australia. AS/NZS 4360-2004: Risk management.
- Standards Australia. AS 3904.4-1994: Quality management and quality system elements – guidelines for quality improvement.
- Standards Australia. AS 4269-1995 Complaints handling.
- Standards Australia. AS 4608-2004 Dispute management systems.

Further Reading

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2.1 QUALITY IMPROVEMENT AND RISK MANAGEMENT STANDARD

Criterion 2.1.3 *Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.*

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CLINICAL FUNCTION

SUPPORT FUNCTION

CORPORATE FUNCTION

2.2 HUMAN RESOURCES MANAGEMENT STANDARD

The standard is: **Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff.**

This standard should be read in conjunction with criteria 1.1.2 care planning and delivery, 2.3.1 records management systems, 3.1.3 credentialling, 3.1.4 external service providers and 3.2.1 safety management systems.

The intent of the Human Resources Management (HRM) standard is to ensure the organisation's human resources are recruited and managed in a manner that supports the provision of quality and safe care and services. Human resources management practices should also support the organisation's goals and objectives.

The standard for the management of HRM practices contains five criteria. These are:

2.2.1 **Human resources planning** supports the organisation's current and future ability to address needs.

2.2.2 **The recruitment, selection and appointment system** ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation.

2.2.3 **The continuing employment and performance development system** ensures the competence of staff and volunteers.

2.2.4 **The learning and development system** ensures the skill and competence of staff and volunteers.

2.2.5 **Employee support systems** and **workplace relations** assist the organisation to achieve its goals.

Human resources management is the policies, practices and systems that influence employees' behaviours, attitudes and performance[1].

Reference

1. De Cieri H, Kramer R, Noe R, Hollenbeck J, Gerhart B, Wright P. Human resource management in Australia: strategy – people – performance. Sydney: McGraw Hill. 2003.

HUMAN RESOURCES MANAGEMENT:
Standard, Criteria, Elements, Guidelines

Standard 2.2 Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff.

Criterion	LA – Awareness	SA – Implementation LA plus the following
2.2.1 **Human resources planning** supports the organisation's current and future ability to address needs.	(a) Recruitment activities are focussed on current needs. (b) Systems exist to ensure that the skill mix of clinical and support staff meets consumer / patient needs. (c) Strategies are in place to ensure safety and quality of treatment and care if prescribed levels of skill mix of clinical and support staff are not available. (d) There are documented policies and procedures for human resources planning and management.	(a) Data related to current human resources are used to develop human resources plans. (b) Human resources management functions and responsibilities are clearly identified. (c) The organisation's human resources planning reflects current and future needs of consumers / patients and staff. (d) There is a system to identify consumer / patient needs and to involve staff in planning to achieve the desired skill mix. (e) The human resources strategic plan is clearly linked to the organisation's strategic direction and goals. (f) Staff members are advised of the human resources policies and procedures. (g) There are contingency plans to manage workforce shortages.

These guidelines should be read in conjunction with criterion 2.1.2 risk management and 3.1.1 strategic planning.

The **health workforce** refers to the workforce that provides health care in Hong Kong. The health workforce ranges from workers with no formal qualifications providing support services in home based settings through to highly qualified specialists working in technology intensive hospital settings and also includes non-clinical staff. It should be noted most of the workforce in Hong Kong are working on a full time basis. It is acknowledged that the workforce is supported by volunteers and carers.

The health workforce is referred to as 'staff' in this standard. The term staff encompasses full-time, part-time, sessional and casual employees, volunteers and in some criteria (2.2.1 and 2.2.2 recruitment, selection and appointment) agency staff and contract staff but does not include external service providers. Organisations should define their own health workforce. In the public sector staff may include visiting medical officers.

Human resources **planning** involves identifying current and future human resources needs for an organisation and planning the necessary steps to meet those needs. Human resources planning should be linked with other organisation-wide plans. Some organisations may not have a specific human resources plan as human resources is covered in the organisation's **strategic plan.** Planning should be informed by the best available evidence, utilisation of services and the needs of the community. Data related to human resources that may assist in planning includes staff hours, skill mix, rostering, absenteeism and turnover, responses to advertisements, workers compensation and industrial relations incidents.

Human resource planning should consider:[2]

- human resources needs – skills, behaviour, culture

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The human resources policy, plan, goals and strategic direction are regularly reviewed and improvements are made as required. (b) Staff are involved in the evaluation of the human resources strategy.	(a) Performance indicators and processes for human resources planning are measured, compared internally and with external systems, and improvements are made to ensure better practice. and / or (b) The organisation conducts research and develops innovative ways to improve human resources management.	(a) The organisation demonstrates it is a leader in planning for current and future human resources requirements.

- human resources practices – recruitment, performance management, industrial relations, job analysis, job design, selection, employee learning and development, pay structure, incentives, benefits
- human resources capacity – skills, abilities, knowledge
- human resources actions – behaviours, results (productivity, absenteeism, turnover)
- organisational performance – productivity, quality, profitability.

Strategies for human resources planning may include:

- assessment of human resources requirements to define the current status and the desired outcome
- consideration of the impact of internal and external environment changes
- participation of staff, service providers and consumers / patients to ensure realistic strategies are developed and implemented
- developing a set of human resources targets for the year. Progress against these targets should be reviewed at least annually.

To make optimal use of workforce skills and ensure the best health outcomes, it is recognised that new roles may be created or existing roles may be realigned. Human resources planning should ensure any workplace or role redesign addresses health needs, the provision of sustainable quality care and the required competencies to meet service needs.

Human resources planning should include diversity management. The method of managing diversity is a process of management built on a set of values which recognise that the differences between people are a potential strength for the organisation[3]. Human resources levels, policies and practices take account of cultural issues. This may be reflected in:

2.2 HUMAN RESOURCES MANAGEMENT STANDARD

Criterion 2.2.1 Human resources planning supports the organisation's current and future ability to address needs.

(Continued)

- inclusion of cultural knowledge and skills within position descriptions (particularly for staff directly serving cultural groups)
- orientation, training and appraisal processes
- staffing levels and workloads of personnel with a cultural advisory role
- flexible work practices to accommodate religious requirements.

Human resources policies and procedures may include:

- recruitment, selection, appointment and reappointment
- retention
- orientation, training and education
- leave, illness and accidents
- equal employment opportunities (EEO)
- access to support services
- workplace relations including industrial relations, grievance procedures and dispute resolution
- performance review
- confidentiality
- aggression and violence containment
- uniform policy / dress code
- pay and rewards policy
- travel and other allowances
- contingency plans for workforce / staff or skill shortages; organisations should show they have considered issues and mechanisms to manage these, are in place
- overseas recruitment
- cultural issues
- work experience students
- university or other students.

The above policies are applicable and should be available, to both staff and volunteers.

Where the organisation offers clinical education for students there should be a documented agreement with the educational institution which identifies commitments and responsibilities of each party.

Workload monitoring systems can ensure a safe staffing mix and that levels are consistently achieved.

Organisations may provide evidence of achievement in this criterion through:

- human resources management plan and strategic plan
- staff involvement in human resources and workforce planning, such as staff satisfaction, committee meetings
- evidence of contingency plans to address staff shortages
- evaluation of human resources strategies and plan
- human resource policies, position descriptions etc.

References

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2. De Cieri H, Kramer R, Noe R, Hollenbeck J, Gerhart B, Wright P. Human resource management in Australia: strategy – people – performance. Sydney: McGraw Hill. 2003.
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HUMAN RESOURCES MANAGEMENT:
Standard, Criteria, Elements, Guidelines

Standard 2.2 Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff.

Criterion	LA – Awareness	SA – Implementation LA plus the following
2.2.2 The **recruitment, selection and appointment system** ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation.	(a) Recruitment, selection and appointment are undertaken in accordance with legislative requirements, territory regulations and organisational policy. (b) Recruitment processes ensure staff and volunteers have the necessary licences, registration, qualifications, skills and experience to perform their work. (c) Recruitment, selection and appointment processes are transparent and documented.	(a) The recruitment system ensures an adequate number and skill mix of staff to provide the organisation's services. (b) All departments / units comply with the organisation's recruitment, selection and appointment requirements. (c) The volunteer recruitment system ensures an adequate number and mix of volunteers to provide applicable services. (d) There is a system and program for the orientation and integration of all staff and volunteers.

The intent of this criterion is to ensure all aspects of recruitment, selection and appointment meet the needs of the organisation and individuals.

The **changing health environment** necessitates flexibility and a forward thinking approach to recruitment, selection, appointment and orientation systems. Organisations may draw upon local and international research and development in these areas and use evidence to update their systems. This may include looking outside the established ways of doing things including the health setting, for new ideas and approaches.

Research shows that we now have a multigenerational workforce.[1] This is the first time in history that the workforce has comprised four generations all of which have a different approach to their jobs, careers, families and personal lives. Such differences will require organisations to adapt their approaches to managing people.

The **recruitment system** should meet the needs of the organisation, the employer and the employee and be in accordance with legislative requirements and best practice. The organisation should consider:

- how human resources are aligned with the organisation's strategic plan, goals, mission
- organisational demographics where applicable
- whether there are sufficient numbers of qualified staff and support staff available to the service at all times to achieve the objectives of the organisation
- professional guidelines regarding staffing requirements
- review of position descriptions at the time of recruitment for validity and ongoing relevance.

The organisation should have verified information (where relevant) about staff and volunteers including:

- education and training that is consistent with applicable legal and regulatory requirements and organisational policy
- individual contracts, industrial awards and workplace agreements
- organisation-wide policies which ensure legislative and organisational requirements are met. This may include professional registration and licensing requirements, industrial awards and enterprise agreements
- records of interviews and references that are maintained for all staff.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Performance indicators are used to evaluate and improve recruitment, selection, and appointment systems. (b) Recruitment, selection and appointment systems are adapted to changing service requirements. (c) The orientation system and program is evaluated and improved as required.	(a) Performance indicators and processes for recruitment, selection, appointment and orientation are compared internally and with external systems, and improvements are made to ensure better practice. and / or (b) Developments in research inform the recruitment, selection, appointment and orientation systems.	(a) The organisation demonstrates it is a leader in the development and implementation of recruitment, selection, appointment and orientation systems.

The recruitment system may include:

- staff security and background checks
- health screening for relevant staff to ensure fitness to do the job
- screening for the organisation's protection, territory legislation
- aptitude tests, ability tests, psychological profiles.

Selection and recruitment of **agency staff and contract staff** (excluding external service providers) should include the checking of licences, registration, competencies and skills.

All categories of newly appointed staff should participate in an orientation program. The orientation program should be appropriate to the size and type of organisation. There may be different programs for different categories of staff such as agency and contract staff. This may include:

- information about the organisation's philosophy and objectives, consumer / patient rights and responsibilities, the organisational structure and services, equal employment opportunities, staff suggestions and complaints procedures
- explanation about individual duties and functions, lines of authority, responsibilities, methods of evaluating staff performance and evaluation of the service
- education / training which may include organisational policies and procedures, infection control, occupational safety and health (OSH), fire, confidentiality and security of information, general security and personal safety, manual handling, food hygiene, basic life support, clinical risk management, corporate risk management, incident and near miss reporting, customer care training
- tour of the facility, induction booklet.

There is good evidence that a reputation for providing high quality care results in health care organisations becoming a magnet for health care professionals. **Magnet hospitals** tend to have better staffing ratios and leadership structures than other health care providers[2]. Magnet status generally 'attracts and retains' (like a magnet) all levels of employees to the facility, from the medical staff to the support organisations. Together, the entire team is recognised for its delivery of excellent patient care.[3]

2.2 HUMAN RESOURCES MANAGEMENT STANDARD

Criterion 2.2.2 The **recruitment, selection and appointment system** ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation.

(Continued)

Organisations may provide evidence of achievement in this criterion through:

- recruitment policies, showing compliance with legislation and how registrations are checked
- assessment of staffing needs
- orientation processes for staff and volunteers
- documented selection criteria
- recruitment policy
- demographic data
- evaluation of recruitment process.

References

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2. Armstrong F. Magnet Hospitals – What's the Attraction? Australian Nursing Journal. March 2005; 12 (8): 14-17.

3. Government of South Australia Department of Health, What are Magnet Hospitals?, Available at: http://www.nursingsa.com/office_magnet.php

HUMAN RESOURCES MANAGEMENT:
Standard, Criteria, Elements, Guidelines

Standard 2.2 Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff.

Criterion	LA – Awareness	SA – Implementation LA plus the following
2.2.3 The **continuing employment and performance development system** ensures the competence of staff and volunteers.	(a) Staff and volunteers are provided with a written position description outlining their role, responsibilities and accountabilities. (b) Staff performance is reviewed in accordance with organisation-wide requirements. (c) Staff and volunteers are provided with appropriate supervision by experienced, trained and qualified staff. (d) Accurate and complete personnel records, including training records, are maintained and kept confidential. (e) The organisation has a policy for the process of managing a complaint or concern about a clinician.	(a) There is a performance development system that ensures: (i) clinical, non-clinical staff and volunteers are competent and accountable for their work (ii) areas for improvement and additional educational and development needs are identified. (b) Position descriptions including accountabilities and responsibilities are regularly reviewed. (c) Performance development and review include the active participation of both managers and staff. (d) There is a system that ensures professional staff provide documented evidence to demonstrate their continuing registration with the relevant professional regulatory body. (e) Clinical staff comply with published codes of professional practice, relevant to their professional role. (f) There is a system for managing a complaint or a concern about a clinician.

These guidelines should be read in conjunction with criterion 3.1.3 credentialling and defining the scope of clinical practice.

The intent of this criterion is to ensure that the health care organisation and the individual staff member take equal responsibility for maintaining the skills, performance and competence required to provide quality health care.

The **performance development system** aligns employees' goals, skills, talents, and performance outcomes with the organisation's vision, mission, and goals by supporting continuous learning and competence development, by clarifying job expectations and performance standards and providing feedback, evaluation, and recognition of performance. It is designed to promote and support the professional development of the organisation's employees.[1]

The **continuing employment system** and the performance development system are linked. Both systems encompass position descriptions, staff performance and review, staff accountability and responsibility and staff registration. These processes contribute to ensuring the competence of all staff.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Performance indicators are used to evaluate and improve the performance development system. (b) An evaluation is undertaken to ensure staff including contracted staff and where appropriate volunteers, have participated in performance review and development. (c) The performance development system is integrated with any relevant service plans or changing service requirements. (d) Staff participate in evaluating the performance development system. (e) The system for managing a complaint or concern about a clinician is evaluated and improved as required.	(a) Performance development indicators and processes are measured, compared internally and with external systems, and improvements are made to ensure better practice. and / or (b) The evaluation of the continuing employment and performance development system demonstrates that the system is effective in staff development.	(a) The organisation demonstrates it is a leader in the continuing employment and performance development systems.

Ongoing, periodic **competence assessment** evaluates the staff member's continuing ability to perform throughout their association with the organisation. Competence to perform job responsibilities should be assessed, demonstrated and maintained.

All staff should have a documented, dated **position description,** which is kept current and includes specification of responsibilities, accountabilities, job functions and activities and the frequency and process of performance appraisal. Position description reviews should be transparent and based on evaluation, consultation and research.

Staff should be provided with **supervision, management** and **professional support.** Mentoring programs facilitate professional growth, provide information, guidance and constructive comments, evaluate decisions, support and encourage, highlight shortfalls in agreed performance and maintain confidentiality.

Mentoring is one form of supervision. This may be through informal or formal support by a more experienced person, a mutual relationship where employees share experiences, a developmental process where the mentee grows in skills, knowledge and confidence, a strategy to share

2.2 HUMAN RESOURCES MANAGEMENT STANDARD

Criterion 2.2.3 The **continuing employment and performance development system** ensures the competence of staff and voluteers.

(Continued

intellectual and other resources, guided learning by a mentor; traditionally a one to one relationship but group mentoring may be a beneficial option.[2] Not all supervision and support should be provided by a person's 'superior'. Organisations could consider the use of peer supervision and support. Peer supervision can take a number of forms and is relatively common in both the nursing and allied health professions.[3]

Staff should be informed about how their performance will be managed and the results of their **performance review.** A proper assessment of the employee's performance takes into account both the work related requirements of the organisation and identified employee interests. Aligning individual goals with the goals of the unit, department and organisation ensures that the contributions of individuals help to accomplish the goals of the group and of the organisation.

Performance review of all staff should:[4]

- be assessed and documented three months following initial employment and then annually, or at least biennially for long-term employees
- be impartial, transparent and capable of review
- be based on the staff member's position description
- be in accordance with organisation-wide requirements
- identify strength in performance
- include the active participation of managers and staff
- involve setting performance goals
- be an on going process with feedback taking place throughout the year. Personnel records should be accurate, complete, confidential and only available to authorised personnel and the employee.[5]

Personnel records may include:

- personal details, employment details, job description, terms and conditions of employment, relevant educational and professional qualifications, certificate of registration (as applicable)
- record of staff orientation, record of attendance at fire training
- record of education and training, including mandatory training such as child protection systems
- record of annual performance reviews
- sickness and absence records
- accident record of any compensable injuries
- records of vaccinations
- record of any disciplinary action.

The organisation should demonstrate that there is a formal process for establishing and reviewing the **credentials, experience and competencies** necessary to perform all work roles to a minimum standard. In situations where this is not established, the relevant staff member should be supervised until they are able to demonstrate the required level of competence. The review process should be understood by all staff.

No person should undertake or be endorsed to undertake any work for which they do not possess appropriate registration, qualifications and experience. Organisations should ensure that registration of relevant health professionals is checked within the prescribed timeframe and remains current. Recognised competencies such as the Nursing Council of Hong Kong and the Midwives Council of Hong Kong[6] and relevant industry training skills councils, can be used. The organisation can research and adapt external competence standards where appropriate and relevant to ensure 'fit' with the organisation. Organisations should also ensure that relevant clinical staff participate in continuing professional development (CPD).

A policy and system should be implemented for the **management of complaints or concerns about a clinician.** This is an important component of improving patient safety and clinical quality within an organisation. Management of a complaint or concern about a clinician involves a number of steps to ensure that any clinical risk is identified and managed appropriately and that effective action is

taken to provide safe care and maintain consumer / patient confidence. Steps for managing a complaint or concern about a clinician include: [7]

- identification of the complaint
- notification to relevant managers / stakeholders
- investigation of the complaint
- actions in response to the identified performance issues
- reporting of the outcomes to the relevant bodies.

Some organisations may choose to address the process for management of a complaint or concern about a clinician in their by-laws.

Recruitment and planning systems assist and encourage staff to maintain their competence and ability to meet professional standards. Individual contracts and workplace agreements (however called) can be used by the organisation to advocate changes to work level standards and competence standards.

Organisations should ensure needs analysis includes the collection and an analysis of data relating to the exit of staff and staff turnover. Retention strategies and succession planning may also need to be considered.

Organisations may provide evidence of achievement in this criterion through:

- systems for performance development
- system to address non-compliance with competencies
- system to address complaints or concerns about a clinician
- position descriptions are current and signed, identify competency standards, date for review etc
- personnel records secure and current.

References

1. De Cieri H, Kramer R, Noe R, Hollenbeck J, Gerhart B, Wright P. Human resource management in Australia: strategy – people – performance. Sydney: McGraw Hill. 2003.

2. Farmer E, McIntyre E, Mills J, Weston K. Mentoring matters. Adelaide: Primary Health Care Research & Information Service, Flinders University, 2003.

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4. University of Denver. Performance review & development system. Denver: University of Denver.

5. Standards Australia. AS ISO 15489: Records Management.

6. Nursing Council of Hong Kong, available at www.nchk.org.hk

7. Midwives Council of Hong Kong, available at www.mwchk.org.hk

8. Department of Health NSW. Complaint or Concern about a Clinician – Management Guidelines. 2006.

HUMAN RESOURCES MANAGEMENT:
Standard, Criteria, Elements, Guidelines

Standard 2.2 Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff.

Criterion	LA – Awareness	SA – Implementation LA plus the following
2.2.4 The **learning and development system** ensures the skill and competence of staff and volunteers.	(a) The organisation provides training in accordance with legislative requirements. (b) Staff and volunteers are consulted about their learning and development needs.	(a) There is a planned and documented staff development program. (b) There is a learning and development system accessible to all staff and volunteers that: (i) identifies both the needs of the organisation and the staff (ii) ensures staff remain competent to perform their work (iii) is linked to the performance development system. (c) Staff contribute to the teaching and supervision of students where relevant. (d) There is a process to identify mandatory training for staff and volunteers. (e) The organisation provides adequate resources for learning and development.

The intent of this criterion is to provide a structured, planned and comprehensive program for implementing a learning and development system in the organisation. Further, the criterion is designed to ensure that organisations play a role in the teaching and training of health care providers and students to add to the competence of individuals and the organisation. In the case of volunteers, formal training may not be viable and a process of orientation, in-house training and regular revision of competencies may be followed. Any steps of this process should be documented in personnel records.

The **learning and development** system identifies the development and education needs of the organisation and individual staff.[1] The system should include:

- a documented learning and development plan linked to the organisational strategic plan
- documentation which includes learning objectives, evaluation forms, reports, compliance with learning and development needs, records of all internal and external training undertaken by staff
- identification of the organisation's mandatory training components and evidence that staff attend applicable mandatory training sessions, for example fire training, infection control, risk management, CPR, OSH
- continuing education programs (internal and external) relevant to their work, such as team work, human factors education, clinical practice improvement methods and caring for patients from diverse backgrounds
- links to the performance development system
- training for staff who use specialised equipment including competence assessment, supervision and retraining if required
- professional development.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Performance indicators are used to evaluate learning and development systems and the systems are improved as required. (b) The student teaching and supervision program is evaluated and improved as required.	(a) Performance indicators for learning and development are measured, compared internally and with external systems, and improvements are made to ensure better practice. and / or (b) There are innovative practices for learning and development. and / or (c) The student teaching and supervision program is compared with external programs, and improvements are made to ensure better practice.	(a) The organisation demonstrates it is a leader in planning and providing learning and development systems. (b) Teaching and supervision programs developed by the organisation are used as models of best practice by other organisations.

The learning and development system can be evaluated using performance indicators to demonstrate:

- participants have current knowledge and skills including relevant competencies
- compliance with legislative requirements
- changing needs of the organisation and the staff are met
- staff and volunteers attend appropriate training and education programs relevant to their work.

Organisations may provide evidence of achievement in this criterion through:

- ongoing education programs / training linked to assessment
- documented staff development plan
- identified mandatory training schedule
- links from education program to identification of training needs in performance appraisal system
- assessment / evaluation of learning and development needs – satisfaction of staff
- conference attendance support
- access to journals and reference material.

References

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HUMAN RESOURCES MANAGEMENT:
Standard, Criteria, Elements, Guidelines

Standard 2.2 Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff.

Criterion	LA – Awareness	SA – Implementation LA plus the following
2.2.5 **Employee support systems and workplace relations** assist the organisation to achieve its goals.	(a) The workplace rights and responsibilities of management and staff are clearly defined, communicated and respected. (b) Management and staff have access to information about grievance processes. (c) Staff know how to access support services. (d) Managers have the skills to identify 'at risk' staff behaviour. (e) Staff are consulted about industrial relations and support services in their workplace.	(a) There is an employee assistance program in place. (b) Managers facilitate staff access to support services. (c) There is a system that motivates staff and identifies the value of staff contribution through reward and recognition. (d) There is a consultative and transparent system to identify, manage and resolve workplace relations issues. (e) Management and staff work cooperatively to achieve effective workplace relations. (f) Workplace relations are coordinated with relevant external groups. (g) The organisation supports flexible work practices to sustain work-life balance.

The intent of this criterion is to ensure a structured, planned and comprehensive system for managing workplace relations and to ensure that there is an effective employee assistance system that is tailored to specific staff requirements and allows the development of a supportive network within the organisation.

Workplace relations apply to any organisation in which an employee / employer relationship exists.

An **employee assistance program** is a proven strategy for assisting employees and their families with personal and work related problems, difficulties and concerns which they may experience from time to time. These problems, difficulties and concerns can and do affect the work performance of an employee.[1]

An employee assistance program may include:

- mechanisms for early intervention to enable staff to seek assistance and support
- encouragement of staff to recognise and seek assistance with personal problems before they escalate
- an effective human resources and OSH framework that promotes workplace health, preventative services and the wellbeing of staff
- child care information and referral services
- elder care information and referral services
- support groups for employees with family issues
- counselling services
- recognition and reward programs
- caring for those with work and non-work related injuries.

Work-life balance is an important aspect of diversity management and is enabling employees at different stages of their lives and with different family responsibilities and interests to lead healthy balanced lives.[2]

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Performance indicators are used to evaluate staff support services and services are improved as required. (b) Performance indicators are used to evaluate workplace relations and improvements are made as required.	(a) Performance indicators for workplace relations are measured, compared internally and with external systems and improvements are made to ensure better practice. and / or (b) Performance indicators for staff support services are compared internally and with external systems and improvements are made to ensure better practice.	(a) The organisation demonstrates it is a leader in the management of workplace relations. (b) The organisation demonstrates it is a leader in the planning, development and provision of staff support services.

Organisation-wide **support systems** place importance on personal growth and development in order to make the most of human potential. They develop relationships that give people the opportunity to share professional and personal experiences and to grow and develop in the process. Demands placed on staff should respect the need for a balance between work and personal activities and responsibilities.

The successful management of **workplace relations** is essential to the effective operation of the organisation. Regulating relationships in the workplace underpins the culture of the organisation, its values and goals, and ensures productivity, efficiency and a positive morale. Workplace relations should be open, transparent, honest, supportive and non-confrontational. Mediation is preferable to arbitration.

All staff have a **right** to a workplace that is free of harassment and discrimination. Both employers and employees have a responsibility to ensure good workplace relations.

Workplace relations include communication, consultation, discrimination (age, sex, race, colour, religion etc), harassment (bullying etc), fair distribution of work, rostering, fixed term employment contracts, hours of employment and conditions for part-time and casual staff, staff grievances and disputes, violence between staff, discipline, termination and redundancy, staff satisfaction and compliance with organisational policies and procedures.

Strategies that may be used to implement **effective workplace relations** could include:

- incident monitoring that identifies workplace issues
- rights and responsibilities, for example code of conduct, prevention of harassment, discrimination, natural justice, standards of workplace behaviour, compliance with policies and procedures, OSH standards, access to industrial information
- policies and procedures and statutory requirements

2.2 HUMAN RESOURCES MANAGEMENT STANDARD

Criterion 2.2.5 Employee support systems and workplace relations assist the organisation to achieve its goals.

(Continued)

- identification of relevant external groups
- active involvement of managers, employees and where applicable, their representative associations
- formal training and development for managers and staff
- a formal mechanism for staff representation and evidence of regular consultation and communication between staff and management
- a process to manage potential misunderstandings / disputes
- an appropriate monitoring of the workplace relations management system.

Data on workplace issues should be monitored and analysed and systems should be in place to facilitate this. Workplace relations management should be included in the overall risk management plan of the organisation.

Workplace **grievances** should be managed in an effective and fair way for all parties concerned. Organisations should ensure:

- grievance procedures are understood by both management and staff
- all staff have access to effective and fair process
- legislative and individual state / territory requirements are met.

The system that provides staff support services may include the following:

- development of a productive and harmonious workplace
- a comprehensive and flexible staff support program that meets individual needs.

The system for providing support services should be developed and reviewed in consultation with staff and according to staff needs and priorities.

Programs known as 'work and family' or 'family friendly' may include a variety of policy initiatives such as flexible hours, part-time work, job sharing, telecommuting or working from home, use of employee sick days to attend to family commitments, employee assistance programs and relocation services. Other policies or systems may include:

- paid maternity and paternity leave
- paid leave for adoptive parents.

Organisations may provide evidence of achievement in this criterion through:

- policies on workplace relations and support systems
- orientation programs
- evidence of staff consultation in implementing support services
- staff access to policies
- evidence of evaluation of support services
- motivation and reward systems
- flexible rostering.

References

1. Australian Government, Comcare Quality of Working Life Strategy: Supervisors handbook; Managing staff with stress responses, Available at: http://www.comcare.gov.au/pdf_files/OHS_23_Aug04_V3.pdf

2. Westpac. Results from the 'Best employers to work for in Australia' study, conducted by Hewitt Associates (in conjunction with Australian graduate School of Management and the Australian Financial review). Sydney, 2001.

CLINICAL FUNCTION

SUPPORT FUNCTION

CORPORATE FUNCTION

2.3 INFORMATION MANAGEMENT STANDARD

The standard is: **Information management systems enable the organisation's goals to be met.**

The intent of this standard is to ensure data and information meet the organisation's needs and support the delivery of quality care and service.

The principles of good information management are the same regardless of the size and type of organisation and the complexity of the information technology. There are increasing requirements for information management to support organisational performance and health care delivery.

There are four criteria in this standard. They are:

2.3.1 **Records management systems** support the collection of information and meet the organisation's needs.

2.3.2 **Information and data management and collection systems** are used to assist in meeting the strategic and operational needs of the organisation.

2.3.3 **Data and information are used effectively** to support and improve care and services.

2.3.4 The organisation has an integrated approach to the planning, use and management of **information and communication technology** (I&CT).

INFORMATION MANAGEMENT:
Standard, Criteria, Elements, Guidelines

Standard 2.3 Information management systems enable the organisation's goals to be met.

Criterion	LA – Awareness	SA – Implementation LA plus the following
2.3.1 **Records management systems** support the collection of information and meet the organisation's needs.	(a) There is a records management policy and system that ensure: (i) the secure, safe and systematic storage of data and records (ii) timely and accurate retrieval of records stored on or offsite (iii) consumer / patient privacy when information is communicated for care (iv) retention and destruction according to all relevant requirements. (b) Each consumer / patient is allocated an organisation-specific unique identifier. (c) Where multiple records for the consumer / patient exist they are cross-referenced. (d) Clinical classification is undertaken for all inpatient admissions in accordance with national standards. (e) Coders have access to WHO standards, where available, or guidelines for each type of classification used with reference to latest ICD code.	(a) The records management system is managed with reference to any relevant standards, codes of practice and industry guidelines. (b) Storage areas or systems meet the organisation's retention requirements, or alternative arrangements are implemented. (c) There is a system to support the allocation and maintenance of the unique identifier. (d) A central index of identifiers is maintained. (e) The health record is linked to other health information systems using the unique identifier. (f) Coding and reporting timeframes meet internal and external requirements.

Records management involves the planning, control and protection of records and documents of the organisation. For the purpose of this criterion, records refer to all clinical and non-clinical records, both electronic and paper-based. In Hospital Authority, doctors and coders refer to Manual for Proper Clinical Documentation for reporting diagnosis and procedures.[2]

The intent of this criterion is to ensure the organisation's records management systems facilitate the provision of care, effective management of the organisation and research and education activities. An organisation should ensure theintegrity, safety, controlled access to and security of all records, including consumer / patient records, staff records, clinical registers, film, prints, financial information and minutes of meetings. Policies and procedures for the records management system should include the following areas:

- information privacy (refer to criterion 2.3.2)
- management of updating information, such as patient information
- storage
- damage
- retrieval
- retention
- destruction

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Performance indicators are used to evaluate the records management system and improvements are made as required. (b) Checks are regularly made on the central index for consumers / patients that have multiple identifiers and improvements / links made where required. (c) Health records are evaluated to ensure that the clinical content supports high quality care and improved as required.	(a) Records management systems are compared internally and with external systems and improvements are made to ensure better practice. and / or (b) Systems for managing unique identification are compared internally and with external systems and improvements are made to ensure better practice. and / or (c) Coding performance indicators are compared externally and improvements are made to ensure better practice.	(a) The organisation demonstrates it is a leader in systems for records management. (b) The organisation demonstrates it is a leader in unique identification and other organisations use its innovative systems. (c) Comparison of coding performance indicator results identifies that the organisation is a leader in the field of clinical classification.

- unique identification (Hong Kong identity card for Hong Kong residents, and hospitals provide a unique number for non-residents)
- personal identification
- clinical classification.

Personal Data (Privacy) Ordinance (Cap 486) governs the protection of privacy of consumer/ patient information.

Damage to paper records can be minimised by ensuring that light, humidity, heat, vermin and moisture are monitored and controlled and that fire prevention practices and detection systems are used.

Storage areas or systems should enable storage of records for as long as required. Organisations should ensure that records stored by contractors meet standards and organisational policy.

To ensure data / information retrieval, whether the record is in primary or secondary storage, organisations should look at:

- record filing systems
- record tracking systems
- timeliness of record retrieval
- accuracy of monitoring record movements

2.3 INFORMATION MANAGEMENT STANDARD

Criterion 2.3.1 Records management systems support the collection of information and meet the organisation's needs.

(Continued)

- policies and procedures which are useful especially for casual employees and after-hours staff
- compliance with policies and procedures
- whether the retrieval system meets needs.

Each health care organisation has set schedules for retention and disposal of various record types. The policy and procedure should direct staff as to how long records should be kept. For patient records, reference is made to the Limitation Ordinance (Cap 347) and Chapter VIII of Manual of Good Practices in Medical Records Management of Hospital Authority.

Destruction procedures should consider:

- destruction according to the retention schedule
- systems for easy identification of records to be culled and destroyed, such as having a year of last use on the front of the record, filing minutes in chronological order, archiving staff records in year order of leaving
- confidentiality
- that contractors, if used, are destroying records according to the contract and that evidence of destruction is provided
- the best method of destruction, for example incinerating or shredding for hard copy records, wiping disks clean or the disks physically destroyed for electronic records.

A **unique identifier** is an organisation produced number, code, or letters, of whatever sort, given to one consumer / patient only for that consumer / patient for the first and every subsequent attendance at the organisation. The unique identifier helps identify each consumer / patient and ensures continuity of care. Safety and quality can be compromised if the consumer / patient is not correctly identified and wrong or insufficient health information is used for care. Development of a policy and procedure would include consideration of:

- personal details that should be collected to adequately allocate the consumer / patient unique identifier. Hospital Authority has a guideline on Patient Master Index
- systems to support the allocation and maintenance of the unique identifier
- cross-referencing of unavoidable multiple records
- how to differentiate between people with the same name.

An electronic patient master index or central index, used to store the unique identifiers, can range from simple databases to complex systems depending on organisational size, corporate / regional infrastructure and available resources.

Clinical classification is the process of translating data, such as diseases, conditions, injuries and interventions, from a consumer / patient record into a coded format using a relevant classification system. This allows the comparison, analysis and interpretation of collected data. Coded data can be used for clinical and non-clinical decision making, external reporting, quality improvement activities, funding mechanisms, benchmarking etc.

Coding policies and procedures help ensure data are accurate through the identification of the need to check accuracy and the monitoring of results for whatever classification system is used. Coding performance indicator results can be trended and compared to other organisations to identify if the organisation meets best practice and help identify opportunities for improvement. Mechanisms to assist internal and external timelines being met include:

- ongoing coding education for relevant staff
- access to support mechanisms, such as standards and guidelines
- monitoring of coding workload and allocation of resources
- monitoring of turnaround time

Organisations may provide evidence of achievement in this criterion through:

- systems for management of health records, including:
  - storage / location /
  - security retrieval processes
  - unique identifiers
  - use of clinical classification
  - health record evaluations.
- policies and procedures for health records management
- evidence of qualifications of health records management staff
- performance indicators
- patient master index or central index
- systems for managing business needs, including:
  - acts, legislation and regulation management
  - asset registers
  - contracts
  - financial and accounting records
  - corporate reports
  - correspondence
  - human resources management records
  - minutes of meetings
  - manuals and policies etc.

References

1. The Manual of Good Practices in Medical Records Management, Hospital Authority http://informatics.home/files/Standards_&_Information_Management/Medical%20Record%20Manual/01-manual/01-manual%20-%20current/CONTENT/08%20-%20Retention%20of%20Medical%20Records%200903.doc
2. Manual for Proper Clinical Documentation, Hospital Authority http://ha.home/ho/casemix/CM-G030.pdf
3. Personal Data (Privacy) Ordinance (Cap 486).
4. Limitation Ordinance (Cap 347).
5. Code of Practice for Private Hospitals, Nursing Homes and Maternity Homes.

INFORMATION MANAGEMENT:
Standard, Criteria, Elements, Guidelines

Standard 2.3 Information management systems enable the organisation's goals to be met.

Criterion	LA – Awareness	SA – Implementation LA plus the following
2.3.2 **Information and data management and collection systems** are used to assist in meeting the strategic and operational needs of the organisation.	(a) Data received from external entities and their uses are identified. (b) The collection of data complies with professional and statutory requirements. (c) Planning processes include the identification of information required and data sources.	(a) An information management strategic plan exists and identifies the needs of the organisation at all levels. (b) Data storage and retrieval are facilitated through effective classification and indexing. (c) Data are available at the point of care for care planning and decision making. (d) The organisation provides regular training for staff on information and data management. (e) Databases are linked to provide access within and across units and departments. (f) Liaison with external bodies improves the quality of information supplied and received.

The intent of this criterion is to ensure that the systems for collection of information and data and the creation of information from data meet the organisation's needs.

The information and data management system should address the key issues to ensure that information and data are managed in a way that meets the strategic and operational needs of the organisation. Polices and procedures for information and data management and collection systems may include:

- identifying and planning for the organisation's information needs
- defining and capturing data and information from various sources and in compliance with all statutory requirements
- linking and combining different types of data and information within and outside the organisation
- analysing data and transforming them into information that is easily interpreted by the user
- transmitting and reporting data and information
- management of all types of records
- storing data and information so they are easy to retrieve
- educating and training users on the appropriate and ethical ways of collecting and using data and information
- obtaining input from users to ensure the data collected and reported are useful and relevant
- ensuring data and information are available at points of care for care planning and decision making
- processes to monitor the quality of data and information, including data reliability, accuracy and validity from both internal and external sources
- comparing organisational performance and outcomes internally and externally with other health care organisations and best practice standards.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Monitoring and analysis of clinical and non-clinical data and information occurs to ensure: (i) accuracy, integrity and completeness (ii) timeliness of information and reports (iii) the needs of the organisation are met and improvements are made, as required. (b) Training is evaluated to ensure improved skills in information and data management.	(a) Systems for the management of information and performance indicator results are compared internally and externally and improvements are made to ensure better practice. and / or (b) Information and data management and collection systems are compared internally and with external systems and improvements are made to ensure better practice. and / or (c) The organisation undertakes research into information and data management and collection systems and acts on results.	(a) Information and data management and collection systems are innovative and are used by other organisations. (b) The organisation is recognised as a leader in information and data management and collection systems.

Data and information that are available from other clinical information systems[1], either internally or externally can be utilised in conjunction with health record data providing that ethical and privacy concerns are addressed. Having timely information from these sources can enhance care. Examples of these types of clinical information systems include:

- pathology and radiology results by secure or encrypted phone / fax / computer / email
- external pharmacy data
- films, images, graphs and prints
- clinical pathway variance data
- Public-Private Interfacae-Electronic Patient Record Sharing Program (PPI-ePR)
- Doctors Reference site
- Cochrane Database
- Medline.

Organisations may provide evidence of achievement in this criterion through:

- information management strategic plan
- types of data collected and the utilisation of data
- evidence of data linkages
- evidence of training for staff in data management
- reported errors in coding
- reported errors in records
- satisfaction with financial reports and budget development
- evaluation of data collected.

Reference

1. Drs Reference Site: Information on databases and links. Available at: http://www.drsref.com.au/index.html

INFORMATION MANAGEMENT:
Standard, Criteria, Elements, Guidelines

Standard 2.3 Information management systems enable the organisation's goals to be met.

Criterion	LA – Awareness	SA – Implementation LA plus the following
2.3.3 **Data and information are used effectively** to support and improve care and services.	(a) Mandatory requirements for reports to external entities are met. (b) Data are available for: (i) research (ii) development (iii) improvement activities (iv) education (v) corporate and clinical decision making. (c) Reference and resource materials are available for use by staff. (d) Policy exists for the validation and protection of data and information.	(a) Health care professionals participate in the analysis of data including clinical classification information. (b) Sufficient resources exist for the assessment, analysis and use of data. (c) Responsibility and accountability for action on data and information are clearly delineated. (d) There are systems to produce information for authorised stakeholders, consistent with Personal Data (Privacy) Ordinance (Cap 486) (e) The organisation contributes to national databases and registers. (f) The needs of staff for information resources are identified, analysed and prioritised. (g) A system exists for validation and protection of data and information.

The intent of this criterion is to ensure that information created from data is available to those who require it in a timely manner and that it is used effectively.

Each organisation should be aware of mandatory **external data collection** and reporting requirements. To meet these requirements data should be accessible and reporting timelines and mechanisms identified. Some of these data collections include:

- inpatient statistics collection
- infectious disease notification
- jurisdictional data collections
- cancer notifications
- Hong Kong College of Obstetrics & Gynaecology – Obstetrics Audit Form
- suspected child abuse
- domestic violence
- deaths / coroner's cases
- victims of crime
- employer responsibilities to the Inland Revenue Ordinance
- payroll information, such as Inland Revenue Ordinance (Cap 112), Employment Ordinance (Cap 57), Mandatory Provident Fund Schemes Ordinance (Cap 485), Occupational Retirement Schemes Ordinance (Cap 426)

External entities often use an organisation's information. Organisations should ensure that there is a system in place to produce such information for external entities and that they have the authority to access and use the information in compliance with local legislation and other requirements. These external entities include:

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Data use and reporting processes are evaluated and improved as required. (b) Performance indicators for data and information use are monitored to ensure: (i) information is timely and accurate (ii) reports meet user needs (iii) data are used for improving care (iv) changes or improvements reflect service requirements. (c) The organisation reviews results from national databases and registers and improves care and services as indicated. (d) Reference management and resource material systems are evaluated and improved, as required. (e) Systems used for validation and protection of data and information are evaluated and improved as required.	(a) Data use and reporting systems are compared with external systems and improvements are made to ensure better practice. and / or (b) Performance indicator results relating to information management are compared internally and with external systems and improvements are made to ensure better practice. and / or (c) Systems for the management of reference and resource material are compared internally and with external systems, and improvements are made to ensure better practice.	(a) The organisation is identified as a leader in the use of data and information to improve care and services.

- departments of health
- funders of health care
- insurers
- accreditation and certification agencies
- legislators
- coroner
- courts of law
- media
- stakeholders
- local government
- benchmarking groups
- local community.

Information use should be appropriate and managed effectively. Data should be sorted into categories so that a problem or issue can be understood. Analysing data, and identifying the essential elements, creates information and helps organisations to consider what needs to be done next. Health care professionals who use and report data should be involved in its analysis. Responsibility and accountability for action on data and information and accuracy of data, should be clearly defined within the organisation and communicated to all staff.

Information can be used to improve performance, for research and development, education (staff and consumer / patient) and decision making (clinical and non-clinical). Examples of uses include:

- demographic information to update local health promotion strategies

2.3 INFORMATION MANAGEMENT STANDARD

Criterion 2.3.3 Data and information are used effectively to support and improve care and services.

(Continued)

- clinical indicator data to review care delivery systems or treatment protocols
- complication rates or variance data to inform the development of clinical pathways
- complaints data used to improve care and services
- infection surveillance data used for clinical decision making
- relative utilisation rates used for assessing appropriateness of services
- incident data used to improve systems of care
- Diagnosis Related Groups (DRG) information to assist planning of new services.

Staff access to, and utilisation of, **reference, research and other resource materials**[1] are of crucial importance in supporting evidence-based practice and improving quality programs and services in health care.

An organisation's processes for managing reference, research and other resource materials should be based on current and future needs and utilise links with relevant external databases, information networks, bodies of expert help and administrative or research knowledge.

An information system will:

- manage knowledge-based resources according to established practices and standard documented processes
- have details of external databases, information networks, bodies of expert help
- have details of methods used to inform staff of what information is available and how to access it
- have details of information sources to support the organisation's clinical, educational, administrative, research and technical information needs
- implement and manage processes to continuously evaluate and improve the quality of knowledge-based resources and services.

Organisations may provide evidence of achievement in this criterion through:

- systems to manage information on:
  - document control
  - relevant monitoring
  - validation and protection of data
  - evaluation of systems
- policies and procedures, such as mandatory reporting, accountability etc.
- evidence of mandatory reporting
- access to reference materials
- utilisation of database information
- reports from the coding manager.

INFORMATION MANAGEMENT:
Standard, Criteria, Elements, Guidelines

Standard 2.3 Information management systems enable the organisation's goals to be met.

Criterion	LA – Awareness	SA – Implementation LA plus the following
2.3.4 The organisation has an integrated approach to the planning, use and management of **information and communication technology (I&CT).**	(a) There is an I&CT policy and procedure for all aspects of I&CT. (b) Licences are purchased as required. (c) Relevant users are involved in the selection of I&CT systems. (d) There is a documented plan for managing risks and crises. (e) A system of I&CT operational support exists.	(a) Current and future I&CT needs, are identified, budgets allocated and acquisitions planned. (b) The integrated I&CT system supports the collection, aggregation and analysis of data. (c) An I&CT standard operating environment is applied across the organisation. (d) Support exists for the management of external data, which need to be accessed, analysed and used for organisational purposes. (e) Strategies for: (i) backup (ii) security (iii) virus detection are in place and used. (f) A strategy for disaster recovery is in place. (g) There is a planned system for preventative maintenance for I&CT. (h) There is a system to ensure appropriate access to information. (i) I&CT project management is used and reviewed to assist trouble free implementation of systems.

The intent of this criterion is to ensure that the organisation's information and communication technology needs are met.

An I&CT plan supported by policies and procedures for all aspects of I&CT management is needed. This develops the organisation's capacity to effectively manage I&CT applications and infrastructures to support the organisation's operations and business.

Effective use of I&CT requires an integrated approach to the **planning and use of technology.** Planning helps ensure that the I&CT improves the effectiveness and efficiency of the organisation's management of information via collection, aggregation and analysis of data.

Larger organisations often use a separate information technology plan which form an integral part of the information management plan. Smaller organisations often have information management and I&CT within the overall strategic and business plans. Whatever approach, the organisation should consider its strategic goals, information needs and resources required. Wide consultation can help ensure users' needs and expectations are appropriately addressed when planning.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The I&CT system is evaluated and improved as required. (b) Compliance with licensing requirements and user needs are evaluated and improved as required. (c) Users are involved in the evaluation of I&CT. (d) Compliance with the standard operating environment is monitored and improved, as required. (e) The preventative maintenance system for I&CT is evaluated regularly and improved as required. (f) The I&CT risk and crisis management system is evaluated and improved as required.	(a) The I&CT system is compared with external systems and improvements are made to ensure better practice. and / or (b) The preventative maintenance system is compared with external systems and improvements are made to ensure better practice. and / or (c) I&CT innovation is supported within the I&CT strategy. and / or (d) Risk and crisis management systems are compared with external systems and improvements are made to ensure better practice. and / or (e) The organisation undertakes research into I&CT systems and implements improved systems.	(a) The organisation is identified as a leader in I&CT systems. (b) The organisation is recognised as a leader in I&CT risk management.

It may be useful to also consider the following issues:

- responsibility for management of the organisation's information technology
- users' needs and expectations
- the form in which information will be kept for example, electronic or microfilm
- the relationship between information held in various forms
- how systems will be linked and work together including support for management of the systems
- data uniformity through the definition of key data elements
- standard operating environment across the whole organisation
- version control
- state / territory, national and international guidelines and standards
- legal issues, such as legally authorised use of software

2.3 INFORMATION MANAGEMENT STANDARD

Criterion 2.3.4 The organisation has an integrated approach to the planning, use and management of **information and communication technology (I&CT).**

(Continued)

- confidentiality issues
- I&CT purchases requiring consultation with key personnel, purchasing against set criteria, related to business requirements
- applications and infrastructure
- coordination of service specific databases
- education for relevant staff in I&CT use, organisational policies and staff responsibilities
- management if systems are upgraded / changed to ensure access to existing data
- the need for specific types of management planning systems which will enhance an organisation's I&CT systems, such as behaviour management, cost management, I&CT change management, I&CT project management, availability management and capacity management.

As with all systems in health care the organisation should consider a **risk management** framework when addressing risks to I&CT. This includes the need for regular backup processes, planned preventative and maintenance processes, emergency operating procedures, recovery plan with systems priority, disaster and contingency planning, security and breaches of security, software, hardware, telecommunication networks and technical expertise to control and maintain operational processes. No matter how good a risk management system is, crises will occur. Systems should be in place to manage crises when and as they occur. This should include a prioritisation schedule.

Logical security are security features that are built into communications, information technology (IT) and other information management (IM) systems. Secure data storage is of the utmost importance in a health care setting. Compliance with the National Privacy Principles (NPP) and the relevant state legislation[1] should be considered at all times. Paper records, both consumer / patient health records and organisation management records, should be stored securely.

Organisations should have reliable backup systems for electronic data and a disaster recovery plan. All computer terminals should have secure access with screensavers and default to standby if the terminal is left unattended after a certain period of time. Firewalls and other relevant security systems should be installed in all computers.

As organisations increasingly depend on I&CT, a contingency plan becomes more important in case of emergency or disaster. Contingency planning protects I&CT services and supports care and service by:

- reducing vulnerability by maintaining or preserving services and minimising disruption
- reducing the risk of threats by using risk analysis and management
- ensuring viability by reducing the impact of the disaster
- recovery of IT systems in a controlled way
- reducing time lost by the availability of a continuous service.

Suggestions for consideration in a **contingency plan** include:

- regular backup
- maintaining integrity
- virus detection
- system priority and service level guarantee
- testing of the plan to ensure systems become operational and improvements made if required
- emergency operating procedures
- staff awareness and competence in downtime procedures
- staff familiarity with the procedures
- service procedures.

Networking with similar size or type organisations is a useful way for organisations to identify strategies to improve their contingency planning. All fall back plans should identify strategies for how care and service staff operate if systems cannot be recovered in the short term.

Some **other I&CT risk management issues** include:

- controlling access and ensuring security of data. Data should be securely available to all authorised users while denied to others. Security passwords can be used on stand-alone computers. Passwords and security access levels can be used on networked systems. Security should be considered when data are transferred from one system to another
- use of fire walls and other electronic devices which control the flow of data in and out of the organisation
- remote access procedures
- storage of backup, for example, away from electromagnetic sources or off-site
- accidental and deliberate viral corruption or sabotage
- security of faxes, email and telephones, including mobiles and the preservation of confidentiality. Policies and procedures for sending faxes and emails that contain sensitive information help minimise risk.

Reviewing records of equipment purchase and **maintenance** records, and the monitoring of system and technology failures and costs, assist in the development of strategies to ensure systems are operating effectively. Data on failures and resource use can be used to monitor performance. Preventative maintenance reduces downtime and the need for crisis maintenance. It also can increase users' satisfaction.

Organisations may provide evidence of achievement in this criterion through:

- policies, including all aspects of information handling
- maintenance schedules of information technology hardware
- contingency plans for emergencies or disasters
- evidence of licences for software
- evidence of consultation with staff / relevant stakeholders to determine current and future needs for hardware / software
- risk management strategies
- evidence of monitoring of downtime and disasters
- schedule for maintenance of systems
- evaluation of systems.

References

1. Personal Data (Privacy) Ordinance (Cap 486).
2. Telecommunications Ordinance (Cap 106).
3. Copyright (Amendments) Ordinance (Cap 528).
4. Electronic Communication Policies http://ha.home/circular2/IT-01-05.pdf
5. Operation Circular No. 02/2008 – Guidelines on the Use of Mobile Phones & Other Radio Frequency (RF) – Transmitting devices in hospitals.
6. Corporate Internal Audit (GIA) (2005-2008)

i.	3Q2008	Web Application Control and Security Follow-up
ii.	1Q2008	IT Network Availability
iii.	3Q2007	Data Centre Facilities
iv.	2Q2007	Web Application Control and Security
v.	2Q2007	IT Continuity Planning Follow-up
vi.	1Q2007	Clinical System Data Access
vii.	2Q2006	Information Security Management
viii.	4Q2005	Wireless System Access Risks and Vulnerabilities
ix.	3Q2005	Electronic Communications Policy
x.	3Q2005	Outsourced Data Centre
xi.	2Q2005	Security and Controls of Extranets & Medical Networks
xii.	2Q2005	System Development Life Cycle Framework
xiii.	1Q2005	User Access Management

CLINICAL FUNCTION

SUPPORT FUNCTION

CORPORATE FUNCTION

2.4 POPULATION HEALTH STANDARD

The standard is: **The organisation promotes the health of the population.**

The intent of this standard is to ensure that all health care organisations take responsibility for promoting the health and wellness of the Australian population, in some way. The extent of this responsibility is dependent on the size and type of organisation and on the location of the service.

There is one criterion in this standard. This is:

2.4.1 Better **health and wellbeing** for consumers / patients, staff and the broader community are promoted by the organisation.

This standard and criterion focus on three main aspects of population health:

- health promotion
- health protection
- surveillance.

A great deal of progress has been made in improving the health of the population over the past 20 years through a combination of improving social and environmental conditions, providing a wider range of prevention services and public education. Health care organisations, the community, government and public and private organisations cannot however become complacent.

During this time, the burden has shifted from communicable diseases to non-communicable diseases such as heart disease, chronic respiratory disease, diabetes type 2 and mental health problems. New diseases, new threats to health and new health challenges constantly emerge and need to be managed in effective and innovative ways. Increasing health inequalities will have a significant effect on population health status in a range of ways. At the same time, the demography of the Australian population is changing, bringing new resources, opportunities and issues. All health care organisations have roles to play in the process of improving population health.

POPULATION HEALTH:
Standard, Criterion, Elements, Guidelines

Standard 2.4 The organisation promotes the health of the population.

Criterion	LA – Awareness	SA – Implementation LA plus the following
2.4.1 **Better health and wellbeing** for consumers / patients, staff and the broader community are promoted by the organisation.	(a) Information on population health principles and strategies is provided to staff. (b) The organisation is aware of the current and emerging health priority areas. (c) The organisation is aware of its statutory requirements for reporting public health matters.	(a) A policy exists that considers health needs, supports population health programs and interventions, and local priorities. (b) Surveillance systems are appropriate to the organisation. (c) The organisation uses external organisations and available resources to support health promotion activities. (d) Opportunistic health promotion strategies are undertaken for consumers / patients and staff. (e) Training and resources are available for staff. (f) The organisation optimises the delivery of population health programs and interventions through effective partnerships where relevant.

These guidelines should be read in conjunction with criterion 1.4.1 effectiveness, 1.5.2 infection control and 2.2.5 employee support systems.

There is a requirement that all health services **assess the level of action** required of that organisation in relation to management and improvement of the health and wellbeing of the population. For some, such as population health services, this standard and criterion will require significant attention. For other smaller organisations, the requirement may go no further than perhaps providing immunisations for staff and information to patients about smoking cessation or weight reduction programs, for example. Such organisations may find it difficult to evaluate the outcomes achieved by their systems and this would then not be required. They would however be required to assess whether their system reaches at least the majority of the population at which it is aimed. For example if an organisation implements a health promotion strategy that is aimed at all smokers who receive treatment in the organisation, an evaluation of whether the majority of smokers are captured would be expected.

Health is defined as 'a state of complete physical, social and mental wellbeing and not merely the absence of disease and infirmity'[1]. The many determinants of health include a range of personal, social, economic and environmental factors, which influence the health status of individuals and populations.

Health promotion is the process of enabling people to increase control over, and to improve their health'.[1] It is described as the use of activities that are designed to advance health status. Health promotion is concerned not only with strengthening the skills and capabilities of individuals but also with actions directed towards changing social, environmental and economic conditions in order to improve population and individual health.

Health promotion programs often focus action on the reduction of levels of major non-communicable diseases, such as cardiovascular diseases, cancer, chronic respiratory diseases, diabetes and communicable diseases, through coordinated, comprehensive health promotion and disease prevention measures. The aim is to

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Performance indicators are used to evaluate the effectiveness of population health programs and interventions implemented by the organisation. (b) Population health programs and interventions are evaluated and improved as required. (c) Partnerships are evaluated where relevant and improved as required.	(a) Population health programs and interventions together with results are compared internally and externally and improvements are made to ensure better practice. and / or (b) Service plans are informed by population health data and reflect current national and local priorities. and / or (c) Research is undertaken into population health programs and interventions and results are published in peer review journals.	(a) The organisation contributes to local initiatives and research in population health. (b) The organisation is recognised as a leader in providing population health programs and strategies.

promote healthier lifestyles in communities and to prevent and control common risk factors, such as hypertension, hyperlipidemia, obesity, smoking, alcohol abuse, unhealthy diet and sedentary lifestyle.

Health promotion for some organisations can mean providing access or education material about healthy lifestyle options to both consumers / patients and staff such as for smoking cessation. For smaller health services and day procedure centres, information on ongoing care for the condition they have been treated for, can help demonstrate that the service is providing educative materials, such as exercise regimes post surgery, ongoing eye care, information on glaucoma, dental hygiene strategies.

Consideration should also be given to the display of promotional information from other agencies, such as the Department of Health (DH) to assist in meeting organisational responsibilities.

Health promotion strategies in larger public organisations should be based on the World Health Organisation's *Ottawa Charter for Health Promotion*[2] which was developed in 1986 and remains the basis upon which population health strategies are developed. It has five key components:

- building healthy public policy
- creating supporting environments
- supporting and strengthening community action
- developing personal self-care skills
- reorienting health services

as well as:

- promoting health promotion in other health and disability services.

Health protection involves activities that are designed to prevent any deterioration in health status. Health protection is primarily concerned with preventing or minimising the exposure of the community to potential preventable illness. It is particularly concerned with risks to health arising where the individual has little or no control.[1]

2.4 IPOPULATION HEALTH STANDARD

Criterion 2.4.1 Better health and wellbeing for consumers / patients, staff and the borader community are promoted by the organisation.

(Continued)

Health protection programs include strategies such as the provision of clean water, effective sewerage systems, radiation safety, waste management, safe food and immunisation and other disease prevention interventions.

Health protection for some organisations may include provision of vaccinations, for example hepatitis, influenza and other occupational vaccination programs.

Surveillance is defined as the ongoing, systematic collection, analysis and interpretation of health related data essential to the planning, implementation and evaluation of public health practice, closely integrated with the timely dissemination of these data to those responsible for prevention and control.[3]

All health care organisations should be aware of their **legislative obligations** in relation to surveillance and for the reporting of infectious diseases[4]. A system should exist in all organisations for the emergency management of a consumer / patient who is identified with a highly infectious or communicable illness. Such a system will be different for different organisations, for example a large regional hospital may manage the initial presentation of a consumer / patient with a possibly infectious rash differently from a day procedure centre. Organisations may prefer to manage these responsibilities through criterion 1.5.2 infection control.

Like many developed economies, Hong Kong faces the challenges posed by changes in health risk profile with ageing populaton. An increasing burden from non-communicable diseases (NCD) is envisaged. Recognising that most NCD share common risk factor, DH has developed a strategic framework on prevention and control of NCD in Hong Kong, which aims at tackling the situation more effectively and efficiently. The document entitled “Promoting Health in Hong Kong: A Strategic Framework for Prevention and Control of Non-communicable Diseases”[5] has been launched to call for community support.

If the role of a health care organisation is to provide comprehensive population health programs to their community, the organisation is encouraged to become involved with and / or involve external expert organisations and communities in their strategies. Expert organisations include non-government organisations such as the World Cancer Research Fund Hong Kong.

A health care admission for whatever purpose provides an ideal health protection and health promotion opportunity for consumers / patients to be made aware of health and wellness strategies they may adopt in order to improve their health and wellbeing. Opportunistic health promotion strategies for consumers / patients could include exercise programs, breastfeeding, weight loss, cessation of smoking. It is not suggested that all health care organisations should be providing these programs, but that they know how and where to access them. Smaller organisations could consider engaging in health promotion and protection strategies for staff for example immunisation, smoking cessation and exercise programs.

Organisations may provide evidence of achievement in this criterion through:

- declared commitment / policy / philosophy
- health protection programs, including staff vaccination records
- survey data regarding disease prevalence
- immunisation program and staff vaccination records
- evidence of staff education programs
- health promotion programs and information available on relevant programs for consumers / patients
- review of care plans / pathways
- evaluation of discharge plans
- policies and procedures on:
  - reporting infectious diseases
  - management of consumers / patients with infectious diseases

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3. Center for Disease Control. CDC surveillance update. Atlanta: Center for Disease Control, 1988.

4. Notification of Infectious Diseases. Centre for Health Protection, Department of Health at: http://www.chp.gov.hk/notification.asp?lang=en&id=33&pid=13&ppid=

5. Promoting Health in Hong Kong: A Strategic Framework for Prevention and Control of Non-communicable Diseases. http://www.dh.gov.hk/english/pub_rec/pub_rec_ar/pub_rec_ncd.html

Further Reading

The following table is a collection of ideas that health services can consider for consumers / patients and staff, in their health promotion and health protection planning and strategy development.

2.4 POPULATION HEALTH STANDARD

Criterion 2.4.1 Better health and wellbeing for consumers / patients, staff and the borader community are promoted by the organisation.

Strategy Objective	Strategies	Useful Resources
Cancer risk reduction	• Smoking cessation programs • Creating a smoke free environment • Promotion of breast feeding • Promotion of healthy eating • Promotion of physical activity • Reduction of harmful use of alcohol	*Information from the Department of Health (DH):* • Smoking Cessation. Tobacco Control Office: http://www.tco.gov.hk/eindex.html • Breast feeding. Family Health Service: http://www.fhs.gov.hk/eindex.html • Promoting Health in Hong Kong: A Strategic Framework for Prevention and Control of Non-communicable Diseases. Non-communicable Disease Division. Surveillance and Epidemiology Branch, Centre for Health Protection: http://www.dh.gov.hk/english/pub_rec/pub_rec_ar/pub_rec_ncd.html • EatSmart@restaurant.hk' Campaign and 'EatSmart@school.hk' Campaign. Central Health Education Unit: http://www.eatsmart.gov.hk/ *Information from other organisations:-* • Hong Kong Anti-Cancer Society: http://www.hkacs.org.hk/content/anti_cancer_society.php
Screening	• Promotion of cervical screening programme	*Information from the Department of Health (DH):* • Cervical Screening Programme. Surveillance and Epidemiology Branch, Centre for Health Protection: http://www.cervicalscreening.gov.hk/eindex.php
Prevention of non-communicable diseases	• Healthy eating and dietary programs • Exercise programs • Tobacco control	*Information from the Department of Health (DH):* • Promoting Health in Hong Kong: A Strategic Framework for Prevention and Control of Non-communicable Diseases. Non-communicable Disease Division. Surveillance and Epidemiology Branch, Centre for Health Protection: http://www.dh.gov.hk/english/pub_rec/pub_rec_ar/pub_rec_ncd.html • Exercise prescription. Central Health Education Unit: http://exerciserx.cheu.gov.hk/ • Stair Climbing to Health. Central Health Education Unit: http://stairclimbing.cheu.gov.hk • 'EatSmart@restaurant.hk' Campaign and 'EatSmart@school.hk' Campaign. Central Health Education Unit: http://www.eatsmart.gov.hk/ • 'Two plus Three'. Central Health Education Unit: http://2plus3.cheu.gov.hk/ • Tobacco Control Office: http://www.tco.gov.hk/eindex.html
Prevention of communicable diseases	• Vaccination programs	*Information from the Department of Health (DH):* • Vaccination Schemes. Centre for Health Protection http://www.chp.gov.hk/en/view_content/17980.html

2.4 POPULATION HEALTH STANDARD

Criterion 2.4.1 Better health and wellbeing for consumers / patients, staff and the borader community are promoted by the organisation.

Strategy Objective	Strategies	Useful Resources
Improved fitness	• Exercise programmes	*Information from the Department of Health (DH):* • Exercise prescription. Central Health Education Unit: http://exerciserx.cheu.gov.hk/ • Stair Climbing to Health. Central Health Education Unit: http://stairclimbing.cheu.gov.hk *Information from the Leisure and Culture Services Department (LCSD):* • Healthy Exercise for All Campaign: http://www.lcsd.gov.hk/healthy/b5/index.php • Community recreation and sports programme: http://www.lcsd.gov.hk/en/ls_act_week.php
Improved nutrition and diet	• Healthy eating at schools • Nutrition labeling	*Information from the Department of Health (DH):* • 'EatSmart@school.hk' Campaign.; Central Health Education Unit: http://www.eatsmart.gov.hk/ • 'Two plus Three'. Central Health Education Unit: http://2plus3.cheu.gov.hk/ *Information from the Centre for Food Safety (CFS), Food and Environmental Hygiene Department (FEHD):* • http://www.cfs.gov.hk/english/whatsnew/whatsnew_act/whatsnew_act_19_Nutrition_Labelling_Scheme.html
Improved infant health	• Breastfeeding promotion • Immunisation programs	*Information from the Department of Health (DH):* • Family Health Service: http://www.fhs.gov.hk/eindex.html
Oral health	• Oral health promotion	*Information from the Department of Health (DH):* • Dental Service: http://www.dh.gov.hk/english/main/main_ds/main_ds.html
Falls prevention	• Balance exercise • Home modification • Drug Review • Use of appropriate walking aid	Information from the Department of Health (DH): • Elderly Health Service: http://www.info.gov.hk/elderly/english/index.htm
Needlestick injury prevention	• Report all needlestick and sharp object injuries • Promote safety culture and education on safe use of sharps	Information from the Department of Health (DH): • Recommendations on the Postexposure Management and Prophylaxis of Needlestick injury or Mucosal Contact to HBV, HCV and HIV (2007). Centre for Health Protection: http://www.chp.gov.hk/files/pdf/g198_20080128_en.pdf
Heighten public awareness of organ donation	• Organ donation promotion	*Information from the Department of Health (DH):* • Organ Donation: http://www.organdonation.gov.hk

CLINICAL FUNCTION

SUPPORT FUNCTION

CORPORATE FUNCTION

2.5 RESEARCH STANDARD

The standard is: **The organisation encourages and adequately governs the conduct of health and medical research to improve the safety and quality of health care.**

The intent of the Research standard is twofold:

- to ensure that if health care organisations engage in clinical or health services research, the research is governed effectively, in accordance with acceptable guidelines and standards
- to encourage organisations to participate in research to further the evidence available to health care organisations for providing high quality care.

There is one criterion in this standard. This is:

2.5.1 The organisation's **research program** promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research.

Most organisations have developed and implemented policies and systems for clinical and corporate risk management, human resources and information management and for managing the environment in which health care is provided. Organisations begin to focus on and should understand their responsibilities for the management or governance of research, and this responsibility should not only rest with a research ethics committee (REC).

RESEARCH:
Standard, Criterion, Elements, Guidelines

Standard 2.5 The organisation encourages and adequately governs the conduct of health and medical research to improve the safety and quality of health care.

Criterion	LA – Awareness	SA – Implementation LA plus the following
2.5.1 The organisation's **research program** promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research.	(a) The organisation fosters and encourages clinical and health services research. (b) The governing body demonstrates its responsibility for the governance of research. (c) A policy exists and is publicly available for governing the quality of research in the organisation. (d) The research policy is consistent with: (i) Declaration of Helsinki [10] (ii) HK Medical Council Code of Professional Conduct[11] (iii) Pharmacy And Poisons Ordinance (Cap 138) for Drug Trials. (e) Staff are aware of the research policy.	(a) The research policy is implemented. (b) Ethics approval processes are timely, transparent and effective. (c) Scientific review standards of research are timely, transparent and effective. (d) Researchers are appropriately trained and qualified for the roles they are undertaking. (e) The respective responsibilities of all parties involved in research are identified and documented. (f) The role and reporting line of the organisational research ethics committee (REC) are clearly defined. (g) The REC is adequately resourced. (h) Consumers and researchers work in partnership to make decisions about research priorities, policies and practices. (i) Formal agreements exist with collaborating agencies.

Research involves a systematic enquiry or investigation in order to discover facts or principles:

- in health care organisations that utilises resources should be acknowledged and supported by the governing body.
- Research that involves humans and has any risk of causing harm physically, psychologically, spiritually or may breach confidentiality or privacy should always be submitted to a properly constituted Research Ethics Committee (REC). This includes research where staff are participants.
- In general, quality improvement projects, clinical audits and the activities of students and others conducting literature searches do not constitute research as defined for the purpose of this standard. If there is any doubt the advice of a REC should be obtained.[1, 2] Postgraduate student projects do constitute research.

Research governance is 'a framework through which institutions are accountable for the scientific quality, ethical acceptability and safety of the research they sponsor or permit'.[3]

The UK National Health Service in 2001, further described research governance as 'a system that sets standards of research practice, provides mechanisms to deliver those standards, provides for monitoring and assessment of research practice and applies to all professional groups who are involved in health research and those who deliver patient care'.[3]

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
a) Performance indicators are used to evaluate the effectiveness of the governance of research. (b) The system for ensuring effective research governance is evaluated and is improved as required.	a) Research outcomes are implemented in the organisation and are used to demonstrate improvements in health care. and / or (b) The organisation participates voluntarily in a regular external evaluation of research governance.	(a) The organisation demonstrates that its research program and the governance thereof are outstanding.

The application of a standard across research practices will provide many benefits to all involved. These include:

- enhanced contribution to organisational goals, culture and knowledge
- best practice performance
- increased marketability for an individual clinical research professional
- confidence in the competence and level of expertise of employees
- external recognition as an organisation that adheres to best practice standards through self- regulation
- a benchmark for the content of education and training programs for researchers
- enhanced standards within clinical research
- increased efficiency in bringing safe and effective new therapies and organisational improvements to and for the consumer.[4]

The three key components of **research governance responsibility** are:

- The protection of consumers / patients, carers and staff involved in research: this includes such matters as consent, the provision of appropriate and safe facilities in which clinical research is undertaken and monitoring of consumers / patients clinical wellbeing.
- The protection of researchers: this includes training, facilities, processes for proper conduct of research and appropriate employment arrangements.

2.5 RESEARCH STANDARD

Criterion 2.5.1 The organisation's **research program** promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research.

(Continued)

- The protection of the organisation: this includes matters that might bring an organisation into disrepute, for example the risk to the reputation of an organisation around dishonest research, financial risk, intellectual property risk, commercial arrangements and liability around patient harm.

An organisation's **research policy** should include:

- responsibilities of all parties
- participant indemnity
- participant consent processes
- protection and support of researchers
- financial management
- data management
- ethics approval processes that are timely and transparent
- intellectual property rights and publication practices
- project and risk management
- complaints handling and conflict of interest processes and be publicly available to consumers / patients, staff and any other interested person.

In addition to effectively governing research that is conducted in the organisation, health care organisations should **foster and encourage** research. This does not necessarily mean that all health care organisations will be directly involved in conducting research. Organisations should however, show a commitment to the systematic gathering of information for use in decision making and improvement. For very small organisations, this may simply mean allowing and enabling individuals to participate in research undertaken by another organisation or enrolling consumers / patients in research studies being conducted by other organisations.

Organisations should understand that if the organisation is engaged in clinical or health services research, the governing body is responsible for the governance of that research. In relation to clinical research, the responsibility does not rest, by default or any other means with the research ethics committee (REC). Such committees have a different role that is related to the research, but it is not for the governance of the research and the role of the REC should be clearly defined. Further, the organisation is responsible for the delivery of high quality research. That is, the research undertaken should add to the health sciences knowledge pool and should advance health care or the health and wellbeing of the community.

Organisations may provide evidence of achievement in this criterion through:

- policies on research
- involvement in research programs
- evidence of ethics approval processes
- evidence of awareness of research in relevant areas
- evidence of qualifications for roles undertaken
- evidence of consumer / patient participation in research
- evidence of formal agreements or contracts
- minutes from meetings.

References

1. National Health and Medical Research Council. National statement on ethical conduct in research involving humans. Canberra: National Health and Medical Research Council, 1999.

2. National Health and Medical Research Council, Accessed August 2006, When does quality assurance in health care require independant ethical review? Available at: http://www.nhmrc.gov.au/publications/_files/e46.pdf

3. Walsh MK, McNeil JJ and Breen KJ. Improving the governance of health research. Medical Journal of Australia. 2005;182 (9): 468-471.

4. The Institute of Clinical Research. Clinical research operational standards for professional practice. U.K.: The Institute of Clinical Research. 2005.

5. National Health and Medical Research Council. Joint NHMRC/AVCC statement and guidelines on research practice. Canberra: National Health and Medical Research Council, 1997.

6. National Health and Medical Research Council. Values and ethics — guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research. Canberra: National Health and Medical Research Council, 2003.

8. National Health and Medical Research Council. A model framework for consumer and community participation in health and medical research. Canberra: National Health and Medical Research Council, 2004.

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10. World Medical Association Declaration Of Helsinki – Ethical Principles for Medical Research Involving Human Subjects www.wma.net/en/30publications/10policies/b3/index.html

11. Code of Professional Conduct for the Guidance of Registered Medical Practitioners, Medical Council of Hong Kong www.mchk.org.hk/Code_of_Professional_Conduct_2009.pdf

12. Handbook for Good Clinical Research Practice, Guidance for Implementation, World Health Organisation http://whqlibdoc.who.int/publications/2005/924159392X_eng.pdf

13. Hospital Authority Research Ethics Guidelines

14. Pharmacy and Poisons Ordinance, (Cap 138) http://www.legislation.gov.hk/blis_ind.nsf/WebView?OpenAgent&vwpg=CurAllEngDoc*138*100*-138#138

Further Reading

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CLINICAL FUNCTION

SUPPORT FUNCTION

CORPORATE FUNCTION

3.1 LEADERSHIP AND MANAGEMENT STANDARD

The standard is: **The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services.**

The intent of this standard is to ensure that an organisation is aware of and manages all the key components of governance of a health care organisation. The standards and criteria contained in this functional area provide guidance on how health care organisations can achieve effective corporate and clinical governance.

There are five criteria in this standard. They are:

3.1.1 The organisation provides quality, safe care through **strategic and operational planning and development.**

3.1.2 **Governance** is assisted by formal **structures** and **delegation practices** within the organisation.

*3.1.3 Processes for **credentialling and defining the scope of clinical practice** support safe, quality health care.*

3.1.4 **External service providers** are managed to maximise quality care and service delivery.

*3.1.5 **Documented corporate and clinical policies** assist the organisation to provide quality care.*

These standards and criteria emphasise the need for strong leadership, governance and direction.

LEADERSHIP AND MANAGEMENT:
Standard, Criteria, Elements, Guidelines

Standard 3.1 The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services.

Criterion	LA – Awareness	SA – Implementation LA plus the following
3.1.1 The organisation provides quality, safe care through **strategic and operational planning and development.**	(a) An organisational strategic plan has been developed and includes values, vision and mission. (b) There is a planned approach to development of facilities and services. (c) There is an awareness of the need to develop relationships with relevant organisations and communities to achieve organisational and strategic goals. (d) Internal and external challenges are identified when developing plans. (e) The activities of the organisation are covered by appropriate by-laws, articles of association and / or policies and procedures.	(a) Organisational and service planning aligns with corporate objectives. (b) Clinical and non-clinical service planning reflects projected service demands. (c) Stakeholders, including staff, and where feasible consumers / patients are involved in the development and implementation of plans. (d) Planned changes are clearly communicated to staff. (e) Relationships with relevant external organisations are formally recognised in the planning process. (f) Change management strategies are a component of the strategic and operational plan. (g) Forward planning identifies priority areas for care / service development and the most efficient use of resources.

These guidelines should be read in conjunction with criteria 2.1.1 quality improvement, 2.1.2 risk management, 1.3.1 appropriateness and 1.4.1 effectiveness.

The intent of this criterion is to ensure that the health care organisation has a planning process that begins at the strategic level. A well articulated plan at the operational level will assist everyone in the organisation in working towards the same vision, mission and values.

Strategic planning is a management tool that helps an organisation to assess and adjust the organisation's direction in response to a changing environment – to focus its energy, to ensure that members of the organisation are working toward the same goals.[1]

Being strategic means:

- being clear about the organisation's objectives
- being aware of the organisation's resources
- incorporating both into being responsive to the environment in which the organisation operates.

The **strategic plan** establishes an organisation's overall objectives, is organisation-wide and responsive to the organisations risks. It identifies the organisation's long-term direction, where its resources are to be allocated, what services are available and what is needed. The governing body approves the plan that is implemented and revised as necessary.

The **operational plan** is the short-term plan that details how the strategic plan will be accomplished. The operational plan identifies responsibilities and timeframes in a format that can be easily understood. The strategic plan and the operational plan can be aligned using performance indicators.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The governing body evaluates progress towards strategic plan objectives and takes remedial action if required. (b) Organisational changes are evaluated in consultation with relevant stakeholders.	(a) The process of service planning and development is compared with external systems and improvements are made to ensure better practice. and / or (b) Achievement against strategic objectives is compared with external systems and improvements are made to ensure better practice. and / or (c) Information on effective and innovative successes are shared with other health care organisations and showcased.	(a) The organisation is recognised as a leader in strategic and operational planning and development. (b) The organisation is recognised by its peers to be a leader for its systems to address legislative requirements.

Long and short-term organisational and service planning incorporates the corporate objectives identified in the strategic plan. For example, if the strategic plan outlines the development of a new service, based on the needs of the community it serves, the corporate objective would be to outline a financial plan, timeframe and specific funding for that service. Long and short-term goals are essential for effective management of the organisation. The organisation's strategic and operational plans are integrated, responsive to the needs of the community and developed cooperatively by management, staff, the community and other relevant health service providers and stakeholders. The operational plan includes performance improvement, change management and risk management processes to ensure the achievement of outcomes identified in the strategic plan.

Recognising and formally considering the **relationships that exist with external bodies** that the organisation works closely with, such as other health services, community organisations, health funds and government bodies will ensure a comprehensive approach to planning.

Change management is the process of managing the effective implementation of organisational strategies, ensuring that permanent changes in goals, behaviours, relationships, processes and systems are achieved to the organisation's advantage.

Broad consultation will help identify and address the needs and expectations of the organisation's internal and external customers. The involvement of managers, staff and the community in strategic and operational planning will ensure that needs and expectations are considered. Informing staff and the community of any planned changes and

3.1 LEADERSHIP AND MANAGEMENT STANDARD

Criterion 3.1.1 The organisation provides quality, safe care through **strategic and operational planning and development.**

(Continued)

the reasons for them will assist in enlisting their support and cooperation.

When developing the strategic and operational plans, identifying and planning for possible internal and external challenges will assist the organisation to be prepared. An external challenge could be described as a challenge imposed on an organisation by external forces. An internal challenge may be described as a challenge imposed by the organisation.

External challenges may be:

- changes in legislation or regulation
- technological advances
- government department restructures
- governing organisation restructures or takeover
- territory-wide workforce shortages
- external disasters such as earthquakes, bus / train accidents or bushfires
- outside competition
- change in government policy that may have an impact on the organisation.

Internal challenges may be:

- the inability to recruit
- technological crises
- the emergency department being full to capacity
- an unavailability of beds in the organisation
- a continuing adverse financial trend.

The organisation's willingness and ability to adapt to changing circumstances, with the development of an alternate strategy will assist the organisation to continue to achieve its overall goals and mission.

Evidence of where organisations have planned or adapted to changing circumstances can be used to demonstrate a component of this criterion.

In summary:

- Anticipate change and be responsive to change in a planned manner.
- Use contemporary change management strategies.
- Support staff through change processes.
- Identify and measure the outcomes of any significant change process; review and evaluation of achievement against planned outcomes feeds back into the planning process.
- Consult in a timely manner with relevant staff and consumers who may be affected by proposed changes.
- Be open and transparent in communication with stakeholders:
    - internal stakeholders such as staff, visiting medical officers
    - external service providers, such as local government community services and general practitioners
    - external stakeholders, such as state government and corporate office.

Organisations may provide evidence of achievement in this criterion through:

- framework and process for developing strategic and operational plans including categories for participants
- vision, mission, goals and value statements
- strategic and operational plans with objectives and targets
- communication and distribution channels for informing management, staff and the community of plans and any changes
- examples of internal and external challenges that have been addressed
- examples of issues where change management strategies are used
- reports of progress to objectives and targets in the strategic and operational plans
- reports of evaluation of changes to the organisations services, structures, practices.

Reference

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LEADERSHIP AND MANAGEMENT:
Standard, Criteria, Elements, Guidelines

Standard 3.1 The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services.

Criterion	LA – Awareness	SA – Implementation LA plus the following
3.1.2 **Governance** is assisted by formal **structures and delegation practices** within the organisation.	(a) The governing body is aware of its role for strategy and monitoring. (b) The governing body's duties and responsibilities are defined, documented and comply with relevant legislation. (c) Terms of reference, membership and procedures are in place for meetings of the governing body. (d) A formal system to appoint senior managers exists. (e) Financial processes are consistent with legislative and government requirements. (f) The organisation has a budget development and review process.	(a) There is formal orientation to the governing body's role. (b) Education is provided to the governing body. (c) Terms of reference, membership and procedures are defined for committees of the governing body and all committees within the organisation. (d) Minutes, decisions and actions of committee and governing body meetings are recorded and confirmed. (e) Decisions of the governing body are implemented. (f) The organisation has sound financial management practices that ensure its ongoing financial viability. (g) Accurate detailed financial reports are provided to the governing body and managers.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The governing body collectively assesses its performance, and the performance of its members and improvements are made as required. (b) The governing body receives, evaluates and acts on reports about the quality of clinical care and service. (c) The effectiveness of formally constituted committees is monitored, regularly evaluated and improved as required. (d) Organisational structures and processes are regularly reviewed to ensure quality services are delivered. (e) Compliance with delegations is monitored and evaluated and improved as required. (f) By-laws, operating requirements and management requirements are regularly reviewed to reflect current requirements. (g) Financial performance is evaluated and improved as required.	(a) Corporate and clinical governance structures are compared with external systems and models and improvements are made to ensure better practice. and / or (b) The organisation demonstrates that its governance enables a culture that results in good clinical outcomes, as demonstrated through clinical indicator and business performance data. and / or (c) Delegations are compared with external systems and improvements are made to ensure better practice. and / or (d) Financial management performance indicators are compared with external organisations and improvements are made where required. and / or (e) All members of the governing body have qualifications in governance.	(a) The organisation is recognised as a leader in governance. (b) The organisation is recognised as a leader in systems for delegation.

3.1 LEADERSHIP AND MANAGEMENT STANDARD

Criterion 3.1.2 Governance is assisted by formal **structures and delegation practices** within the organisation.

The intent of this criterion is:

- to ensure that the required structures and processes are in place for effectively managing the organisation
- to ensure that individual roles and responsibilities are understood and there are clear channels of communication and accountability.

It is particularly important that decisions impacting on clinical care involve clinicians and are well integrated into the organisation's decision making processes and structures.

The governing body may have a number of roles. It is essential that organisations understand what governance means and understand the **role of the governing body**. Tricker[1] provides a very simple model that describes the responsibilities of the governing body as strategy and monitoring, both internal and external to the organisation.

Tricker Model

<table>
<tr><td>Role / Environment</td><td>Compliance</td><td>Strategy and Performance</td></tr>
<tr><td>External</td><td>Provide External Reporting Accountability</td><td>Strategy, Planning and Formulation</td></tr>
<tr><td rowspan="2">Internal</td><td colspan="2">Work with and through the CEO</td></tr>
<tr><td>Monitoring and Supervising Internal Compliance</td><td>Policy Making</td></tr>
<tr><td></td><td>Past & Present Oriented</td><td>Future Oriented</td></tr>
</table>

Central to the model is the recognition that the board has to work with, and through, the chief executive officer, however named.

Governance is the system by which organisations are directed and controlled.[2]

According to the National Health Service (NHS) United Kingdom, there are two main aspects of governance in health care:

- Corporate governance – 'the processes by which the organisation is directed, controlled and held to account. It encompasses the systems, processes and arrangements by which authority, accountability, stewardship, leadership, direction and control are exercised in an organisation'.[3]
- Clinical governance – 'the framework through which health care organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish'.[3]

In July 2004, the Australian Council on Healthcare Standards (ACHS) Board defined clinical governance as 'the system by which the governing body, managers and clinicians share responsibility and are held accountable for patient safety, minimising risks to consumers and for continuously monitoring and improving the quality of clinical care.'

The form that the **governing body** takes will vary from organisation to organisation. The governing body is the individual or group of individuals that has the legal accountability and responsibility for the organisation. Depending on the type of organisation, the governing body may be an individual owner in the case of the small private organisation or a group of senior managers who have responsibility for that organisation. Public organisations may have a board of directors, a group of senior managers and / or a chief executive appointed by a government body.

The governing body has **responsibilities in relation to legislation** relating to its own operations and also in relation to financial processes that they must ensure are sound with the assistance of accurate and detailed reports so that financial viability is assured.

The members of the governing body will understand these responsibilities if there is a **formal orientation** and they participate in ongoing education.

The governing body is assisted in its responsibilities by committees that have well defined structures – terms of reference, membership and documented minutes.

The **structure** specifies the distribution of rights and responsibilities among different participants of the organisation such as board members, managers and shareholders.[2]

A **formal organisational structure** outlines the leadership within the organisation, lines of responsibility and an appropriate committee structure that can facilitate the monitoring and management of health care services.[4]

Formal organisational structures include:

- its composition, such as appointments of senior leaders and clinicians representation of disciplines, professional bodies and committee structures
- delegation of authority appropriate to individual's roles and responsibilities within the organisation for the operation of clinical and non-clinical services
- linkages with stakeholders and facilities
- reporting mechanisms to the governing body, internally within the organisation and to stakeholders.

The key component of **clinical governance** is a recognition by managers and clinicians that they have a responsibility for the quality of the care delivered by the service and that this responsibility is shared by both the managers and the clinicians of the organisation.[5] Therefore the successful implementation of clinical governance requires the development of strong and effective partnerships with clinicians and managers for the safe and effective provision of health care. Lines of responsibilities for all aspects of clinical care that are communicated and known will support these partnerships.

A clinical governance committee structure is just as important as a corporate governance committee structure. If the governing body establishes an effective structure it will:[6]

- provide an environment that fosters quality
- monitor the quality of care
- provide a regular report to the governing body on the quality of care
- minimise the risk of and identify deficiencies in the quality of care
- effectively address these deficiencies.

For smaller organisations, these structures can be incorporated into the general governance structures.

The governing body **delegates authority** to managers and ensures their responsibilities are defined so that the organisation is managed effectively to achieve the organisation's mission, values, business and clinical goals. Appropriate delegation to the senior executives and managers for the operation of clinical and non- clinical services will ensure that they can fulfil their duties and meet the expectations of their roles. If the relationship between the governing body and its managers operate as a partnership it is likely to be more effective.

Delegation policies may include as a minimum:

- the limits of delegation
- the instrument of delegation
- how the policy was formulated
- implementation and compliance.

Regular review of the delegation structure and whenever there is a significant change, such as an alteration to the role of the organisation or its services, will ensure that delegations remain appropriate. Review can also determine:

- the degree of awareness amongst managers of their own delegations
- the system of accountability for ensuring compliance with delegations
- whether the level of delegation is appropriate considering the role of the individual in the organisation and scope of responsibilities.

3.1 LEADERSHIP AND MANAGEMENT STANDARD

Criterion 3.1.2 Governance is assisted by formal **structures and delegation practices** within the organisation.

(Continued)

Organisations may provide evidence of achievement in this criterion through:

- the structure of the governing body, its roles and responsibilities, terms of references, minutes of meetings, attendance registers
- orientation and education programs and attendances for members of the governing body
- structures of committees, terms of reference, reporting lines, minutes of meetings
- organisational structure or chart
- policies and procedures for budget development reviews
- policies and procedures for financial management
- annual reports
- delegation documents, instruments
- position descriptions
- reports of reviews of governing body compliance to legislation in its responsibilities
- reports of reviews of the financial system compliance to legislation
- reports of reviews of the delegation documents.

References

1. Tricker RI. International Corporate Governance. Simon & Schuster (Asia) Pty Ltd. 1994: 244-245.
2. Organisation for Economic Co-operation and Development. OECD principles of corporate governance. Paris: Organisation for Economic Co- operation and Development, 2004.
3. National Health Service (NHS). A First Class Service, Quality in the new NHS. Great Britain, 1998.
4. Bryson JM. Strategic planning for public and nonprofit organizations: a guide to strengthening and sustaining organizational achievement. San Francisco: Jossey Bass, 1995.
5. Heard S, Schiller G, Aitken M, Fergie C, McCready Hall L. Continuous Quality Improvement, educating towards a culture of clinical governance. Quality in Health Care. 2001;10(110): II70-II78.
6. NSW Health. A framework for managing the quality of health services in New South Wales. Sydney: NSW Department of Health, 1999.

Further reading

1. Hospital Authority Ordinance (Cap 113).
   - Governance (s3 & Sch 3)
   - Delegation (s6)
   - Financial (s10)
   - Committee (s13)
2. Hospital Authority By-law (Cap 113A).
3. Code of Practice for Private Hospitals, Nursing Homes and Maternity Homes.
4. Manual on the Operation of Hospital Governing Committees.
5. Model Standing Order for Hospital Governing Committees.
6. Hospital Authority Financial and Accounting Manual (Part V Delegation of Authority – Finance Functions).
7. Procurement and Materials Management Manual (Appendix I Schedule of Authority Limits).
8. Delegation of Authority Manual on Human Resources Functions in Hospitals.

LEADERSHIP AND MANAGEMENT:
Standard, Criteria, Elements, Guidelines

Standard 3.1 The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services.

Mandatory Criterion	LA – Awareness	SA – Implementation LA plus the following
3.1.3 *Processes for **credentialling and defining the scope of clinical practice** support safe, quality health care* This is a Mandatory Criterion.	(a) The governing body is aware of its responsibilities for ensuring services are provided by competent health professionals and medical clinicians. (b) Clinicians* hold current registration in the Hong Kong Special Administrative Region (c) There is an organisational policy for credentialling and defining the scope of clinical practice. (d) A policy exists for the safe introduction of new interventions.	(a) There is a credentialling system to ensure the formal qualifications, training, experience and clinical competence of health professionals and medical clinicians providing health services. (b) The process of defining the scope of clinical practice is organisation or facility-specific and relates to the role and capabilities of the organisation. (c) A process for reviewing the scope of clinical practice is in place and is defined as part of the appointment process. (d) The process for assessing the credentials of an applicant and recommendation of the scope of clinical practice is consistent with territory wide standards and guidelines. (e) A system exists for the safe introduction of new interventions. (f) The scope of a clinician's clinical practices is reviewed prior to the introduction of new services, procedures or other interventions.

* clinician refers to a health professional, such as a medical doctor, allied health professional, or nurse, involved in clinical practice

These guidelines should be read in conjunction with criterion 2.1.2 risk management and standard 2.2 human resources management.

The intent of this criterion is to ensure that the skills and competence of all clinicians are correctly aligned with the competence of a health care organisation, so that the right clinicians are providing the right care and services in the right health care organisations.

The purpose of **credentialling and defining the scope of clinical practice** is to protect consumers / patients. Such a process is an essential component of any patient safety or clinical governance framework.

Defining the scope of practice for a clinician is the outcome of matching the clinician's qualifications, skills, experience and competence with the required services and the role and capabilities of the organisation. The qualifications, skills, experience and competence of an individual clinician should not be the only factor in determining whether that clinician is approved to provide particular services or procedures at a particular health care organisation. Further, the scope of clinical practice granted to a clinician in one organisation may differ from those granted at another organisation. A system for monitoring the practice of medical practitioners providing services in the organisation

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The system/s for credentialling and defining the scope of clinical practice for clinicians is reviewed, evaluated and improved as required. (b) Results of monitoring are trended and demonstrate that credentialling systems continuously meet all requirements of external standards and guidelines. (c) Systems are in place for ongoing monitoring and review of performance and this is linked to the credentialling and defining the scope of clinical practice system. (d) The system for the safe introduction of new interventions is evaluated and improved.	(a) The system/s for credentialling and defining the scope of clinical practice for clinicians is compared externally and improvements are made to ensure better practice. and / or (b) Research on credentialling and clinical practices is used by the organisation to inform improvements. and / or (c) The system for the safe introduction of new interventions is compared with external systems and improvements are made to ensure better practice.	(a) The organisation demonstrates that it is a leader in systems of credentialling and defining the scope of clinical practice. (b) The organisation demonstrates that it is a leader in the safe introduction of new interventions.

will ensure that the 'matching' remains current. Monitoring will be achieved in different ways in different organisations. The organisation will determine the most effective way to achieve this, for example monitoring of clinical outcomes, adverse events, complaints and clinical / peer review meetings.

There are two main components of the process for defining the scope of practice of a clinician.[1] They are:

1. **Credentialling**, which is the review of a clinician's qualifications, skills, experience and competencies.
2. The matching of these with the role, needs and **capabilities** of the health care organisations level of service provision, staffing, facilities, equipment and support systems available.

There are broad principles that underpin a system for credentialling and defining the scope of clinical practice:

- Consumers / patients have the right to be treated by competent clinicians.
- In conjunction with the applicable college or society, the health care organisation is responsible for ensuring the competence of clinicians working in that organisation.

3.1 LEADERSHIP AND MANAGEMENT STANDARD

Criterion 3.1.3 *Processes for* ***credentialling and defining the scope of clinical practice*** *support safe, quality health care.*

(Continued)

- All clinicians should have their scope of clinical practice reviewed at regular intervals throughout the period of their employment and appointment in accordance with contracts or by-laws, using defined clinical indicators.
- The assessment of scope of clinical practice should be undertaken by peers and associated professionals such as medical advisory committees* and other specialty groups in line with territory wide standards and guidelines.

  (* Different hospitals have different name for the medical advisory committee)
- The principles of natural justice should be observed at all stages.
- No clinician should be denied practice on the basis of any elements of discrimination.
- Organisations should consider their organisational capacity and need.
- The perspective of consumers / patients and the public should be sought and taken into account when decisions affecting the provision of health care are made.
- The role and infrastructure of the health care organisation is to be taken into account in determining the clinical practice that will be allowed.
- Clinical practice and scope of practice may be reviewed at any time at the request of the organisation or the clinician.

The credentialling of junior medical staff is not accepted in general and most medical administrators believe that this should be competency based, rather than through formal credentialling.

The governing body is responsible for developing and implementing a policy or by-laws on credentialling and defining the scope of clinical practice for all clinicians.[1] The policy or by-laws should:

- comply with all relevant legal requirements
- allocate responsibility to a defined organisational committee to ensure effective processes for credentialling and for continually monitoring the clinical practice
- incorporate an appeals committee and the appeals process
- include the conditions, if any, under which clinicians may administer necessary treatment outside their authorised scope of clinical practice in emergency situations where a patient may be at risk of serious harm if treatment is not provided, and no health professional or medical practitioner with an appropriate authorised scope of clinical practice is available
- include provision for the processes of credentialling and defining the scope of clinical practice to be undertaken in emergency situations where clinical expertise is required on a temporary basis, and clearly identify who has delegated authority to undertake these processes
- identify the circumstances under which an unplanned review of a clinician's credentials and / or scope of clinical practice may be initiated, the authorised persons and bodies within or outside the organisation from whom a request for an unplanned review will be accepted and how the results of such a review will be implemented
- identify the maximum elapsed time following which the processes of credentialling and defining the scope of clinical practice will be repeated
- identify the provisions for suspension, either temporary or permanent, in part or full, of a clinician's right to practice within the organisation if specific circumstances apply
- specify that clinicians who are required to be registered are granted rights to practice within the organisation contingent at all times on the clinician maintaining appropriate professional registration
- specify that a clinician's right to practice within the organisation will be concluded, terminated or suspended on conclusion, termination or suspension of the clinician's appointment to the organisation

- specify the maximum time periods for the conduct of the process of credentialling and defining the scope of clinical practice and any appeals
- specify the extent to which and to whom, the organisation will disseminate information about each medical practitioners authorised scope of clinical practice.

The **safe introduction of new interventions** will assist organisations to provide safe, quality contemporary care and service. Safe introduction will be based on a policy and system that includes the demonstration of evidence to support the new intervention, the successful completion of any required training and a cost benefit analysis. Relevant staff and consumer participation in this process could also assist a comprehensive consideration of all aspects of the new intervention. An evaluation process – monitoring problems in the delivery of the service, outcomes and adverse events, consumer feedback and costs – will allow decisions for the continuation of the intervention to be made in a timely and informed manner. The process should not be used to limit appropriate professional initiatives or inappropriately restrict measures taken in an emergency situation.

In developing our system on credentialing and scope of clinical practice, reference also can be made to other national policy such as Australian Standard for credentialling and defining the scope of clinical practice of the Australian Council for Safety and Quality in Health Care (ACSQHC)[2].

Organisations may provide evidence of achievement in this criterion through:

- evidence of compliance with policies on credentialling, introduction of new interventions etc
- data on annual registration checks, including authentication and expiry date of licences
- by-laws that include credentialling committees
- minutes of medical advisory council (MAC) meetings
- credentialling policy and procedures, including the credentialling application and the monitoring and review processes
- staff lists matching the skills of clinicians to the capabilities of the organisation
- policy and procedure for the introduction of new interventions
- reports of data (outcomes, adverse events, incidents of non-compliance, feedback) used for monitoring the credentialling system and actions taken
- reports of reviews of the introduction of new interventions including data on outcomes, adverse events, feedback, costs.

References

1. NSW Health. Policy Directive: Delineation of clinical privileges for visiting practitioners and staff specialists – policy for implementation. Sydney: NSW Department of Health, 2005.
2. Australian Council for Safety and Quality in Health Care (ACSQHC). Standard for credentialling and defining the scope of clinical practice. Canberra: Australian Council for Safety and Quality in Health Care, 2004.

Further Reading

1. Hospital Authority Mechanism for the Safe Introduction of New Procedure / Technology (HAMSINP) 2001.
2. Hospital Authority Human Resources Guide to Appiontment.
3. Core Competency for RN & Advanced Nursing Practice in HA 2002.
4. Core Competency for Allied Health.
5. Hong Kong Academy of Medicine.
6. Code of Practice for Private Hospitals, Nursing Homes and Maternity Homes.

LEADERSHIP AND MANAGEMENT:
Standard, Criteria, Elements, Guidelines

Standard 3.1 The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services.

Criterion	LA – Awareness	SA – Implementation LA plus the following
3.1.4 **External service providers** are managed to maximise quality care and service delivery.	(a) Policy exists for the management of external service providers.	(a) There are documented agreements with all external service providers that include performance indicators. (b) Services provided externally are consistent with specific standards. (c) External service providers can demonstrate compliance with relevant regulatory requirements. (d) External service providers provide evidence of internal evaluation for the services that they are providing to the organisation. (e) Dispute resolution mechanisms are identified and communicated to the external provider.

The intent of this criterion is to ensure that external service providers are managed effectively to provide safe, quality care and services.

Many organisations use **external contractors and / or services** to provide specific services that are essential to the ongoing operation of the organisation. Examples of such services may include:

- radiology
- oncology
- pathology
- allied health
- transport
- laundry
- food
- cleaning
- maintenance
- security
- education
- employee assistance programs.

While a contract or service agreement is important for both the health care organisation and the service provider to ensure quality maintenance of the service, the fundamental responsibility for quality still rests with the contracting health care organisation and the governing body. However, it is reasonable for an organisation to outline in its service agreements / contracts exactly what level of service is expected and evidence of compliance with that service's regulatory or industry standards. This might be evidence of accreditation or infection control compliance with laundry services or Hazard Analysis and Critical Control Food Standards.

Documented agreements / contracts for all external service providers, should specify the level of service that is expected and that the quality of services to be provided is consistent with relevant legislation and standards. This will assist the organisation to ensure that the care and service are of the same standards as if they were being provided by the organisation itself. Such documented

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Agreements with external service providers are reviewed regularly and improved as required. (b) The organisation evaluates the performance of external service providers through agreed key performance indicators and improved as required.	(a) Agreements with, and systems for monitoring the performance of external service providers, are compared with external systems and improvements are made to ensure better practice.	(a) The organisation is recognised as a leader in management of external service providers.

agreements will ensure that the external service providers understand their responsibility to ensure quality maintenance of care and service. A quality service will also be more likely if agreements with external service providers include a clause that the organisation's quality improvement efforts and strategies including the accreditation process are supported.

Care should be taken when appointing external contractors where it could be construed that there is conflict of interest.

Please note: This section of the standards does not refer to contracted visiting medical practitioners. The contracting of medical services is addressed in the Human Resources Management standard and criteria. Private medical practitioners operating within a private health care organisation are addressed under the credentialling criterion 3.1.3.

Organisations may provide evidence of achievement in this criterion through:

- a framework for the contracts / agreements for external providers
- lists of external service providers and the contracts for each provider
- procedures for the review of accreditation status of external service providers
- reports of ongoing monitoring of services provided by external providers such as outcomes, targets, incidents, feedback
- lists of formal performance evaluation of external service providers.

Reference

1. Food Standards Australian New Zealand, Food Standards Code and Food Safety Information Available at: http://www.foodstardards.gov.au/

LEADERSHIP AND MANAGEMENT:
Standard, Criteria, Elements, Guidelines

Standard 3.1 The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services.

Mandatory Criterion	LA – Awareness	SA – Implementation LA plus the following
3.1.5 ***Documented corporate and clinical policies*** *assist the organisation to provide quality care* This is a Mandatory Criterion.	(a) Documented corporate and clinical policies refer to by-laws, operating and management requirements. (b) Management is aware of: (i) territory wide standards (ii) professional guidelines (iii) codes of practice (iv) codes of ethics. (c) Management is aware of legislative requirements.	(a) There is adherence to by-laws, operating requirements and management requirements. (b) A framework for corporate and clinical policy development and review is in place. (c) Corporate and clinical policy is evidence based wherever possible. (d) Policies reference: (i) current issues (ii) territory wide standards (iii) legislation (iv) professional guidelines (v) codes of practice (vi) codes of ethics (vii) evidence. (e) Policies are relevant to the size and role of the organisation. (f) A system for monitoring compliance with policies and procedures is in place. (g) Staff are involved in the development of local policy. (h) A process to inform and educate staff about policies and procedures is in place. (i) A process for the distribution and implementation of new and reviewed policies is in place. (j) Changes to practice and service in clinical and non- clinical areas are reflected in updated policies and procedures. (k) A system for document control is in place. (l) A system exists that: (i) audits compliance with relevant legislation (ii) informs relevant staff of new or amended legislation (iii) educates staff on relevant legislation applicable to their area of responsibility.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The framework for policy development and review is evaluated and improved as required. (b) Policies and procedures are regularly reviewed, updated and improved as required. (c) The system for ensuring implementation of and compliance with key or amended legislative requirements is evaluated and improved, as required.	(a) The framework for corporate and clinical policy development and management is compared with internal and external systems and improvements are made to ensure better practice. and / or (b) Other organisations review and use the organisation's policies as a framework for their policy implementation.	(a) The organisation demonstrates it is a leader in the development, implementation and evaluation of its corporate and clinical policies.

3.1 LEADERSHIP AND MANAGEMENT STANDARD

Criterion 3.1.5 ***Documented corporate and clinical policies*** *assist the organisation to provide quality care*

These guidelines should be read in conjunction with criterion 1.4.1 effectiveness and this criterion is related to all criteria where policies are required.

The intent of this criterion is that the organisation is guided by well constructed, effective and appropriate policy. Further, management, staff, external contractors, volunteers, consumers / patients and other stakeholders should be well informed of policy and processes relevant to their roles within the organisation.

There is an expectation that employers and managers are aware of the legislation that relates to their particular work environment. Systems to incorporate legislation into everyday practice will ensure that practice is up-to-date. This can be managed within an organisation with a division of responsibilities within an overarching framework. For example, the person responsible for payroll would be responsible for remaining appraised of changes to the Inland Revenue Ordinance (Cap 112). Mental health staff implement the Mental Health Ordinance (Cap 136) and would be consulted by other staff when required. Membership of an advisory body that automatically notifies of relevant changes and updates to legislation can assist organisations to remain informed.

Systems to disseminate information when new legislation is implemented or amendments are made to existing legislation will keep staff informed of their legal responsibilities. Organisations that have a comprehensive internal audit system in place to ensure compliance with relevant requirements tend to have strong quality and accreditation systems.

Territory wide standards, guidelines and professional codes of practice are rarely legislated. Therefore, there is an expectation that an organisation has made reference to these standards in policy and compliance is demonstrated through evaluation processes.

An important issue for organisations is that there are guiding principles / policies to which the organisation adheres.

Corporate policies may include:

- appointment of senior staff
- delegations
- credentialling
- committee structures
- reporting and outcomes
- disciplinary action
- recruitment and retention
- advertising
- secondary employment
- information management
- privacy
- safe introduction of new interventions
- occupational health and safety.

Clinical policies may include:

- discharge of consumer / patient
- clinical handover
- infection control
- pressure ulcer prevention and management
- admissions
- management of specific diseases
- medication management
- falls prevention and management
- blood and blood component management
- correct patient, correct procedure, correct site
- consent
- end-of-life decision making
- mortality management.

A framework for developing policies will ensure that the policies are consistent across the organisation and that all the essential elements are included – the aim, and expected outcome, the evidence and references used to develop the policy, how and when the outcomes are to be monitored, reviewed and updated.

Quality care cannot be provided unless there is a system that ensures that the organisation's policies are read by relevant staff and that a sufficient level of understanding is attained. Where departures from the policy (identified by reviews of incidents, ongoing monitoring of non-compliance, staff discussions about policies or audits) occur, the analysis of the reasons for the departures will allow decisions to be made to determine if a new or amended policy is required.

Organisations may provide evidence of achievement in this criterion through:

- framework for the development of policies
- schedules for policy development and review
- corporate and clinical policy documents
- systems for identification and dissemination of information on new or amended legislation, territory wide standards, codes of practice, guidelines etc
- the process to incorporate legislation, territory wide standards, codes of practice, guidelines, ethics etc. into policies
- an example of adaptation of a new standard / legislation etc for example, Personal Data (Privacy) Ordinace (Cap 486)
- evaluation of compliance to policies
- evidence of regular review and update of policies
- system to retrieve changes and updates to:
  - legislation information
  - relevant standards
  - codes of practice
  - codes of ethics
  - professional guidelines.

Relevant Hospital Authority standards or guidelines

- Buildings Ordinance (Cap 123)
- Manual of Good Practices in Medical Records Management
- Clinical Data Policy Manual
- Guideline on Application of the Data Quality Management Mechanism
- Manual on Personal Data (Privacy) Ordinance
- Medico-legal Guidelines
- Centre for Disease Control and Prevention Guideline http://www.cdc.gov (Guideline for Disinfection and Sterilisation in Healthcare Facilities, 2008)
- Hospital Authority Risk Management Guidelines
- Security and Guarding Service Ordinance (Cap 460)
- Occupational Safety and Health Ordinance (Cap 509)
- Mental Health Ordinance (Cap 136)
- Inland Revenue Ordinance (Cap 112)
- Personal Data Privacy Ordinance (Cap 486)

CLINICAL FUNCTION

SUPPORT FUNCTION

CORPORATE FUNCTION

3.2 SAFE PRACTICE AND ENVIRONMENT STANDARD

The standard is: **The organisation maintains a safe environment for employees, consumers / patients and visitors.**

This standard should be read in conjunction with criterion 2.1.2 on risk management.

The intent of the Safe Practice and Environment standard is to ensure that the health care environment is safe and health care providers work in a safe manner. Safe Practice and Environment criteria all require the systematic application of risk management principles to determine priorities and eliminate risks or implement controls.

There are five criteria in this standard. They are:

3.2.1 ***Safety management systems*** *ensure safety and wellbeing for consumers / patients, staff, visitors and contractors.*

3.2.2 **Buildings, signage, plant, equipment, supplies, utilities and consumables** are managed safely and used efficiently and effectively.

3.2.3 **Waste and environmental management** supports safe practice and a safe environment.

3.2.4 ***Emergency and disaster management*** *supports safe practice and a safe environment.*

3.2.5 **Security management** supports safe practice and a safe environment.

Further information on safety can be found on:

- needlestick injury prevention in criterion 1.5.2
- protective clothing and equipment provided to staff where necessary and their usage and correct storage monitored in 1.5.2
- falls management in 1.5.4
- management of incidents and near misses in 2.1.3.

CONTINUITY OF CARE:

Standard 3.2 The organisation maintains a safe environment for employees, consumers / patients and visitors.

Mandatory Criterion	LA – Awareness	SA – Implementation LA plus the following
3.2.1 ***Safety management systems*** *ensure safety and wellbeing for consumers / patients, staff, visitors and contractors.*	(a) Documented policies for safety management systems are in accordance with relevant state / territory legislation and include: (i) workplace health and safety (ii) workers compensation (iii) manual handling (iv) radiation safety (v) management of dangerous goods and hazardous substances. (b) Health and safety risks that may cause harm are identified. (c) Staff are educated about and provided with information on workplace health and safety and their responsibilities. (d) External service providers are supplied with relevant information and comply with the organisation's health and safety requirements. (e) Occupational Safety & Health (OSH) requirements are communicated to carers and visitors as required.	(a) There is an organisation-wide system to assess health and safety risks, determine priorities and eliminate the risks or implement controls. (b) Safety management systems are managed with reference to any relevant: (i) Hong Kong ordinances and regulations (ii) Code of practice (iii) Industry guidelines (c) There are documented safe work practices / safety rules for all relevant procedures and tasks. (d) Staff with OSH responsibilities are appropriately trained. (e) Service planning includes health and safety together with injury prevention strategies. (f) Staff are involved in decisions that affect workplace health and safety and wellbeing. (g) There is an injury management program that reflects legislation.
Manual Handling		(h) Manual handling risks are assessed and appropriate controls are implemented.
Radiation	(f) A register is kept on the safe disposal of all radioactive waste. (g) A current register is kept for all radiation substances and radiation equipment. (h) A personal radiation monitoring system is in place, together with any relevant area monitoring.	(i) Radiation safety management plans are coordinated with the Radiation Board of Hong Kong. (j) Exposure to radiation is controlled to minimise exposure to acceptable standards. (k) A radiation safety report is provided to the ethics committee on any research proposal involving irradiation of human subjects. (l) Consumer / patient radiation is kept to a minimum whilst maintaining good diagnostic quality.
Dangerous goods and hazardous substances This is a Mandatory Criterion.	(i) There are documented policies and procedures on the procurement, management and disposal of dangerous goods and hazardous substances.	(m) A hazards identification system identifies risks and implements controls and takes corrective action.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The safety management system is evaluated and improvements are made to support safe practice and a safe environment. (b) The design and layout of the organisation's current (or planned) physical environment are evaluated.	(a) Regular review of performance indicators for safety management systems are measured and compared internally and with external systems and improvements are made to ensure better practice.	(a) The organisation is recognised as a leader in the development, implementation and evaluation of safe management systems.

3.2 SAFE PRACTICE AND ENVIRONMENT STANDARD

Criterion 3.2.1 ***Safety management systems*** *ensure safety and wellbeing for consumers / patients, staff, visitors and contractors.*

These guidelines should be read in conjunction with criteria 1.5.4 Falls and standard 2.2 Human Resources Management. All applicable national and state / territory guidelines should be available in organisations and referred to in any policies, procedures, systems etc.

The intent of this criterion is to ensure that health care organisations take responsibility for the health and safety of all employees, contractors, management, consumers / patients and visitors. Responsibilities should be clearly outlined and may be stated in position descriptions or similar and in policies and procedures.

Organisations, depending on their size should have a health and safety officer or **Occupational Safety and Health (OSH)** committee on which all staff groups or departments are represented, as required by legislation. Where appropriate, there should be an employee representative involved in the process, not just management representation. Organisations should also have evidence of how their preferred consultation mechanism is utilised within the organisation, such as OSH minutes, safety bulletins / alerts, evidence of safety officer meetings with staff or other notification advice options used. These should include evidence of feedback from staff on these issues.

There should be a continuing staff training program for health and safety which includes a mechanism for the provision of training and advice relating to all aspects of workplace **health and safety**. This can either be provided internally for large organisations or by external means for smaller organisations.

There should be a process to ensure that all staff have read and understood health and safety policies and procedures and this should be part of the induction process. Written policies for health and safety may include:

- manual handling
- radiation safety
- slips / trips
- electrical safety
- noise control
- hazardous substances and dangerous goods
- smoking
- ergonomics – assessments of all working environments including workstations
- violence and aggression
- management of incidents and near misses
- off-site attendance to patients
- needlestick injury prevention
- provision of protective clothing and equipment.

Manual handling describes an activity requiring the use of force exerted by a person to lift, lower, push, pull, carry or otherwise move, hold or restrain any person, animal or thing. Tasks involved can vary from keyboard use, patient positioning and transfer to handling large containers.[1]

There are three steps to reducing manual handling incidents. They are:

1. identification
2. assessment
3. control.

Manual handling tasks should be **identified and documented**, with particular attention to the tasks associated with the most risk. To identify these tasks, two types of information should be gathered: past experiences such as injury statistics, and information on current activities, gathered from staff consultation or observation.

The severity of the risk should then be **assessed**. For example, patient lifting in a surgical or orthopaedic ward would pose a greater risk than in a paediatric ward. While both require manual lifting of a patient, the latter would normally require the lifting of a smaller load / patient. The risk of patients having a fall and therefore requiring assistance post-fall occurs in every health care organisation, including day procedure centres and community health centres. The use of anaesthesia increases the risk of a fall occurring and appropriate risk management strategies should be employed to minimise identified risk.

The Occupational Safety and Health Ordinance (Cap 509) and subsidiary regulations call for risk factors to be identified, assessed and controlled. Risk controls may include, but are not limited to, redesigning the job and providing general training. It is important to involve the staff, OSH committee members and workplace managers in any redesigning of manual handling procedures. The use of patient lifters is one way of demonstrating that redesign has occurred. The retention of staff training and competency checks relating to the use of the lifters supports training in the new task.

If redesign is not reasonably practicable, or as a short-term / temporary measure, the organisation could provide mechanical aids such as slide sheets, pat sides, and trolleys, personal protective equipment, team lifting and training and supervision in the use of these. Often the best solution may be a combination of one or more of these controls. Ergonomic principles should be considered prior to the purchase of any equipment, design of a task or any work modifications. There should be procedures for the use and trial of equipment prior to use, including training for staff using the equipment. Records of these equipment trials and associated training should be retained to support these actions.

Sources of **radiation** are essential to modern health care. Radiation is a vital diagnostic tool, such as in imaging departments as well as radiotherapy which is commonly part of the treatment of malignancies.[3] There are potential exposures that need to be managed; the development of policies and procedure to support this management will be a requirement for a large group of organisations.

There are three main concepts in protecting staff from radiation. They are:

- Time: The amount of radiation exposure received is proportional to time. Minimise the time spent handling radioactive substances or with radiation producing equipment.
- Distance: The intensity of radiation drops rapidly the further away from the source. So maximise distance from sources of radiation at all times. This includes for example, using tongs instead of bare hands to handle radioactive samples.
- Shielding: Increasing shielding around a radiation source will reduce exposure.

These three concepts use the ALARA (As Low As Reasonably Achievable) principle for limiting exposure to radiation and this principle should be considered at all times where risk of exposure exists.

There are radiation protection standards and guidelines that all organisations should be familiar with. These can be found in the Radiation Ordinance (Cap 303) and subsidiary regulations, the International Basic Safety Standards and related guidelines promulgated by the International Basic Safety Standards and related guidelines promulgated by the International Atomic Energy Agency, radiological protection recommendations issued by the International Commission on Radiological Protection as well as other local reference information on radiation protection available on the website of the Radiation Health Unit, Department of Health. These can be found at the Radiation Health Series No. 1-4, Radiation Health Unit, Department of Health.

Control procedures and safe systems of work with radioactive materials and / or radiation apparatus, including lasers, should address:

- room shielding
- exposure control
- monitoring
- health surveillance with records kept for the period stated in any relevant legislation
- licensing checks conducted by the appropriate authorities
- evidence of appropriate professional qualifications or industry approved training courses.

Maintenance and inspection for radioactive materials should address:

- storage
- signage with relevant information, labelling and identification, including any information from provider
- safe handling and use including emergency procedures in case of spillage, transport, disposal and storage.

3.2 SAFE PRACTICE AND ENVIRONMENT STANDARD

Criterion 3.2.1 ***Safety management systems*** *ensure safety and wellbeing for consumers / patients, staff, visitors and contractors.*

(Continued)

Radiation documentation should note those persons responsible for handling and purchase of any materials, licences and compliance with any standards or legislation.

A radiation safety report should be provided to the organisation's ethics committee (or equivalent) where any research proposal involves irradiation of human subjects. Approval for amendment of the radiation licence to cover the proposed research shall be sought from the Radiation Board. Radiation safety guidelines are developed under the Radiation Safety Committee, Quality and Safety Division of Hospital Authority Head Office. Staff radiation exposure should be reviewed by a designated safety / quality review committee in each organisation.

Serious risks of injury to the eye and skin can result from lack of awareness of laser safety. Where lasers are in use, an appropriate laser safety plan should be developed and implemented. The plan should include a risk assessment process, nomination and training of designated laser safety officers and ensuing appropriate warning signage. Staff who work in the laser area need to be properly trained which includes training in the correct use of Personal Protective Equipment. User of laser could make reference to Code of Practice-Health Care Laser System: Hong Kong (2nd Edition) July 2007 jointly published by the Hong Kong Medical Association and the Hong Kong Surgical Laser Association.

Dangerous goods are those substances that are listed in the Dangerous Goods Ordinance. They refer to all explosives, compressed gases, petroleum and other substances giving off inflammable vapours, substances giving off poisonous gas or vapour, corrosive substances, substances which become dangerous by interaction with water or air, substances liable to spontaneous combustion or of a readily combustible nature, radioactive material.

Hazardous substances refer to the various chemicals used in the workplace that may contain harmful substances.

The application of risk management principles and compliance with each state / territory hazardous substances code of practice is essential in ensuring the safety and wellbeing of consumers / patients, staff and visitors to the organisation. Where no individual policy for the management of hazardous materials exist, the risk management policy should cover areas such as:

- storage / parking / isolation
- signage / information / labelling / identification (including information from provider)
- handling / use
- spillage (including emergency procedures)
- exposure control, monitoring and health surveillance (records of any monitoring or health surveillance should be kept for 30 years)
- records
- transport
- disposal
- induction and training
- licensing
- maintenance / inspection – review of controls
- workplace legislation – hazardous substances, dangerous goods
- biological hazards.

Where hazardous and dangerous substances are stored and where staff are working with these substances, organisations should ensure there is adequate space and ventilation for safe handling. For example, stored oxygen is a dangerous good. Risks can be minimised by reducing the number of cylinders stored onsite, including any empty cylinders. This can be achieved by assessing the oxygen use and arranging more frequent delivery of a smaller quantity of cylinders.

Cytotoxic drugs are medicines that are used in cancer chemotherapy treatments. Many cytotoxic drugs have been found to be mutagenic, teratogenic and carcinogenic on the basis of cell DNA, chromosomal studies and, to a lesser degree, experience in treated patients. The risk associated with occupational low level exposure has not been determined. Therefore, risk is presumed to be present and proportional to any exposure.

Since these treatments may be given in many health care settings including the home, consideration should be given to all aspects of safe management including procurement, storage and distribution, manipulations to prepare or administer injections

or other forms of treatment, storage in treatment areas, waste disposal, spillage, protection of staff and consumers / patients, including from contaminated bodily fluids. [8]

Material Safety Data Sheets (MSDS) should be available for staff at point of use and for applicable emergency agencies such as the fire brigade. Hazardous substances are to be properly labelled and maintained on a register of all hazardous substances in the workplace. Labels should never be altered and substances should be stored in their original containers.

Chemicals and cleaning solutions bought in domestic quantities from a supermarket or other supplier, should be handled according to manufacturer's instructions and encouraged to be utilised sparingly within the organisation. In any health care organisation, higher standards apply than in the home.

Organisations may provide evidence of achievement in this criterion through:

- completed checklist and action plan to address identified deficiencies for each health industry hazard in line with state / territory bodies
- occupational health and safety reports, audits and / or meeting minutes
- incident reports
- availability of Material Safety Data Sheets and master index
- policies and procedures on safety management systems
- risk identification and management reports, including radiation
- staff involvement in workplace health and safety
- staff training and competency checks in workplace health and safety
- register of safe work method statements.

References

1. Boilers and Pressure Vessels Ordinance (Cap 56).
2. Air Pollution Control Ordinance (Cap 311).
3. Buildings Ordinance (Cap 123).
4. Electricity Ordinance (Cap 406).
5. Fire Services Ordinance (Cap 95).
6. Gas Safety Ordinance (Cap 51).
7. Lifts and Escalators (Safety) Ordinance (Cap 327).
8. Waste Disposal Ordinance (Cap 354).
9. Prevention and Control of Disease Ordinance (Part 8) (Cap 599).
10. Employees' Compensation Ordinance (Cap 282).
11. Occupational Safety and Health Ordinance (Cap 509).
12. Radiation Ordinance (Cap 303).
13. Dangerous Goods Ordinance (Cap 295).
14. Factories and Industrial Undertakings Ordinance (Cap 59).
15. Hospital Authority OSH Safety Manual, available at http://osh.home/resources.html
16. ANSI Z136.1 (2007) Safe Use of Lasers.
17. ANSI Z136.3 (2005) Safe Use of Lasers in Health Care Facilities.
18. LIA Guide for the Selection of Laser Eye Protection. (Laser Institute of America).
19. Code of Practice – Health Care Laser Systems: Hong Kong (2nd edition) July 2007.
20. IEC 60825-1 Edition 2.0 (2007-03) Safety of laser products – Part 1: Equipment classification and requirements.
21. IEC 60825-8 Second Edition (2006-12) Safety of laser products – Part 8: Guidelines for the safe use of laser beams on humans.
22. Hospital Authority Human Resource Administration Manual.
23. Radiation Health Series, No. 1-4, Radiation Health Unit, Department of Health.
24. Radiation Safety Guidelines, Radiation Safety Committee, Quality and Safety Division, Hospital Authority.
25. Environmental Impact Assessment Ordinance (Cap 499).
26. IEC-60601-X series, Medical Electrical Equipment.

SAFE PRACTICE AND ENVIRONMENT:
Standard, Criteria, Elements, Guidelines

Standard 3.2 The organisation maintains a safe environment for employees, consumers / patients and visitors.

Criterion	LA – Awareness	SA – Implementation LA plus the following
3.2.2 **Buildings, signage, plant, equipment, supplies, utilities and consumables** are managed safely and used efficiently and effectively.	(a) Plant and equipment are installed and operated in accordance with manufacturer specifications. (b) Plant logs exist and are in accordance with manufacturer requirements. (c) Purchase and supply procedures ensure that products are available or that appropriate alternatives are supplied. (d) Written policies / procedures for: (i) buildings / workplaces (ii) plant (iii) equipment (iv) supplies (v) utilities (vi) consumables (vii) workplace design address health, safety and service requirements. (e) There is clear external signage at appropriate locations. (f) The organisation has identified disability and cultural signage needs. (g) Disability access and facilities meet legislative requirements[2] (where they exist) and / or are based on recognised guidelines.	(a) There is a system to plan, manage and operate: (i) buildings / workplaces (ii) plant (iii) equipment (iv) supplies (v) utilities (vi) consumables. (b) Buildings, plant, equipment, utilities, consumables and supplies are managed with reference to any relevant: (i) Hong Kong ordinances and regulations[1,3,4,5,6,12] (ii) codes of practice (iii) industry guidelines. (c) There is a documented, planned and coordinated, preventative maintenance system. (d) Services / departments are sign posted appropriate to the needs of the community and the organisation. (e) Sign posting reflects the use of multilingual / international symbols appropriate to the community's needs.

These guidelines should be read in conjunction with criteria 1.6.3 culturally and linguistically diverse and special needs and 3.2.4 emergency and disaster management.

The intent of this criterion is to ensure that all buildings, signage, plant, equipment, utilities, supplies and consumables owned or used by a health care organisation are managed and operated to support a safe health care environment[6].

The building, structure or workplace is defined as a place that is occupied by people, for example offices or public buildings. In some instances, a motor vehicle may also constitute a workplace where health and safety policies must be complied with by staff in possession of the vehicle. A **health care building** is usually a building where occupants or consumers / patients are undergoing medical treatment and generally would need physical assistance to evacuate the building during an emergency.

Planning and development covers the facilities and physical environment of the organisation. It addresses how the organisation maximises the

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Performance indicators are used to evaluate and improve the safety and accessibility of the buildings / workplace and the safe and consistent operation of plant and equipment. (b) Incidents and hazards associated with building, plant, equipment, utilities, consumables and supplies are documented, evaluated and action is taken to reduce risk. (c) Repair costs and potential replacement costs are documented and evaluated. (d) The organisation regularly evaluates whether the signage meets community needs and makes necessary improvements.	(a) Performance indicators for the management of buildings, plant, equipment, utilities, consumables and supplies are measured and compared internally and with external systems and improvements made to ensure better practice. and / or (b) Signage and physical access are compared with available published standards and external data, and improvements are made, to ensure better practice.	(a) The organisation is recognised as a leader in the safe and consistent management and operation of: (i) buildings / workplaces (ii) plant (iii) equipment (iv) supplies (v) utilities (vi) consumables. (b) The organisation demonstrates it is a leader in signage systems and physical access.

safety, comfort and needs of the community it serves. The design and layout of the organisation's current, or planned physical environment should consider ergonomic and workplace design factors. In existing facilities, it can be difficult to redesign workspaces without major renovation, but there are a few points that can be considered:

- The use of walkways and passages for storage can cause accidents and mishaps.
- Use bench surfaces compatible with the task, a higher bench height for standing tasks and lower for seated.
- Make sure storage cabinets are secure.
- Step ladders are used for high places.
- Do not store anything heavy above chest height.
- Ensure easy access to emergency equipment and drug storage, keeping in mind that this should be kept from public access as well.

Details of relevant regulations and codes of best practice should be adhered to by the organisation in the design and layout of the physical environment. Procedures for workplace design / redesign,

3.2 SAFE PRACTICE AND ENVIRONMENT STANDARD

Criterion 3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

(Continued)

refurbishment and service planning should be documented. All buildings should comply with relevant legislation and building codes relating to fire safety.

The workplace may include **vehicles**. It is the responsibility of the organisation to safely maintain owned, operated or leased vehicles, as applicable. Issues to consider for the maintenance and operation of vehicles include:

- details of the vehicle
- documented processes for maintenance / service
- vehicle operators (including volunteers) job description identifies appropriate training and licence
- workplace non-smoking requirements[12]
- safe transport of consumers / patients[11]
- equipment transported is safely secured
- accidents are recorded as incidents
- OSH issues associated with vehicles are considered, for example seating, boot access, storage, manual handling[8].

Clear and accurate **signage** should be installed throughout the health care organisation. This relates to:

- access to the organisation
- hours of access
- after-hours access
- telephone numbers
- other health care organisations in the area, for example, nearest accident and emergency.

Signage inside the organisation should include:

- clear directions to particular areas
- warning of any hazards
- non-smoking signs / approved smoking areas
- exit signs.

The **plant, equipment and supplies** purchased by the organisation should support the provision of care and services, and protect the health and safety of consumers / patients, staff and others within the organisation. Effective planning and assessment of equipment may include reviewing the community's needs, involving staff who use the equipment and seeking opinions of those consumers / patients who use the equipment.

The process for the assessment of new plant, equipment and supplies prior to purchase should include:

- compliance with relevant legislative requirements, codes of practice, Hong Kong ordinances and regulations
- intended use and user and consumer / patient needs
- cost benefits
- safety, including manual handling
- infection control, including waste management issues[9,10,13]
- efficiency
- training needs
- storage and distribution.

Installation of equipment should be in accordance with the manufacturers' specifications, with the equipment appropriately tested and commissioned and any necessary licences obtained. Current information and scientific data from manufacturers relating to their products' requirements should be available for reference and guidance for both the operation and maintenance of plant and equipment.

The safe use of **electrically operated equipment** used in health care should be monitored in regard to electric shock, thermal, radiant and mechanical hazards. Organisations should follow Hong Kong legislation or may refer to AS/NZS 2500: *Guide to the safe use of electricity in patient care*, as well as any other relevant standards, guidelines and Hong Kong legislation.

Plant logs and maintenance processes should ensure equipment is maintained and serviced by people trained in maintenance of that equipment and in accordance with the manufacturer specifications and relevant standards including maintenance on high risk plant such as cooling towers and pressure vessels. Documented

processes for procurement, upgrading and replacing equipment, supplies and medical devices should be in place. The organisation may address the issues of planning, purchasing and provision through a comprehensive asset management system.

A program to address breakdown or any planned, deferred and / or outstanding maintenance requirements should be developed.

Specialised equipment should only be operated by trained staff to minimise the likelihood of injury and to obtain the best results.

The effective management of utilities is required to minimise risk of failure or internal or external emergencies. Policies should cover emergency and disaster management of utilities. Utilities include:

- water
- ventilation
- power, including emergency power (the provision of an emergency power supply should be appropriate to the needs of the organisation in the event of a failure of local supply)
- medical gases and suction systems
- communication systems, such as telephones, intercoms etc.

Supplies and consumables are generally commodities with a shorter life while in use than items that would remain in inventory after distribution or assignment for use. Supplies can be consumable goods, such as dressings, syringes, respiratory equipment, ostomy supplies, catheters and IV supplies and first aid supplies. There should be systems for storage, distribution of goods, control of inventory and implementation and use of safety-engineered medical devices that are safe, applicable to the size of the organisation and meet the needs of staff. There should be a system to manage recalled devices according to Department of Health recommendations.

Items designed for single use should not be reused unless the organisation has specific policies and guidelines for safe reuse incorporating relevant organisation requirements and codes of practice.

Organisations may provide evidence of achievement in this criterion through:

- risk ratings / assessment
- preventative maintenance plan, including deferred maintenance records
- preventative maintenance plan review
- systems for handling recalled devices
- incident reports
- evidence of disability and cultural needs identification
- policies on:
  - purchase and supply
  - buildings, plant, equipment, supplies, utilities and consumables
  - workplace design
- asset register
- contracts, including biomedical contracts
- results of mandatory plant equipment testing.

References

1. Buildings Ordinance (Cap 123).
2. Disability Discrimination Ordinance (Cap 487).
3. Electricity Ordinance (Cap 406).
4. Fire Services Ordinance (Cap 95).
5. Lifts and Escalators (Safety) Ordinance (Cap 327).
6. Medical Clinics Ordinance (Cap 343).
7. Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap 165).
8. Occupational Safety and Health Ordinance (Cap 509).
9. Prevention and Control of Disease Ordinance (Cap 599).
10. Quarantine and Prevention of Disease Ordinance (Cap 141).
11. Road Traffic Ordinance (Cap 374).
12. Smoking (Public Health) Ordinance (Cap 371).
13. Waste Disposal Ordinance (Cap 354).

SAFE PRACTICE AND ENVIRONMENT:
Standard, Criteria, Elements, Guidelines

Standard 3.2 The organisation maintains a safe environment for employees, consumers / patients and visitors.

Criterion	LA – Awareness	SA – Implementation LA plus the following
3.2.3 **Waste and environmental management** supports safe practice and a safe environment.	(a) There is an organisation-wide waste and environmental management policy. (b) Waste management streams are identified and signage is displayed. (c) Staff are instructed in and provided with information on their responsibilities in waste and environmental management. (d) External service providers comply with any requirements for the handling, transport and disposal of waste.	(a) There is a system to assess, separate, handle, transport and dispose of all waste streams. (b) Recycling, reducing and reusing processes support resource conservation and waste and environmental management. (c) Waste management systems are coordinated with Environmental Protection Department (EPD). (d) Controls are implemented covering identification, handling, separation and segregation of clinical, radioactive and hazardous waste and non-clinical waste. (e) Waste is managed with reference to any relevant: (i) Hong Kong ordinances and regulations (ii) state / territory legislation (iii) codes of practice (iv) industry guidelines.

These guidelines should be read in conjunction with criterion 1.5.2 on infection control.

The intent of this criterion is to ensure that health care organisations demonstrate responsible environmental practices in relation to waste management.

Health care organisations are accountable for their waste from the point of generation to final disposal. Changes in infection control have resulted in the increased use of disposable clinical products, thereby generating more waste. Due to these changes, it is even more important for organisations to identify the best strategies to minimise waste.

It is essential to segregate and dispose of clinical waste in a responsible manner in accordance with local legislation [1,2,5]. The assessment, handling, collection, transportation and disposal of waste should conform to:

- relevant statutory requirements
- codes of practice
- Environmental Protection Department (EPD) and Department of Health's (DH) requirements
- Waste Disposal Ordinance (Cap 354)
- Occupational Safety and Health Ordinance (Cap 509).

Strategic planning for **waste and environmental management** should consider the classification of waste, which can be clinical, chemical, radioactive, cytotoxic, recyclable, organic, liquid and general waste with appropriate signage.

Clinical, chemical, radioactive and cytotoxic waste is classified as **hazardous waste** and there should be an effective process for identification, handling,

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) The waste and environmental management system is evaluated and improved as required.	(a) Performance indicators for the management of waste are measured and compared internally and with external systems, and improvements	(a) The organisation is recognised as a leader in the safe and consistent management of waste.

separation and segregation of hazardous waste. The organisation should also consider meeting licensing requirements, staff training in waste management and the provision of personal protective equipment.

Waste minimisation strategies should be implemented where possible. The use of reusable items should be considered where it does not compromise consumer / patient safety and is suitable for the size and location of the organisation. A program of reuse, reduction and recycling should consider:

- safe use of equipment
- management of waste
- reporting faulty equipment
- specific staff training in all waste management processes.

The health care organisation has the responsibility to ensure waste is segregated and packaged correctly before **transportation off-site**. Reference should be made to the appropriate local ordinance and legislation

The reasons for strict policies and procedures in waste management are:

- for the protection of public health and safety
- to provide a safe work environment
- to minimise the environmental impact of waste generation treatment and disposal
- to reduce waste handling and disposal volumes / costs without compromising health care.

3.2 SAFE PRACTICE AND ENVIRONMENT STANDARD

Criterion 3.2.3 Waste and environmental management supports safe practice and a safe environment.

(Continued)

Organisations may provide evidence of achievement in this criterion through:

- policies and procedures on waste and environmental management
- waste identification strategies and evidence of their effectiveness
- waste reduction strategies
- waste promotion strategies
- results of waste audits
- evidence of staff education
- contracts with external service providers such as waste removal contracts
- waste management performance indicator reports.

References

1. Dangerous Goods Ordinance (Cap 295).
2. Dangerous Drugs Ordinance (Cap 134).
3. Occupational Safety and Health Ordinance (Cap 509).
4. Ozone Layer Protection Ordinance (Cap 403).
5. Waste Disposal Ordinance (Cap 354).

SAFE PRACTICE AND ENVIRONMENT:
Standard, Criteria, Elements, Guidelines

Standard 3.2 The organisation maintains a safe environment for employees, consumers / patients and visitors.

Mandatory Criterion	LA – Awareness	SA – Implementation LA plus the following
3.2.4 ***Emergency and disaster management*** *supports safe practice and a safe environment.* This is a Mandatory Criterion	(a) There is an organisation-wide policy for emergency and disaster management and business continuity. (b) Likely emergencies are identified and response and evacuation plans are prominently displayed. (c) Emergency practice / drill exercises including fire and evacuation are regularly conducted. (d) External service providers comply with the organisation's requirements for the prevention of emergencies. (e) Staff are educated and trained at orientation and annually in fire and evacuation. (f) There is documented evidence that an authorised external provider undertakes a full fire inspection of all premises at least once within each EQuIP cycle and in accordance with state / territory legislation	(a) There are systems for the management and coordination of any emergencies with reference to Hong Kong ordinance and guidelines and include triage and deployment of medical teams, where appropriate. (b) There is evidence that the systems to manage emergencies operate with reference to any relevant: (i) Hong Hong Standards / Guidelines (ii) Hong Kong ordinances and regulations (iii) codes of practice (iv) industry guidelines. (c) Communication systems are in place to handle any emergencies or disasters. (d) Internal and external emergency and disaster plans are developed and reviewed in consultation with relevant authorities. (e) Relevant staff have access to first aid equipment and supplies and are trained in their use. (f) There is a documented plan to implement the recommendations from the fire action plan. (g) There is an appropriately trained fire officer.

These guidelines should be read in conjunction with criterion 3.2.2 buildings and signage.

The intent of this criterion is to ensure that health care organisations have systems, policies and procedures in place that identify and manage potential emergency situations that may arise either internally or externally in terms of consequence, exposure, probability and preventative actions.

Organisations should demonstrate development and implementation of appropriate emergency response systems in consultation with relevant external emergency response organisations. All identified potential emergency risks should be communicated to all personnel within the organisation. Training, practice and preparation for internal / external disasters, with records of staff training and drills, should be maintained.

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Performance indicators are used to evaluate the emergency and disaster management systems and improvements are made as required. (b) Evaluation demonstrates staff training and competence in managing emergency procedures including evacuation.	(a) Performance indicators for emergency preparedness and disaster management are measured and compared internally and with external systems and improvements are made to ensure better practice. and / or (b) Innovative processes which prepare for any disaster are demonstrated by the organisation.	(a) The organisation is a recognised leader in the planning, development and management of systems for potential and actual emergencies and disasters.

External disaster planning and management are based on the organisation's capabilities. Planning will include consultation with community partners and testing of major emergency plans.
When planning external disaster management, the following issues should be considered:

- type of disaster
- effective communication internally and externally
- of adequate basic utilities and supplies – gas, water, food, electricity, essential medical support and materials
- assignment of staff to specific tasks and responsibilities
- efficient system of notifying staff
- defined authority and control
- availability of an emergency control centre

3.2 SAFE PRACTICE AND ENVIRONMENT STANDARD

Criterion 3.2.4 *Emergency and disaster management* *supports safe practice and a safe environment.*

(Continued)

- conversion of all appropriate space into clearly defined areas for efficient triage, casualty observation and for immediate care
- preparations, including decontamination, for special categories of patients
- transport arrangements for casualties
- rehearsal of strategies and periodic review of plans.

Examples of **external disasters**,

- severe weather, such as flooding and / or typhoon
- hill fire
- shipping or major transport accident
- power failure
- human epidemic
- terrorist attack.

All organisations will have some roles in external disaster planning, although these roles will vary depending on the size and location of the organisation. For example, a large public hospital would have emergency procedures in place for those disasters listed above. For some small rural organisations, a traffic accident with multiple injuries may also require activation of their disaster plan.

Private hospitals may also be involved in a disaster response as a result of agreements with the public hospital system. Their contribution may include the provision of supplies, staff, vehicles, as well as the use of physical space as a relocation point for consumers / patients and / or family / familial. Community health organisations may only be required to provide support. All organisations should ensure that any role is clearly defined.

Examples of **internal emergencies** include:

- failure of essential services such as an internal power failure
- hazardous substances incident
- outbreak of infection
- fire / smoke
- medical emergency
- staffing emergency caused by for example, flu epidemic
- bomb threat
- personal threat / violence.

The following points may be useful in developing a coordinated plan in response to potential emergencies:

- use of coding for emergencies in line with local standards
- identification of key responsibilities and accountabilities
- specification of division of duties in an emergency
- development of critical operating procedures
- development of a communication infrastructure
- development of a crisis response infrastructure
- ensuring the availability of appropriate drugs, supplies and equipment for various medical emergencies to assist a rapid and effective response
- development of plans for the deployment of medical teams, if appropriate
- development of an evacuation plan and procedures, including drills and debriefing processes
- regular training and exercises for a range of potential threats
- in some situations, specific hazards will warrant the development of specific plans for inclusion in the emergency plan such as chemical, biological or radiological events.

Fire safety should be effectively managed so that consumers / patients, staff and others are not at undue risk. Emergency and evacuation plans and procedures should be made known to all staff and prominently displayed.

Each organisation should develop an appropriate **fire / internal disaster plan** and specific policies and procedures, to cover all people and all areas of the organisation, covering:

- identification of fire and explosion risks
- fire safety and preventive strategies

- fire and explosion emergency procedures for preparedness, response and recovery
- raising the alarm
- effective arrangements for a fire response team(s)
- an emergency communication system (including methods for activating external services such as fire fighting authorities, ambulance etc)
- assignment of personnel to specific tasks and responsibilities
- information readily available for staff throughout the organisation
- emergency services
- fire fighting response
- evacuation from all parts of the building
- regular fire drills, staff training / education, evacuation drills.

Records of staff attendance at fire drills and training sessions should be kept and the non-attendance reasons identified and actioned. Fire drills and training sessions should cover all sites, shifts and staff categories of the organisation.

Plans should be reviewed and revised annually. The inspection and testing of fire / explosion emergency equipment should comply with relevant statutory requirements, codes of practice and Hong Kong ordinances and regulations. A formal risk control inspection and maintenance system should exist for all detection, alarm and extinguishing equipment.

The organisation should have documented evidence of a **full fire inspection** from an authorised internal or external fire authority such as a certified Fire Authority. An inspection should be performed at least once within each EQuIP cycle and in the event of a major building alteration, development or service alteration. There should be documented response to recommendations made by the fire authority setting out the action already taken or proposed by the organisation, the rationale on which it is based, and the planned timetable for compliance. The timetable should show evidence of priority being given to:

- recommendations which have a direct bearing on issues of consumer / patient safety
- eradication of significant fire hazards
- early compliance with recommendations that are readily achievable.

There should be documented evidence of approval from the fire authority in relation to new buildings, works, and /or alterations. The organisation should ensure compliance with approved fire and alarm detection systems throughout the facility. Fire fighting equipment should be located appropriately and meet relevant standards for testing and maintenance.

Designated **fire safety officers** appropriate to the size and type of organisation should have undertaken appropriate training and have clearly defined accountability and responsibility.

Organisations may provide evidence of achievement in this criterion through:

- disaster management plan
- policies, including information on both internal and external emergencies
- appointment of personnel in the event of a disaster for example fire officers or wardens
- staff education including:
  - fire training
  - CPR training
- evidence of full fire inspection
- annual essential services reports.

References

1. Centre for Health Protection http://www.chp.gov.hk/index.asp?lang=en
2. Prevention and Control of Disease Ordinance (Cap 599).
3. Dangerous Drugs Ordinance (Cap 134).
4. Dangerous Goods Ordinance (Cap 295).
5. Electricity Ordinance (Cap 406).
6. Fire Services Ordinance (Cap 95).
7. Lifts and Escalators (Safety) Ordinance (Cap 327).
8. Pharmacy and Poisons Ordinance (Cap 138).
9. Radiation Ordinance (Cap 303).

SAFE PRACTICE AND ENVIRONMENT:
Standard, Criteria, Elements, Guidelines

Standard 3.2 The organisation maintains a safe environment for employees, consumers / patients and visitors.

Criterion	LA – Awareness	SA – Implementation LA plus the following
3.2.5 **Security management** supports safe practice and a safe environment.	(a) There is an organisation-wide security policy. (b) Major security risks are identified. (c) Staff are educated and provided with information in relation to security risks and responsibilities. (d) External service providers are supplied with relevant information and comply with the organisation's security controls.	(a) There is an organisation-wide system to assess security risks, determine priorities and eliminate risks or implement controls. (b) The system to manage security risks and violence and aggression prevention operates with reference to any relevant: (i) local legislation (ii) codes of practice (iii) industry guidelines. (c) There is an organisation-wide violence and aggression prevention program. (d) Service planning includes strategies for security management. (e) Staff are consulted in decision making that affects organisational and personal risks. (f) Security management plans are coordinated with relevant external authorities.

These guidelines should be read in conjunction with criteria 2.2.5 employee support systems and 2.3.4 information and computer technology.

The intent of this criterion is to ensure that health care organisations plan and manage the security of staff and visitors, buildings and other assets.

The following should be considered within this criterion:

- security and safety of consumers / patients, staff and visitors
- security of information
- security of staff off-site, such as on home visits
- security in geographically remote areas or in isolation
- security of personal belongings
- security of assets
- security of pharmaceuticals
- security of payroll
- defined responsibilities for management and staff and delegated responsibility for the security system
- security assessment as required by local guidelines. Security can be divided into four broad areas:
    - personal security
    - physical security
    - logical security
    - procedural security

Personal Security includes pre-employment checking and human resources policies and procedures. Relevant credentials should be provided by all staff and copies kept in personal

MA – Evaluation SA plus the following	EA – Excellence MA plus the following	OA – Leadership EA plus the following
(a) Performance indicators are used to evaluate the security management system and improvements are made as required. (b) The violence and aggression prevention program is evaluated and improved as required.	(a) Performance indicators for security and violence and aggression prevention management are measured and compared internally and with external systems, and improvements are made to ensure better practice. and / or (b) The organisation demonstrates through performance indicators that security and violence and aggression prevention systems ensure that security breaches and incidents are minimal.	(a) The organisation is recognised as a leader in the development and implementation of systems for the management of security risks and violence and aggression prevention.

staff records. Self declaration of criminal record is required in all applications for annual practicing certificates.

Organisations should have in place an effective risk management plan to address violence and aggression in the workplace. The focus should be on prevention, however when a violent incident does occur, action should be taken to minimise its impact and prevent its recurrence as far as possible, regardless of its source. Identification should be worn by all staff including volunteers. Identification should consider visibility, culture, safety, security and customer focus.

Violence and aggression involve any incident in which an individual is abused, threatened or assaulted and includes verbal, physical or psychological abuse, threats or other intimidating behaviours, intentional physical attacks, aggravated assault, threats with an offensive weapon, sexual harassment or sexual assault.

Organisations should have in place a **violence and aggression prevention program**. This program should include:

- policies addressing zero tolerance, internal violence, aggression and bullying between staff at all levels as well as visitors
- a focus on the elimination of violent behaviour and where risks cannot be eliminated, they should be reduced to the lowest possible level
- control strategies for violence and aggression developed in consultation with staff
- protocols for reporting violent incidents
- a working environment that supports zero tolerance and management commitment to the program

3.2 SAFE PRACTICE AND ENVIRONMENT STANDARD

Criterion 3.2.5 Security management supports safe practice and a safe environment.

(Continued)

- staff education about responding to violent situations.

Zero tolerance should be adopted. This means that in all violent or aggressive incidents, appropriate action will be taken to protect staff, patients and visitors from the effects of such behaviour. Management should demonstrate its support for zero tolerance to all levels of staff through a commitment to education, training and an effective response when incidents are reported.

Physical security includes alarms, guards, lighting, locks, safes, closed circuit television (CCTV) etc. The health care organisation should have a policy addressing safe working conditions. This should ensure lighting is adequate for the area, such as car parks, corridors, access paths and storage areas. Access controls to specific areas, including locks on drug storage areas, reduced face to face contact during supply of pharmaceuticals, designated escape routes and swipe cards to access staff working areas can improve the physical safety of staff. Where CCTV is in use, a large sign indicating that the site is being continuously monitored should be displayed.

Effective communication systems, especially when staff are working away from a fixed base, should be established. This can be in the form of mobile phones or radio contact with arrangements for regular contact with the organisation and teams when visiting patients in unsecured areas or off-site.

Logical security are security features that are built into communications, information technology (IT) and other information management (IM) systems. Further information on logical security can be found in criterion 2.3.4 information and computer technology.

Procedural security concerns the policies and practice guidelines in place to provide an environment which enhances safety. The procedures developed in any organisation should be understood, with relevant staff training provided where necessary. A mechanism to guarantee that policies and procedures have been read and understood should be in place. This can be in the form of a register or part of the annual review of key performance indicators.

Security and patient safety are key concerns in any health care organisation. The integrity of policies and procedures can only be assured by the methods employed to train staff in current procedures and continuously reviewing and updating those procedures as required following consultation with staff.

Organisations may provide evidence of achievement in this criterion through:

- evidence of pre-employment checks
- identification of security risks and plans to manage those risks
- security audits
- evidence of violence and aggression prevention plans
- reported incidents and actions taken on:
  - aggression
  - thefts
  - breeches of secure areas
- policies and procedures
- evidence of staff training
- privacy audits
- property and property check audits
- security licences.

References

1. Office of the Privacy Commissioner for Personal Data, Hong Kong http://www.pcpd.org.hk/
2. Personal Data (Privacy) Ordinance (Cap 486).
3. Occupational Safety and Health Ordinance (Cap 509).
4. Telecommunications Ordinance (Cap 106).

5. Electronic Communication Policies http://ha.home/circular2/IT-01-05.pdf
6. Hospital Authority Bylaws 6-10 (Cap 113A).
7. Hospital Authority Workplace Violence Policy.
8. Pharmacy and Poisons Ordinance (Cap 138).
9. Security and Guarding Services Ordinance (Cap 460).
10. Crimes Ordinance (Cap 200).

6. Glossary 詞彙

access 便捷	ability of clients or potential clients to obtain required or available services when needed within an appropriate time [1] 服務使用者在適當時間內得到所需服務 [1]
accreditation 認證	public recognition of achievement by a health care organisation, of requirements of national health care standards [2] 社會認同一家醫療機構能達到本地認可的醫療標準 [2]
advance care plan / directive 預定醫療指示	instructions that consent to, or refuse, the future use of specified medical treatments. It becomes effective in situations where the patient no longer has the capacity to make treatment decisions [3] 同意或拒絕接受用某些指定醫療方法的意向指示。當病人沒有能力作出醫療決定後，指示才會生效 [3]
adverse event 不良事件	an incident in which unintended harm resulted to a person receiving health care [4] 對接受醫療服務的人無意地造成傷害的事件 [4]
adverse reaction 不良反應	where the correct process was followed for the context in which the event occurred but unexpected and unpreventable harm resulted [4] 跟從正確的程序（治療），但卻造成意料不到和無法預防傷害的事件
aggregation 聚集	to collect, form into a unit 群集而組成一個單位
agreement 協議	a mutually agreed arrangement describing the scope for cooperative ventures between parties and documenting relevant responsibilities 雙方經協商制定的安排，記錄及說明合作範疇及相關責任
analysis 分析	presentation of the essential features into simple basics, such as a summary, outline or identification of the essence of an issue 以摘要、大綱或識別來展示事物的基本特點
appropriate 恰當	care, intervention or action provided is relevant to the consumer / patient needs and based on established standards [4] 遵照既定標準、提供服務使用者／病人需要的護理、介入治療或程序 [4]
appropriateness 合適性	doing the right treatment, intervention or service in the right way 以正確方式進行正確的治療、介入治療或服務
articles of association 機構章程	a document in which the internal structure and functions of an organisation are defined 闡述機構內部結構和功能定義的文件
assessment 評估	process by which the characteristics and needs of clients, groups or situations are evaluated or determined so that they can be addressed. The assessment forms the basis of a plan for services or action [1] 評量或決定不同客戶、群組與情況的特點和需要，以便進行適當處理。評估是服務或行動計劃的基礎 [1]

6. Glossary 詞彙

Australian standards 澳洲標準	national standards developed by Standards Australia or any other recognized body 由「標準澳洲」（Standards Australia）或其他認可機構制定的國家標準
availability 可用性	information being accessible and useable in the required way in a timely manner 及時提供有用及切合需要的資訊
availability management 可用資訊系統	a mechanism for ensuring IT systems are available when required 確保有需要時能夠運用資訊科技系統的機制
benchmark 基準	a criterion against which something is measured [4] 衡量事情的準則 [4]
benchmarking 基準分析	The continuous measurement of a process, product, or service compared to those of the toughest competitor, to those considered industry leaders, or to similar activities in the organisation in order to find and implement ways to improve it. This is one of the foundations of both total quality management and continuous quality improvement. Internal benchmarking occurs when similar processes within the same organisation are compared [5] 持續將產品／服務與最強的競爭對手、行業領袖或機構內進行比較，然後落實改進措施。此為「全面質素管理」和「持續質素改進」的基礎。內部基準分析則是比較機構內部同類運作過程 [5]
best practice 最佳實踐	the way leading edge organisations manage the delivery of world class standards of performance in all aspects of their operations. The concept of continuous improvement is integral to the achievement of international best practice 具領先地位及達世界級水準的機構各業務管理方式，「持續改進」是達至國際最佳實踐不可或缺的部份
business plan 工作規劃	the current action plan for achieving organisational goals, capacities, abilities, resources, assets and strengths of groups or individuals to deal with situations and meet their needs [1] 機構為實現目標所制定的行動計劃，涵蓋機構的服務量、能力、資源、資產，加強團隊／個人應付不同情況的能力 [1]
by-laws 附則	rules, regulations or legislation adopted by the organisation for the regulation of both its internal and external affairs 機構為規管機構內外事務所採用的法規、規章或法例
CALD	culturally and linguistically diverse 文化和語言多樣性
care plan 治理計劃	a written statement developed for an entitled person/s which states the nursing and other interventions to be undertaken, the health outcomes to be achieved and the review of care which will occur at regular intervals [6] 為合資格人士擬定的書面記錄，列明將會提供的治理和其他介入治療、其成效及須定期進行的覆核 [6]

6. Glossary 詞彙

carers 照顧者	those who care for the consumer / patient who are not members of the health care team 照顧服務使用者／病人的非醫療人員
change management 變更管理	the process of managing the effective implementation of organisational strategies, ensuring that permanent changes in goals, behaviours, relationships, processes and systems are achieved to the organisation's advantage. It is the key competence required for managing all strategic initiatives 有效落實機構策略方針、確保恆久改變機構的目標、行為、關係、程序和操作系統以增強機構優勢，此為管理機構所有策略計劃的關鍵
classification system 分類系統	a system of codes, from a set of defined categories, which are used to categorise activity in a consistent and systemised way 以一組既定的類別代碼系統，將活動有系統和一致地分門別類
clinical audit 臨床稽核	the process of reviewing the delivery of care against known or best practice standards to identify and remedy deficiencies through a process of continuous quality improvement [4] 辨識治理服務的不足之處，並通過「持續質素改進」及參照「最佳實踐標準」作出改善 [4]
clinical classification 臨床分類	the process of translating data, such as diseases, conditions, injuries and interventions, from a consumer / patient record into a coded format using a relevant classification system 用相關的分類系統，將病人的數據，例如疾病、狀態、傷患和介入治療轉成編碼格式
clinical governance 臨床管治	a framework through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish [7] 是一套管理框架，機構藉以提供可促進卓越臨床服務的環境，並承擔持續改進服務質素和維護高水準服務的責任 [7]
clinical handover 臨床交接	the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients to another person or professional group on a temporary or permanent basis [8] 將照顧一位或一組病人的部分或全部專業治理責任，暫時或長期轉移至另一專業人員或團體 [8]
clinical indicator 臨床指標	a measure of the clinical management and outcome of care; a method of monitoring consumer / patient care and services which attempts to 'flag' problem areas, evaluate trends and so direct attention to issues requiring further review 用以量度臨床管理和護理成效，也是監察服務使用者／病人照顧與服務的方法，從而「標識」不足之處，分析發展趨勢並對焦在需要進一步檢討的問題上

clinical pathway 臨床路徑	sometimes called care maps, a patient management tool that organises, sequences and times the major patient care activities and interventions of the entire interdisciplinary team for patients with a particular diagnoses or procedure [9] 有時亦稱「護理藍圖」，是跨專科小組的病人管理工具。利用這套工具安排某些接受特別診斷／程序病人在適當時候接受主要治理和介入程序 [9]
clinical privileges 臨床特權	the scope of clinical practice which a health professional is authorised to undertake within an organisation (Also see D – Defining the scope of clinical practice) 醫療專業人員獲授權在機構內執行的臨床作業範圍（參照 D 部－定義臨床實踐範圍）
Clinician 臨床醫療人員	a health professional, such as a medical doctor, allied health professional, or nurse, involved in clinical practice 執行臨床作業的醫療專業人員如醫生、專職醫療人員或護士
code of practice 執業守則	a document prepared for the purpose of advising employers and workers of acceptable ways of achieving declared national standards [10] 為僱主與僱員編撰的文件，建議達致本地認可標準的可行方法 [10]
community 社區	people who live in a defined geographic locality and / or who share a sense of identity or have common concerns 住在特定地區及／或具同樣身份認同感或有共同關心事物的人
competence 勝任能力	guarantee that an individual's knowledge and skills are appropriate to the service provided and assurance that the knowledge and skill levels are regularly evaluated [1] 保證個人知識和技術切合其所提供的服務，確保定期評核其知識和技能水平 [1]
complaint 投訴	an expression of dissatisfaction with something 就某件事情表達不滿
confidentiality 機密性	the restriction of access to personal information to authorised persons, entities and processes at authorised times and in an authorised manner 限制只有獲授權的人士、實體和程序，在授權的時間，以獲授權的形式取得個人資料

6. Glossary 詞彙

consent 同意書	In this document consent covers a number of different legal requirements: 同意書涵蓋多項法律要求： • the patient must be informed in broad terms the nature of any invasive procedure which is performed on the patient. This consent operates as a defence in medico-legal action 必需以描述淺白的文字告知病人任何對其施行的侵入性程序。同意書在醫學法律程序中可作為辯護 • the patient must be informed of material risks inherent in the procedure or treatment. This is part of the duty of care owed to the patient by an appointed medical practitioner who treats the patient. 必須告知病人程序或治療的風險，這是主診醫生對病人應盡的責任 • consent to collection of health information, and to any use of that information or disclosure by the organisation to third parties, is required under Commonwealth and any applicable State or Territory privacy law requirements 根據聯邦法及任何適用的國家或領土私隱法，同意收集和使用健康資料，或讓機構向第三方披露該等資料 註釋：香港的相關條例是【 個人資料 (私隱) 條例 】 • informed financial consent of the patient 病人的財政知情同意書
consent, acknowledgement of 同意書、確認	in the absence of a completed consent form, an acknowledgement of consent form should be present in the health record, signed by the consumer / patient and the treating physician, stating that the proposed treatment, the benefits and risks 在沒有完整的同意書的情況下，醫療記錄內必須包含一份由服務使用者／病人簽署的同意確認文件，主診醫生須在文件中列明建議採用的治療方法、效益和風險
consumer / patient 服務使用者/ 病人	people who directly or indirectly make use of health services [11] 間接或直接使用醫療護理服務的人 [11]
continuity of care 持續護理	the provision of care, coordinated amongst all care providers, in various settings, spanning all phases of the cycle of care including access and entry; assessment; care planning, delivery and evaluation; and separation 由不同類別的醫療服務提供者，互相協調提供的護理服務，服務可在各種環境進行，橫跨不同階段的治療週期（包括入院、評估、護理規劃、治療和評估、離院）
contract 合約	a mutual agreement between two or more competent parties that creates a legally supportable obligation to do or not do something specified 由兩個或多個有能力作出決定的單位為完成（或不完成）某指定事項而共同簽署的具法律效力的協議
coordinate 協調	to bring together in a common and harmonious action or effort. Bring in to order as parts of the whole 為共同行動協力調和，使整體一致
corporate governance 機構管治	understood to be the system by which organisations are directed and controlled and held to account [12] 指揮和監管機構並使其有承擔的管理系統 [12]

credentialed 獲得資格認可	authorised to provide specific consumer / patient care and treatment services, within defined limits, based on an individual's license, education, training, experience and competence 授權在指定範圍內，根據個人專業執照、教育、訓練、經驗和能力，為指定的服務使用者／病人提供治理
credentialing 資格認可	the process of assessing and conferring approval on a person's suitability to provide a defined type of health care (can be synonymous with clinical privileging) 評定和賦予個人提供特定醫療治理服務的資格（亦可稱為「臨床特許權」）
criteria 準則	key components of the standard, that are necessary for meeting the standard; for example, planning care with patients, families and carers and working in partnership with them to achieve the best possible results 「標準」的主要組成部份，為符合「標準」要求所必須實踐的部份，例如與病人、家人和照顧者共同商討醫療計劃，達到最佳療效
cultural appropriateness 文化合適度	the design and delivery of services consistent with the cultural values of clients who use them [1] 為客戶設計和提供的服務需貫切其文化價值 [1]
culture 文化	a shared system of values, beliefs and behaviours [1] 一套共享的價值、信仰與行為系統 [1]
data 數據	unorganised facts from which information can be generated 未經處理整合的事實，經處理後可成為資訊
data collection 數據收集	a store of data captured in an organised way for a specific defined purpose 為特定的目的，搜集數據，並將之儲存
data integrity 數據完整性	accuracy, consistency and completeness of data 數據準確、一致與完整
data security 數據保安	protection of data from intentional or unintentional destruction, modification or disclosure 保護數據免受有意或無意的破壞、改動或披露

6. Glossary 詞彙

defining the scope of clinical practice 界定臨床作業範圍	the process that follows on from credentialing and involves delineating the extent of an individual health professional's clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability, and the needs and the capability of the organisation to support the health professional's scope of clinical practice. 評定資格認可之後的下一步程序；如何界定醫療專業人員在特定機構的臨床作業範圍，取決於其個人資格、能力、表現與專業合適度，以及機構的需要和支援該醫療專業人員臨床作業的能力 Note: this term is preferred to clinical privileging, which creates an undesirable perception of a unilateral conferral of a benefit by an organisation, and fails to suggest a strong, mutual relationship between the employing or contracting organisation and each health professional, centred on the safety and quality of the health care services provided [4] 此項有人稱之為「臨床特許權」，不過這名稱並不理想，因為容易令人誤會這是由機構單方面授與，此外，亦未能帶出有關機構和醫療人員以醫療服務及質素為中心的鞏固互信關係 [4]
developmental criterion 發展準則	a criterion introduced to organisations for the purpose of creating awareness and for commencing collaborative national action in a specific area of quality in health care 為機構引入此準則，在特定的醫療服務領域開展全國協作，增強機構在這方面的意識
disaster recovery 災難復元	a disaster recovery strategy is a set of pre-determined procedures that provides for substitute operations and a quick return to normal after any disruption 災難復元策略是一組預設程序，在服務中斷後執行替代運作系統，並盡快恢復正常運作
discharge and transfer 出院及轉院	The terms discharge and transfer include discharge from the organisation or service (routine or at own risk) and / or death, or transfer between providers or units 【出院及轉院】包括離開醫療機構或服務（常規或自承風險）及/ 或死亡，或者是轉移到不同機構或部門
dissemination 散播	Distribution 分佈
documentation 記錄	process of recording information in the health record and other documents that are a source of information; a written, tangible record of care and services provided 把資訊記錄在健康記錄或其他作為資訊來源的文件的過程；是有實體的醫療或服務提供的書面記錄
document control system 文件管理系統	a planned system for controlling the release, change and use of important documents within the organisation, particularly policies and procedures. The system requires each document to have a unique identification, to show dates of issue and updates and authorisation. Issue of documents in the organisation is controlled and all copies of all documents are readily traceable and obtainable [1] 規劃機構內控制發放、改變和使用重要文件系統，尤其是就政策和程序而言。系統為每份文件建立獨有標籤，顯示建立日期、更新和權限。此系統負責管理機構發行文件，方便追查及取得所有文件副本 [1]

education 教育	systematic instruction and learning activities to develop or bring about change in knowledge, attitudes, values or skills [1] 有系統的指導及學習活動，以發展或帶來知識、態度、價值和技術轉變 [1]
effective 有效	Producing the desired result 產生預期效果
effectiveness 有效性	the extent to which a treatment, intervention or service achieves the desired outcome 一項治療、介入或服務達致預期效果的程度
efficiency 效率	achieving desired results with most cost effective use of resources 以最具成本效益的資源運用方式達致預期效果
electronic records 電子檔案	records communicated and maintained by means of electronic equipment [14]. Electronic records allow rapid, simultaneous access to records by multiple users, electronic clinical and administrative processes, and electronic information for clinical and administrative decision making 使用電子設備傳送及保存記錄 [14] 電子檔案操作快捷，容許多個使用者同步取得記錄、亦使臨床與行政程序電子化。電子資訊亦有助臨牀與行政的決策
elements 元素	identifies what should be in place to achieve the criterion at a certain rating level. It is a description of what is required to achieve the criterion. They provide prompts for improvement and best practice 辨識要達致準則特定水平所需要注意的事項。描述準則要求，提示改進方法和最佳實踐
employee assistance program 員工援助計劃	a strategy for assisting employees and their families with personal and work related problems, difficulties and concerns which they may experience from time to time. These problems, difficulties and concerns can and do affect the work performance of an employee 協助員工及其家屬處理個人和工作相關問題和困難。這些問題和困難確實會影響員工工作表現
entry 進入	a process by which a consumer / patient comes into a health care organisation to receive health care services 服務使用者／病人進入醫療治理機構接受醫療服務
environmental sustainability 環保方面的可持續性	the goal of minimising detrimental effects to the natural environment through an efficient use of resources 透過有效運用資源，盡量減少對自然環境的傷害

6. Glossary 詞彙

error 錯誤	unintentionally being wrong in conduct or judgement. Errors may occur by doing the wrong thing (commission) or by failing to do the right thing (omission) [2] 無意之下做出錯誤的行為判斷，或是做錯事、違規或沒有做正確的事（疏忽）[2]
ethics 倫理	acknowledged set of principles which guide professional and moral conduct 引領專業操守和道德標準的公認原則
evaluation 評估	judging the value of something by gathering valid information about it in a systematic way and by making a comparison. The purpose of evaluation is to help the user of the evaluation to decide what to do, or to contribute to scientific knowledge [16] 透過系統性收集有效資訊並作出比較，衡量事物／事情的價值。評估的目的是為了幫助使用者決定應該採取的行動，亦可能在科學知識層面作出貢獻 [16]
evidence 證據	data and information used to make decisions. Evidence can be derived from research, experimental learning, indicator data, and evaluations. Evidence is used in a systematic way to evaluate options and make decisions [1] 用於決策的數據和資料。證據來自科研、實驗性學習、指標數據和評估，系統化地運用來評量各種選擇和作出決定 [1]
external entity 外部實體	a body / establishment external to the organisation 機構以外的團體／企業
externally based references 外部參考資料	reference and research information generated outside the organisation, such as journals, internet information, research databases, library resources, etc 來自機構以外的參考和研究資料，如期刊、網絡資訊、研究數據庫、圖書館資源等
familial 家庭	term used to describe families of choice, rather than traditional families, for example: same sex partners 泛指家庭的或家庭有關的
feedback 反饋	a communication from a consumer / patient relaying how delivered products, services and messages compare with consumer / patient expectations 服務使用者／病人對產品／服務的期望與實際進行比較的意見
follow-up 跟進	processes and actions taken after a service has been completed [1] 服務完成後的程序和行動 [1]
formalised follow-up 正式跟進	documented processes and actions after a service has been completed 服務完成後有記錄的程序和行動

governance 管治	the system by which organisations are directed and controlled. It ensures the power of organisations is harnessed for the agreed purpose. Governance spells out the rules and procedures for making decisions on organisational affairs [1] 指揮和控制機構的機制，確保機構權力運用事先議定的目的。【管治】亦闡明就機構事務決策的規則和程序 [1]
governing body 管治機關	the individual or group of individuals that has the legal responsibility for the organisation. It may refer to a board of directors, owner / manager, management committee, or the board of an area health service, local health authority or network 為機構承擔法律責任的個人或團體，可能是董事會，所有人／經理、管理委員會、董事會或某地區的衛生服務委員會、當地衛生部門或網絡
goals 目標	broad statements that describe the outcomes an organisation is seeking and provide direction for day-to-day decisions and activities. The goals support the mission of the organisation [1] 為機構期望達致成果的廣泛聲明。也為機構日常決策和工作訂定整體方向。使命為本，目標為輔 [1]
guidelines 指引	principles guiding or directing action. The guidelines in the EQuIP 4 Guide provide essential information for the achievement of the EQuIP 4 standards 行動的指揮或引導的原則。評估及質素標準改進大綱提供達致 EQuIP 4 標準的必要資料
hazard 危害	a circumstance or agent that can lead to harm, damage or loss [2] 可能導致傷害、損害或損失的情況或媒介 [2]
health care 醫療護理	services provided to individuals or communities to promote, maintain, monitor, or restore health. Health care is not limited to medical care and includes self-care [4] 為個人或團體提供的服務，以促進、維護、監察或恢復健康。健康護理不只限於醫護人員提供的護理，也包含自我照顧 [4]
health care provider 醫療保健提供者	staff or individuals who, in cooperation with the consumer / patient, assume responsibility for all aspects of care in response to the diagnosis and needs of the consumer / patient 整體或個別員工，與服務使用者／病人合作，按照診斷結果和服務使用者／病人需要，承擔照顧他們的各方面的責任
health priority areas 健康優先領域	the National Health Priority Areas initiative is a collaborative effort involving the Commonwealth Government and State and Territory Governments that seeks to focus public attention and health policy on those areas that are considered to contribute significantly to the burden of illness in the community, and for which there is potential for health gain [17] 國家衛生優先領域倡議由聯邦政府和地區政府共同協作，將公眾關注和衛生政策的焦點集中於那些加重社會疾病負擔，及促進健康的領域 [17]

6. Glossary 詞彙

health record 健康紀錄	term to cover client record, medical record, care record, health care record or record that documents care or service to a consumer / patient. A health record is a legal document that outlines the total needs, care and management of consumers / patients 涵蓋客戶檔案、病歷、護理記錄、醫療記錄或記錄服務使用者／病人護理或服務的文件。健康記錄是法律文件，概述服務使用者／患者的需求、護理和管理
health workforce 醫療員工	refers to the workforce that provides health care to consumers / patients; ranging from workers with no formal qualifications providing support services in home-based settings through to highly qualified specialists working in technology intensive super-acute hospital settings 為服務使用者/ 患者提供醫療服務的員工，包括在家居環境中提供支援服務的沒有正式資格的員工，以至在技術密集的超急性機構環境中工作的高資歷專家
homeward outlier patient 病房異常患者	one who is being treated in an area of the health service that normally treats a different casemix; for example a patient with a medical condition such as diabetes may be admitted to a surgical ward because of a lack of available medical beds [1] 在非其所屬病例組合的病房接受治療的病人，例如一位糖尿病患者可能因為病床不足而需入住外科病房 [1]
human resources 人力資源	the personnel requirements of the organisation [1] 機構的員工需求 [1]
ICD – 10 – AM	International Classification of Diseases, 10th Revision, Australian modification 國際疾病分類第十次修訂（澳洲修編）
improving performance 提升表現	continuous study and adaptation of processes in order to achieve desired outcomes and meet the needs and expectations of customers 不斷學習和適應服務程序，以達到預期成果，滿足客戶的需求和期望
incident 事件	an event or circumstance which could have or did lead to unintended and / or unnecessary harm to a person, and / or complaint, loss or damage [4] 可能或已經對個人產生意想不到或不必要的傷害，或引發投訴、損失或損害的事件或情況 [4]
include(s) 包括	a list that provides examples and is not limiting 列舉例子，但不限於所列的
indexing 索引	the arrangement of data to allow retrieval and analysis 安排數據的方法，方便檢索和分析

indicator 指標	performance measurement tool, screen or flag that is used as a guide to monitor, evaluate, and improve the quality of services. Indicators relate to structure, process and outcomes [1] 是量度表現的工具、篩選或標籤，是監測、評價和提高服務品質的指引。指標與結構、過程和結果有關 [1]
infection control management plan 感染控制管理計劃	a documented plan to prevent or minimise the risk of infection, in relation to a declared health service for persons receiving services at the facility, persons employed or engaged at the facility and other persons at risk of infection at the facility [18] 防止或盡量減低感染風險的計劃，對象是在某設施內接受服務的病人、受雇員工或工作人員，以及其他有感染機會的人 [18]
information 信息	data elements that have been organised, analysed and provide a basis for decision making 經過處理分析的數據元素，能夠作為決策的依據
information management 信息管理	the process of planning, organising, analysing and controlling data and information. The management of information applies to both computer based and manual systems 規劃、組織、分析和控制數據與信息的過程。信息管理包含電腦與人手系統
information privacy 信息隱私權	the right of a person to control the use and disclosure of information that personally identifies them 任何人控制使用和披露其個人身份信息的權利
information system 信息系統	a system that provides access to information using hardware, software, supplies, policies, procedures and people [14] 運用硬件、軟件、支援產品、政策、程序和人手獲取信息的系統 [14]
information technology 信息技術	mechanical and electronic devices designed for the collection, storage, manipulation, presentation and dissemination of information 收集、儲存、操縱、展示和傳播信息的機械和電子設備
integrity 完整性	the characteristic of data and information being accurate and complete 數據和資料準確而完整
interoperability 相互可操作性	the ability of discrete computer-based systems to interact as if they were one system; often used to indicate that discrete systems can share or exchange information 分散的電腦系統之間的互動能力，令不同系統運作有如屬於同一系統，通常用於表達不同電腦系統之間能夠分享或交換信息

6. Glossary 詞彙

intervention 介入干預	an activity or set of activities aimed at modifying a process, course of action or sequence of events, in order to change one or several of their characteristics such as performance or expected outcome [19] 改變（治療）程序、行動或系列事件的單一或一組行動，以便改變一個或多個特點，如服務表現或預期結果 [19]
IT cost management 資訊科技成本管理	a mechanism to manage IT costs 管理資訊科技成本的機制
IT security 資訊科技安全	a tangible set of physical and logical mechanisms which can be used to protect information held in hard copy, computer systems and information and telecommunication infrastructure, from unauthorised access 有形的物理與邏輯機制，用於保護印刷文件、電腦系統以及信息與電子通訊設施中儲存的資訊，避免經未獲授權的途經泄露出去
IT system 資訊科技系統	a group of interacting, interrelated or interdependent elements forming or regarded as forming a collective entity 一組相互作用、相互關聯或相互依存的元素，形成或被視為一個集體實體
knowledge 知識	acquaintance with facts, truths or principles, a familiarity with a particular subject 認識事實、真相或原則，熟悉某一主題
knowledge based system 知識為本系統	systems that allow reference and research information to be available to enhance knowledge within the organisation 提供參考和研究資料以提升機構內知識水平的系統
leadership 領導	ability to provide direction and cope with change. It involves establishing a vision, developing strategies for producing the changes needed to implement the vision, aligning people and motivating and inspiring people to overcome obstacles [1] 提供方向、處理和適應改變的能力。領導亦包括建立遠景、訂定策略、推展實現遠景必須的變化，結合、激勵和鼓舞人們克服障礙 [1]
legislation 立法	the body of laws made by Parliament. These laws consist of – Acts of Parliament; and Regulations, Ordinances, Rules which are also called “subordinate” or “delegated” legislation [20] 由國會制定的法律，包括議會法；法規、條例、規則－也稱為 “附屬” 或 “授權” 法 [20]
linkages 聯繫	connections, contacts and working relationships established with others [1] 與其他人建立聯繫、接觸和工作關係 [1]
magnet hospital 磁力機構	a term coined in the United States from research that sought to understand why certain hospitals were able to attract and retain staff 美國術語，研究某些醫療機構能夠吸引和保留員工的原因

management 管理	setting targets or goals for the future through planning and budgeting, establishing processes for achieving those targets and allocating resources to accomplish those plans. Ensuring that plans are achieved by organising, staffing, controlling and problem-solving [1] 透過規劃和預算確定未來發展目標，訂定實現這些目標的步驟，合理分配資源以完成計劃。透過機構、人手調配、控制和解決問題確保完成計劃 [1]
mandatory criterion 必達準則	a mandatory criterion is one where it is considered that without moderate achievement (evaluation), the quality of care and / or the safety of people within the organisation could be at risk 必達準則是指沒有達到第三級（良好級別）的時候，代表機構的護理質量和／或機構內人士的安全也可能存在風險
manual handling 人手處理	an activity requiring the use of force exerted by a person to lift, lower, push, pull, carry or otherwise move, hold or restrain any person, animal or thing [21] 需要運用人力來升高、降低、推、拉、攜帶、移動或限制任何人、動物或物件的活動 [21]
medication error 用藥錯誤	any preventable event that may cause or lead to inappropriate medication use or patient harm [22] 可能導致用藥不當或病人傷害的可預防事件 [22]
mission 使命	the purpose of an organisation 機構的目標
monitor 監測	to check, observe critically, measure or record the progress of an activity, action or system on a regular basis in order to identify change [4] 定期檢查、作批判式觀察、量度或記錄活動、行動或系統的進展，以及時發現改變 [4]
morbidity 發病率	the negative consequences (systems, disabilities or impaired physiological state) resulting from disease, injury or its treatment [4] 由疾病、傷害或治療造成的負面結果（人體系統、殘疾或生理障礙）
mortality 死亡率	death from disease or injury 疾病或損傷造成的死亡
multidisciplinary 跨專科	care or a service given with input from more than one discipline or profession 由多個專科或專業共同提供照顧或服務
near miss 險失	an incident that did not cause harm [4] 沒有造成損害的事故 [4]

6. Glossary 詞彙

needs 需要	physical, mental, emotional, social or spiritual requirement for well being. Needs may or may not be perceived or expressed by those in need. They must be distinguished from demands, which are expressed desires, not necessarily needs [1] 與個人福祉相關的生理、心理、情感、社會或精神的需要。 有需要的人未必能體察或表達他們的需要。「需要」不同「需求」,「需求」是人們表達出來的願望，是要求而不一定是真正的需要 [1]
non-clinical information 非臨床資料	Information that is not direct, personal consumer / patient information 間接的個人服務使用者／患者資料
objective 目標	the translation of the goals into specific, concrete terms against which results can be measured 將目標變成具體和可以量度的結果
ongoing care 持續護理	the process of care that follows an admission to a health care organisation 進入醫療機構後的照顧過程
open disclosure 公開披露	the process of open discussion of adverse events that result in unintended harm to a patient while receiving health care and the associated investigation and recommendations for improvement [4] 公開討論病人在接受醫療服務後造成意外傷害的不良事件，相關調查和改善建議 [4]
operational plan 運作計劃	short-term plan that details how the strategic plan will be accomplished 詳細闡明完成策略計劃的短期計劃
organisation 機構	comprises all sites / locations under the governance of, and accountable to, the governing body / owners [1] 由管治機關／業主負責管治的所有場地／位置 [1]
orientation 啟導/ 定向	the process by which staff become familiar with all aspects of the work environment and their responsibilities [1] 讓工作人員全面熟悉工作環境與責任的過程 [1]
outcome 結果	results that may or may not have been intended that occur as a result of a service or intervention 因服務或介入干預導致的預期或意外結果
palliative care plan 紓緩治療計劃	a written statement developed for a patient who is suffering from a life limiting illness, with little or no prospect of a cure, and for whom the primary treatment goal is quality of life, which states the nursing and other interventions to be undertaken, the health outcomes to be achieved and the review of care which will occur at regular intervals [23] 為治癒機會極低的末期病患者制定的書面聲明，主要目標是維持病人的生活質素。聲明內容包括應採用的護理和介入治療、預期醫療成效與定期複檢計劃 [23]

pathway 途徑	a multidisciplinary plan of care that commences before or on admission and finishes at separation 在入院前或入院時制定的跨專科照顧計劃，病人離院後結束
patient master index 病人主索引	a system to identify all consumers / patients that have ever entered the organisation and is the key to locating consumer / patient records and information 識別所有曾經入院的的服務使用者／患者的系統，主要用來搜尋服務使用者／病人的病歷和資料
performance indicator 績效指標	a statistic or other unit of information which reflects, directly or indirectly, the extent to which an anticipated outcome is achieved or the quality of the processes leading to that outcome [24] 直接或間接反映預期結果最終完成的程度、服務過程品質的信息數據 [24]
personal 個人	medical record See Health Record 醫療記錄，參閱健康記錄
physical 物理	relating to the body [25] 與身體相關 [25]
plan 計劃	any detailed scheme, program or method developed for the accomplishment of an objective. Detailed notes of intended proceedings 為完成目標制定的詳細計劃、方案或方法，詳細說明預定程序
planning 規劃	to formulate a scheme or program for the accomplishment or attainment of an object 為完成或達成目標制定計劃
plan of care 護理計劃	plan based on data collected during consumer / patient assessment. It identifies the care and resources needed by the consumer / patient, describes the strategy for providing services to meet those needs, documents treatment goals and objectives and outlines the criteria for specific intervention 根據服務使用者／病人情況評估數據制定的計劃，辨識服務使用者／病人所需護理及資源，闡述為滿足這些需要使用的服務策略，記錄治療目標，概述特定介入治療的準則
policy 政策	a documented statement that formalises the approach to tasks and concepts which is consistent with organisational objectives 以聲明的形式將符合機構宗旨的策略方針與概念正式化
pressure ulcer 褥瘡	any lesion caused by unrelieved pressure resulting in damage of the skin and underlying tissue [26] 持續壓力導致表皮及皮下組織損傷的病變 [26]

6. Glossary 詞彙

prevention and management 預防和管理	a systematic approach adopted by all sections of an organisation to ensure appropriate identification and actions for consumers / patients at risk of an illness or condition 機構內所有部門通過系統化方式，確保及時辨識有疾病風險或潛在狀況的服務使用者／病人，進行適切處理
preventive (preventative) 預防	that which hinders, obstructs or prevents disease [25] 預防疾病 [25]
primary storage 主存儲器	storage area for active records 存儲現用記錄的區域
procedure 程序	a set of documented instructions conveying the approved and recommended steps for a particular act or sequence of acts 一套指示，標明特定操作或系列操作應採取之獲認可及建議的步驟
process 過程	a series of actions, changes / functions that bring about an end or a result 達致結果的一系列行動、變化／功能
psychological 心理	relating to the mind or to mental phenomena [25] 與心靈或精神狀態相關 [25]
qualified 合格	possessed of qualities or accomplishments which fit a person for some function or office 具備某些功能或工作所需素質或資歷
quality 質素	the extent to which the properties of a service or product produces a desired outcome [4] 一項服務或產品達成期望結果的程度 [4]
quality activities 質素活動	activities which measure performance, identify opportunities for improvement in the delivery of care and service, and include action and follow-up 測量與護理和服務（包括跟進照顧）相關表現，確定改善機會的活動
quality control 質素控制	the monitoring of output to check it conforms to specifications and includes action taken to rectify the output 監測產品是否符合規格，亦包含修正成品的工作
quality improvement 質素改進	ongoing response to quality assessment data about a service in ways that improve the process by which services are provided to consumers / patients [1] 回應與服務品質相關的評估數據，以改進為服務使用者／患者提供的服務 [1]

quality use of medicines 用藥質素	the judicious, appropriate, safe and effective use of medicines [27] 明智、恰當、安全和有效地使用藥物 [27]
records 記錄	refers to all records within the organisation, clinical and non-clinical 機構內所有臨床和非臨床記錄
records management 記錄管理	field of management responsible for the efficient and systematic control of the creation, receipt, maintenance, use and disposition of records [28] 有效和系統化控制記錄的建立、接收、維護、使用和處置 [28]
record safety 記錄安全	the physical safety of records such as from light, humidity, vermin, fire and moisture 保護記錄免受光線、濕度、害蟲、火災與潮溼環境的破壞
record storage 記錄儲存	the function of storing records for future retrieval and use [28] 存儲記錄以便將來檢索和使用 [28]
recruitment and selection 招聘和選拔	process used to attract, choose and appoint qualified staff [1] 吸引、選擇和任命合格員工的過程 [1]
research 研究	an active, diligent and systematic process of inquiry in order to discover, interpret or revise facts, events, behaviours, or theories, or to make practical applications with the help of such facts, laws or theories 主動、勤奮而系統化地查證（特定主題），以便發現、解釋或修改事實、事件、行為或理論；也包括事實、法律或理論的實際應用
restraint 約束	use of physical, mechanical or chemical means to restrain the movement of the whole or a portion of a consumer's / patient's body 利用物理，機械或化學方法約束服務使用者／病人全身或身體部份
rights 權利	something that can be claimed as justly, fairly, legally or morally one's own. A formal description of the services that consumers / patients can expect and demand from an organisation [1] 能夠公正、公平、合法與合乎道義地宣稱屬於自己的事物。 闡述服務使用者／患者對機構提供服務的應有期望和要求 [1]
risk 風險	the chance of something happening that will have a (negative) impact. It is measured in terms of consequence and likelihood [2] 有可能產生（負面）影響的機會，根據後果和可能性測量 [2]
risk management 風險管理	the culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects [29] （及早）意識到潛在機會（危機），同時處理負面影響的文化、過程和架構 [29]

6. Glossary 詞彙

root cause analysis 根本原因分析	a systematic process whereby the factors which contributed to an incident are identified [4] 系統化地辨識促成事件發生的不同因素 [4]
safety 安全	Freedom from hazard [2] 免於危險 [2]
seamless 無縫	uninterrupted, anticipated flow of care 按照預定安排連續不斷進行的護理流程
seclusion 隔離	the involuntary confinement of a consumer / patient alone in a room, which the consumer / patient is prevented from leaving, for any period of time 服務使用者／病人在非自願情況下住進單人病房，阻止服務使用者／病人在特定時間內離開
secondary storage 輔助存儲器	a separate storage from the primary storage site of records that have not been utilised for a set period of time but need to be retained according to requirements 在主要的記錄存儲點以外的其他存儲點，即使一段時間內未經使用，仍須按需要保留
senior management 高級管理人員	may include clinical and non-clinical staff and refers to the most senior staff responsible for the day-to-day management of the organisation 包括臨床和非臨床醫務人員，代表負責日常機構管理工作的最高級別員工
sentinel event 嚴重醫療事件	an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called “sentinel” because they signal the need for immediate investigation and response [5] 造成死亡、嚴重生理或心理傷害的事件、或足以造成此等意外的風險的事件。嚴重傷害包括肢體或身體功能喪失。「足以造成此等意外的風險」的例子包括：若（治療）流程上的偏差重複發生，將可能引致嚴重的事件後果。這些意外事件及意外風險稱為「前哨」，意指需即時進行檢查及處理 [5]
services 服務	products of the organisation delivered to consumers / patients or units of the organisation that deliver products to consumers / patients [1] 機構為服務使用者／患者提供的產品，或機構內單位為服務使用者／患者提供的產品 [1]
skillmix 技術組合	the mix of posts, grades or occupations within an organisation. It may also refer to the combinations of activities or skills needed for each job within the organisation [30] 整合機構內部的不同職位、等級或專業。亦指機構內每項工作所需的活動或技術組合 [30]
social 社會	of or relating to life and relation to human beings in a community [25] 與生命相關和與社區內人民的關係相關 [25]

staff 職員	term which includes employed, visiting, sessional, contracted or volunteer personnel 包括短期就業、訪問、兼職、合約員工或義工
stakeholder 持份者	individuals, organisations or groups that have an interest of share in services 與（所提供）服務存在權益關係的個人、機構或團體
standard 標準	describes the overall goal; for example, high quality care for patients with desirable outcomes 闡述整體目標，例如「為病人提供高品質護理以達致最佳療效」
statement of accountabilities 問責聲明	statement that delineates obligations listing the title, reporting relationship, and defining in varying degrees the duties, authorities, and responsibilities for a position 闡明銜頭、上下級關係、職責、權力以及職位應負的責任的聲明
statutory notifications 法定呈報	any notification required by an act of parliament 議會法案列明需要呈報的事項
statutory requirements 法定要求	any requirement laid down by an act of parliament 議會法案列明的要求
strategic plan 策略計劃	plan that is organisation-wide, that establishes an organisation's overall objectives 為實現機構整體目標而全面實施的計劃
strategy 策略	a long-term plan of action designed to achieve a particular goal 長期行動計劃，旨在實現特定目標
Surveillance 監測	the ongoing, systematic collection, analysis and interpretation of health related data essential to the planning, implementation and evaluation of public health practice, closely integrated with the timely dissemination of these data to those responsible for prevention and control [31] 系統化收集、分析和詮釋與公共衛生規劃、實施和評價相關的衛生數據，及時送交負責預防與控制的相關單位 [31]
survey 調查	external peer review which measures the performance of the organisation against an agreed set of standards [1] 機構外同業審查，按既定標準量度機構表現 [1]
sustainability 可持續性	the provision by a health system of infrastructure such as workforce, facilities and equipment, innovation and responsiveness to emerging needs for example from research, monitoring [1] 醫療護理系統需提供諸如員工、設施和設備等基礎建設，以求創新及迅速地回應新出現的服務需求 [1]

6. Glossary 詞彙

system 系統	a group of interacting, interrelated or interdependent elements forming or regarded as forming a collective entity 一組互為影響、聯繫或互相依存的因素所組成的實體
tracking 追蹤	capturing and maintaining information about the movement and uses or records [28] 獲取及保持與檔案移動及使用的相關資料 [28]
training 訓練	the teaching of vocational or practical and relates to specific useful skills; often referred to as professional development 教授職業或實際技能，亦常稱為專業發展
unique identifying number 獨特識別號碼	an organisation produced number, code or letters, of whatever sort, given to one consumer / patient only for that consumer / patient for the first and every subsequent attendance at the organisation 機構為每一位服務使用者／病人提供的一組只供該位服務使用者／病人使用的號碼、代碼或文字，須於每次前往該機構時出示
validation 驗證	to make sound, ratify, confirm, substantiate or to give legal force to. Validity deals with the relationship of the data obtained to the purpose for which it accomplishes, or measures what it seeks to measure 確使完整、批准、確認、證明或賦予法律效力的程序。驗證涉及處理與完成特定目標相關的數據，進行量度
values 價值	principles and beliefs that guide an organisation and may involve social or ethical issues 引導機構的原則和信念，可能涉及社會和倫理問題
vision 願景	description of what the organisation would like to be [1] 闡明機構的發展理想 [1]
waiting list 輪候名單	a register which contains essential details about consumers / patients who have been assessed as needing elective care 登記冊載有經評估後確定為需要接受護理服務的服務使用者／病人的必須資料
workplace 工作場所	any place, including any aircraft, ship or vehicle, where a person works, or is likely to work, and includes any place where a person goes while at work [10] 一個人工作或有可能工作的任何地點，包括工作期間前往的任何地點，包括飛機、船隻或車輛 [10]

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7. Acronyms

A	
ACHS	Australian Council on Healthcare Standards
ACSQHC	Australian Council for Safety and Quality in Health Care (now Australian Commission on Safety and Quality in Health Care)
ADG	Australian Dangerous Goods
AHMC	Australian Health Ministers Conference
AHRQ	Agency for Healthcare Research and Quality
ALARA	As Low As Reasonably Possible
ANZCMHN	Australian and New Zealand College of Mental Health Nurses
ANZICS	Australian and New Zealand Intensive Care Society
ANZSBT	Australian and New Zealand Society of Blood Transfusion
APAC	Australian Pharmaceutical Advisory Council
ARCBS	Australian Red Cross Blood Service
ARPANSA	Australian Radiation Protection and Nuclear Safety Agency
AS/NZS	Australian and New Zealand Standard
A-V	Arteriovenous
B	
C	
CABG	Coronary Artery Bypass Grafting
CALD	Culturally and Linguistically Diverse
CCTV	Closed Circuit Television
CEO	Chief Executive Officer
CIAP	Clinical Information Access Program
CJD	Creutzfeldt-Jakob Disease
CPD	Continuing Professional Development
CPI	Clinical Practice Improvement
CPR	Cardio Pulmonary Resuscitation
CQI	Continuous Quality Improvement
D	
DH	Department of Health
DNA	Deoxyribonucleic Acid
DRG	Diagnosis Related Group
E	
EEO	Equal Employment Opportunities
EPA	Environmental Protection Authority
EQuIP	Evaluation and Quality Improvement Program
F	
G	
g/L	Haemoglobin is measured in grams (g) per litre (L)
GLBTI	Gay, Lesbian, Bisexual, Transgender and Intersex
GP	General Practitioner

7. Acronyms

H	
HA	Hospital Authority
HACC	Health and Ageing Home and Community Care
Hb	Haemoglobin
HIV	Human Immunodeficiency Virus
HREC	Human Research Ethics Committee
HRM	Human Resources Management
HK Guide	The ACHS EQuIP4 Guide, Revised for Hong Kong
I	
I&CT	Information and Communication Technology
ICU	Intensive Care Unit
IM	Information Management
IT	Information Technology
J	
K	
L	
LMCA	Left Main Coronary Artery
M	
MET	Medical Emergency Team
MSDS	Material Safety Data Sheets
N	
NATA	National Association of Testing Authorities
NCDDD	National Cardiovascular Disease and Diabetes Register
NFR	Not For Resuscitation
NHMRC	National Health and Medical Research Council
NHPA	National Health Priority Areas
NHS	National Health Service, United Kingdom
NICS	National Institute of Clinical Studies
NOHSC	National Occupational Health and Safety Commission
NPAAC	National Pathology Accreditation Advisory Council
NPP	National Privacy Principles
NPS	National Prescribing Service
O	
OH&S	Occupational Health and Safety
P	
PDCA	Plan, Do, Check, Act
Q	
QA	Quality Assurance

R	
RAND	Corporation, the name of which was derived from a contraction of the term *research and development*
RCA	Root Cause Analysis
RCNA	Royal College of Nursing Australia
S	
SIDS	Sudden Infant Death Syndrome
T	
TQM	Total Quality Management
U	
UCLA	University of California, Los Angeles
V	
VA	Veterans Affairs
VMO	Visiting Medical Officer
VTE	Venous Thromboembolism
W X Y Z	

8. Chinese Translation Of The 45 Criteria And Common Terms

8.1 The 45 criteria of EQuIP4

下表清晰列明此 3 項功能和 13 項標準（以不同顏色顯示）以及 45 項準則。
The following identifies at a glance, the three functions, the 13 standards (colour highlighted) and each of the 45 criteria.

1. CLINICAL 臨床	2. SUPPORT 支援	3. CORPORATE 機構
1.1 Consumers / patients are provided with high quality care throughout the care delivery process. 在整個醫療服務過程中為服務使用者／ 病人提供高質素服務。	2.1 The governing body leads the organisation in its commitment to improving performance and ensures the effective management of corporate and clinical risks. 機構管治團隊致力提升服務表現，確保有效管理機構及臨牀風險。	3.1 The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services. 管治團隊帶領機構策略發展方向，確保提供優質和安全的服務。
1.1.1 *The assessment system ensures current and ongoing needs of the consumer / patient are identified.* *評審制度確保能夠辨識服務使用者／ 病人當前和持續的需要。*	*2.1.1* *The organisation's continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.* *機構的質素持續改進系統充分展現機構致力改進醫療服務的成效。*	3.1.1 The organisation provides quality, safe care through strategic and operational planning and development. 機構透過策略和運作規劃與發展，提供優質和安全的服務。
1.1.2 *Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.* *與服務使用者／ 病人及照顧者（如適用）共同擬定治理計劃，以達致最佳成效。*	*2.1.2* *The integrated organisation-wide risk management policy and system ensure that corporate and clinical risks are identified, minimised and managed.* *機構整體綜合風險管理政策和操作系統能夠確保有效辨識、盡量減低機構運作和臨床風險。*	3.1.2 Governance is assisted by formal structures and delegation practices within the organisation. 機構設有正式管治架構和委派形式。

1. CLINICAL 臨床	2. SUPPORT 支援	3. CORPORATE 機構
1.1.3 *Consumers / patients are informed of the consent process, understand and provide consent for their health care.* *向服務使用者/ 病人清楚說明，並得到他們的理解和同意接受醫院為他們提供醫療服務。*	*2.1.3* *Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.* *設有醫療事故、投訴和意見管理系統改進護理服務。*	*3.1.3* *Processes for credentialing and defining the scope of clinical practice support safe, quality health care.* *資格認證和界定臨床操作範圍程序能有效支援安全和優質的醫療服務。*
1.1.4 *Care is evaluated by health care providers and when appropriate with the consumer / patient and carer* *醫療服務提供者要評估所提供的醫療服務，及在合適的情況下與服務使用者/ 病人和照顧者共同評估該服務。*	2.2 Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff. 人力資源管理支援高質素醫療服務和勝任的員工隊伍，也為員工提供滿意的工作環境。	3.1.4 External service providers are managed to maximise quality care and service delivery. 有效管理機構外判服務，以提供最佳服務。
1.1.5 *Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.* *出院/ 轉院的過程能夠配合病人的持續醫療需要。*	2.2.1 Human resources planning supports the organisation's current and future ability to address needs. 人力資源規劃能有效支援機構當前和未來發展。	*3.1.5* *Documented corporate and clinical policies assist the organisation to provide quality care.* *機構與臨床政策的記錄有助機構提供優質服務。*
1.1.6 Systems for ongoing care of the consumer / patient are coordinated and effective. 為服務使用者/ 病人提供充分協調和具效率的持續醫療服務。	2.2.2 The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation. 招聘、甄選和任命機制能有效整合員工和義工的技術與能力，從而配合機構需要。	3.2 The organisation maintains a safe environment for employees, consumers / patients and visitors. 機構提供安全環境，保障員工、服務使用者/ 病人及訪客。

8. Chinese Translation Of The 45 Criteria And Common Terms

1. CLINICAL 臨床	2. SUPPORT 支援	3. CORPORATE 機構
1.1.7 Systems exist to ensure that the care of dying and deceased consumers / patients is managed with dignity and comfort. 機構運作系統能夠為末期及離世的病人提供有尊嚴和舒適的服務。	2.2.3 The continuing employment and performance development system ensures the competence of staff and volunteers. 持續招聘和績效改善系統確保員工與義工能勝任其工作。	*3.2.1* *Safety management systems ensure safety and wellbeing for consumers / patients, staff, visitors and contractors.* *安全管理系統有效保障服務使用者/ 病人、員工、訪客和承包商的安全福祉。*
1.1.8 *The health record ensures comprehensive and accurate information is recorded and used in care delivery.* *健康紀錄能夠全面準確地記錄相關資料，以助提供醫療服務。*	2.2.4 The learning and development system ensures the skill and competence of staff and volunteers. 學習和發展制度確保員工與義工能勝任其工作。	3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively. 安全地管理和有效運用建築物、標誌、場地、設備、用品、公共設施和消耗品。
1.2 Consumers / patients / communities have access to health services and care appropriate to their needs. 為服務使用者/ 病人/ 社區提供切合需要的醫療服務。	2.2.5 Employee support systems and workplace relations assist the organisation to achieve its goals. 員工支援計劃和工作間關係有助機構達到服務目標。	3.2.3 Waste and environmental management supports safe practice and a safe environment. 廢物和環境管理支援安全作業與安全環境。
1.2.1 *The community has information on, and access to, health services and care appropriate to its needs.* *市民能接觸到切合需要的醫療服務和相關資訊。*	2.3 Information management systems enable the organisation's goals to be met. 訊息管理系統有助機構達成目標。	*3.2.4* *Emergency and disaster management supports safe practice and a safe environment.* *應急和災難管理有效支援安全作業和安全環境。*

1. CLINICAL 臨床	2. SUPPORT 支援	3. CORPORATE 機構
1.2.2 Access and admission to the system of care is prioritised according to clinical need. 醫療服務的提供須按照病人的臨床需要排序。	2.3.1 Records management systems support the collection of information and meet the organisation's needs. 記錄管理系統根據機構需要收集資料。	*3.2.5* *Security management supports safe practice and a safe environment.* *保安管理支持安全作業與安全環境。*
1.3 Appropriate care and services are provided to consumers / patients. 為服務使用者/ 病人提供合適的醫療服務。	2.3.2 Information and data management and collection systems are used to assist in meeting the strategic and operational needs of the organisation. 訊息和數據管理收集系統符合機構策略和業務需要。	
1.3.1 Health care and services are appropriate and delivered in the most appropriate setting. 在最合適的環境提供適當的醫療服務。	2.3.3 Data and information are used effectively to support and improve care and services. 有效運用數據和訊息，支援並改進醫療服務。	
1.4 The organisation provides care and services that achieve expected outcomes. 機構提供的醫療服務達到預期成果。	2.3.4 The organisation has an integrated approach to the planning, use and management of information and communication technology (I&CT). 機構以綜合方法去規劃、使用和管理資訊與通信科技。	

8. Chinese Translation Of The 45 Criteria And Common Terms

1. CLINICAL 臨床	2. SUPPORT 支援	3. CORPORATE 機構
1.4.1 Care and services are planned, developed and delivered based on the best available evidence and in the most effective way. 以最佳醫療實證和最有效率的方式規劃、開展與提供醫療服務。	2.4 The organisation promotes the health of the population. 機構致力促進市民健康。	
1.5 The organisation provides safe care and services. 機構提供安全的醫療服務。	2.4.1 Better health and wellbeing for consumers / patients, staff and the broader community are promoted by the organisation. 機構致力促進服務使用者/ 病人、員工和社區的健康和福祉。	
1.5.1 Medications are managed to ensure safe and effective practice. 藥物管理方式能夠確保安全和有效使用。	2.5 The organisation encourages and adequately governs the conduct of health and medical research to improve the safety and quality of health care. 機構鼓勵和管治醫療健康研究，以提高醫療服務的安全性和質素。	
1.5.2 *The infection control system supports safe practice and ensures a safe environment for consumers /patients and health care workers.* *感染控制系統支援安全運作，為服務使用者/ 病人和醫療人員提供安全的環境。*	2.5.1 The organisation's research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research. 醫院的研究項目促進知識開發，以及醫療環境的實際應用，以保護服務使用者/ 病人安全，並有效管理與研究相關的風險。	

1. CLINICAL 臨床	2. SUPPORT 支援	3. CORPORATE 機構
1.5.3 The incidence and impact of pressure ulcers are minimised through a pressure ulcer prevention and management strategy. 實行褥瘡預防與管理策略，將褥瘡發病率和影響降到最低。		
1.5.4 *The incidence of falls and fall injuries is minimized through a falls management program.* *推行預防跌倒計劃，將跌倒和受傷的發生機會減至最低。*		
1.5.5 The system for prescription, sample collection, storage and transportation and administration of blood and blood components ensures safe and appropriate practice. 血液和血液成分的處方、樣品採集、儲存、運送和輸血系統能確保運作安全恰當。		
1.5.6 The organisation ensures that the correct patient receives the correct procedure on the correct site. 機構確保正確病人在正確位置接受正確醫療程序。		

8. Chinese Translation Of The 45 Criteria And Common Terms

1. CLINICAL 臨床	2. SUPPORT 支援	3. CORPORATE 機構
1.6 The governing body is committed to consumer participation. 管治團隊致力推動服務使用者參與。		
1.6.1 Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service. 規劃、執行和評估醫療服務時有徵詢服務使用者、照顧者和社區。		
1.6.2 Consumers / patients are informed of their rights and responsibilities. 服務使用者/ 病人明白他們的權利和責任。		
1.6.3 The organisation makes provision for consumers / patients from culturally and linguistically diverse backgrounds and consumers / patients with special needs. 機構能夠照顧不同文化和語言背景，及有特殊需要的服務使用者/病人的需要。		

Key:
說明：

	EQuIP4 Standards 評審及質素改進計劃 4 標準
Italic *斜體*	*Mandatory criteria* *必達準則*

8.2 Achievement Rating

	Achievement Rating			評估級別	
1	**Little Achievement**	**LA**	**Awareness** Awareness of basic requirements. Policy and legislative compliance is in place	**初階級別**	**認識** 認識基本要求，符合相關政策及法例
2	**Some Achievement** (LA + SA)	**SA**	**Implementation** System have been developed and implemented	**進階級別**	**執行** 已開展和執行作業系統
3	**Moderate Achievement** (LA + SA + MA)	**MA**	**Evaluation** Data are collected; evaluation of the system occurs to ensure the system works effectively. Improvement results	**標準級別**	**評估** 搜集數據、評審系統以確保有效運作，改進服務
4	**Extensive Achievement** (LA + SA + MA + EA)	**EA**	**Excellence** Benchmarking and/or research and/or advanced implementation strategies and/or excellent outcomes are achieved	**優異級別**	**傑出** 基準分析及／或研究及／或先進的執行策略及／或成效卓著
5	**Outstanding Achievement** (LA + SA + MA + EA + OA)	**OA**	**Leadership** The organization is a peer leader in systems and outcomes	**模範級別**	**領袖** 醫院的作業系統與成果領先同業

8. Chinese Translation Of The 45 Criteria And Common Terms

8.3 Common Terms

EQuIP	Chinese version
ACHS	澳洲醫療服務標準委員會
Accreditation Surveyors	認證評審員
Access	便捷
Appropriateness	合適度
Best Practice	最佳實踐
Benchmarking	基準分析
Clinical	臨牀
Corporate	機構
Criteria	準則
Consumer	服務使用者
Clinical Privileges	臨床特權
Credentialing	資格認可
Clinical Audit	臨床稽核
Continuity of Care	連續性醫療服務
Consumer focus	以病人為中心
EQuIP	評估及質素改進標準大綱
Element	元素
Effectiveness	成效
Function	功能
Guideline	指引
Gap analysis	差距分析
Mandatory Criteria	必達準則
Near miss	險失事件
OWS	機構評審
Periodic Review	定期覆核
Quality	質素
Restrain	約束
Support	支援

EQuIP	Chinese version
Standard	標準
Stake Holder	持份者
Skill mix	技術組合
Safety	安全性

9. Acknowledgements

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10. Further Information

Part 2 of The ACHS EQuIP 4 Guide contains the standards, criteria and elements only.

Part 1, 3 and 4 of The ACHS EQuIP 4 Guide contain guidelines to assist organisations to achieve the standards, suggestions for performance measures, ACHS clinical indicators and information on accreditation processes.

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