Short Notice Accreditation Assessment Pathway

How to be accreditation ready everyday

Presentation for AAQHC Members May 23

GOVERNANCE PLUS

SETTING THE SCENE

- What is a SNAAP?
  - A SNAAP is a Short Notice Accreditation Assessment Pathway (SNAAP) which will replace the current planned approach of advance notice.
  - 24hour notice period (one full business day) from your accrediting agency of the assessment
  - Rural/remote locations with limited transport options 48 hours notice
  - Permissions required for assessment – 4 weeks notice ie Aboriginal Communities or Prison Services
- What does that mean for your HSO?
  - HSO's must fully comply with all applicable NSQHS Standardsand actions
  - Have in place processes to demonstrate compliance "*at any time*"
  - Ensure their safety and quality systems are well embedded
  - That self-assessments and gap analysis are conducted regularly
  - There are processes to routinely monitor the safety and quality performance against the NSQHS and other related Standards.

SETTING THE SCENE continued…..

- Background
  - SNAAPs introduced in 2019 on a voluntary basis with yearly assessments over a 3 year period.
  - Following evaluation moved to Mandatory from July 2023 refer Fact Sheet 17 Short Notice Assessments. *Note at this time only applies to HSOs which are required to be accredited by regulator and health funds.*
  - Identified benefits - supports continuous improvement, transfer focus to assessment of day to day practice, remove administrative burden, change the perception of Not Met from failure to opportunity for improvement
- Process
  - A SNAAP will occur at least once in a three-year accreditation cycle – at least 6 months following initial assessment and 6 months prior to expiry of accreditation certificate. All relevant standards and actions assessed at one time,
  - Assessment methodology will include Interviews with staff, consumers/consumer reps), Observation – all clinical and operational areas, review of documentation and quality improvement systems.
  - >75% of time to be spent in clinical areas very limited meetings

Assessment Outcomes

- **Ratings – Met, Not Met, Met with Recommendations, Suggestions still apply**
- **Not Met and Met with Recommendations now both have a remediation period of 60 days.**
- **Allowance for additional evidence to be submitted within 10 business days at end of assessment**
- **If the same recommendation for an action is raised as a recommendation in subsequent assessment this can move to a Not Met.**

Not sure if SNAAPS apply? – contact your regulator in each state.

SETTING UP YOUR ORGANISATION FOR SUCCESS

- Successful Accreditation is a by product of safety and quality systems but this still needs to be a strategic priority due to stakeholder requirements.
- The focus needs to shift to ensuring safety and quality systems are delivering safe quality care every day, successful accreditation will confirm this or not.
- Effective, efficient planning and resourcing is essential at all levels of the organisation.
- Effective governance systems are needed to support monitoring and taking action. The Safety and Quality team alone cant do this by themselves.
- Knowing your patient safety and accreditation risks across all standards on any given day (Reporting, Monitoring and Taking Action)
- Ensuring your audit, quality cycles and other assurance mechanisms support the objective of being accreditation ready every day
- Providing continuous education and communication with staff and stakeholders on safety, quality and accreditation requirements.
- Using a centralised and accessible evidence storage system

YOU NEED TO TAKE ACTION AND START NOW!!

KEY ELEMENTS

- Design and implement a centralised evidence storage system, define types of evidence that needs to be maintained for each standard – keep it simple
- Develop SNAAP procedures
  - include naming conventions for evidence
  - save evidence regularly
  - include “accreditation status” checks in meeting agendas at all levels of meetings.
  - Develop checklists - quality manager (logistics), Executive, Managers and Staff
  - Develop quick reference user guides
- Consider an Accreditation Intranet page for quick links – *note this will also be of benefit for assessors*
- Develop a SNAAP Communication Plan for both implementation and assessments.
  - Create templates – email notifications to staff from CEO, patient notification templates, timetables, surveyor packs

KEY ELEMENTS CONTINUED….

- Set up external IT Access for assessors and test it regularly
- Hold MOCK SNAAPs
- Test your SNAAP processes
- Be prepared for changes during assessment

MEETING AGENDAS EXAMPLES

- **Ensure preparedness for SNAAPs is discussed regularly at all meetings and is a key focus**

Committee Meeting Agenda

- Is all evidence saved in storage system?
- Are all risks identified and reviewed?
- Do risk controls reflect current state of safety and quality data?
- Are there linkages discussions risk and quality systems?

Staff Meeting Agenda

- Is all evidence saved in storage system?
- Audits up to date?
- Quality board info current
- Are we improving, what are our risks?
- % complete - Mandatory Training and Performance Reviews

Executive Meeting Agenda

- Current accreditation status?
- Action plans in place and reported on?
- Executive Rounding confirms improvements are embedded?
- Are there linkages discussions risk and quality systems?

INFORMATION PACK FOR ASSESSORS

- **Plan in advance what documentation must have regular review and updates, saved in evidence ready for SNAAP**

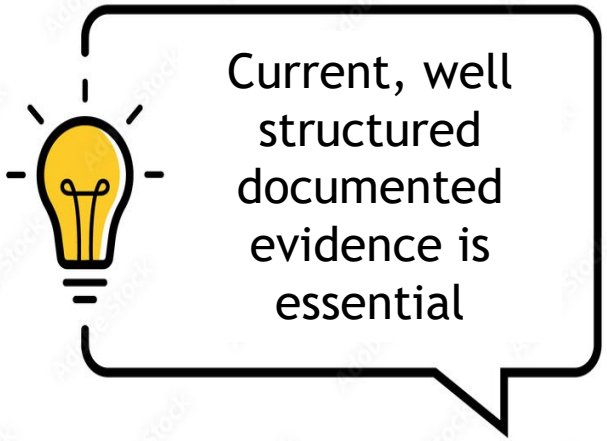
Assessor Pack

- [ ] Governance Map - reporting internal and external, list of key contacts
- [ ] Organisation and Committee charts
- [ ] Risk Register
- [ ] Committee Minutes – last three meetings
- [ ] Quality Reports
- [ ] Quality Improvements – QIs, QI Register/Status
- [ ] Open Disclosure Register
- [ ] Recent external audits ie HICMR
- [ ] Site Maps
- [ ] Evidence location and directions on access

EXAMPLE OF EVIDENCE FOLDER STRUCTURE

- ASSESSOR PACK
- STD 1
- STD 2
- STD 3
- STD 4
- STD 5
- STD 6
- STD 7
- STD 8

- _Advisories Gap Analysis and Action Plan
- _Audit Results
- _Clinical Care Standards Response Statement
- _Committee Meeting Minutes
- _Quality Improvements
- _Staff Meeting Minutes
- _Std 3 Policies
- 3.01
- 3.02
- 3.03
- 3.04
- 3.05
- 3.06
- 3.07
- 3.08
- 3.09



EXAMPLES CHECKLIST for when SNAAP is announced

Clinical Area	Yes	No	If No - Action Plan
>90% completed Performance Review			
>90% completed Mandatory Training			
All evidence saved			
Quality Board up to date			
Health Care Rights displayed			
Patient carer concern signage displayed			
Hand Hygiene signs displayed, products in date			
Storerooms tidy, fridges clean, no expired foods, medications			
Report on incident management/closures			
Fire exits clear, fire plans current			

EXAMPLES CHECKLIST for when SNAAP is announced

Quality Team	Yes	No	If No - Action Plan
Coordinate communications			
Rooms booked			
Catering ordered			
IT Access confirmed			
Access provision to assessors			
Patient notifications of SNAAP			
Timetable coordination with Lead Assessor			
Consumer representatives for availability			
Executive Team	**Yes**	**No**	**If No - Action Plan**
Send out communication to staff			
Confirm/document any declarations			
Meet with committee leads to understand status of improvements			

FINAL POINTS for SNAAPs

- V2 of the standards have now been in place for 5 Years
- Accreditation focus is now on evaluation and improvement, it is expected systems and processes are in place well embedded and meeting needs
- Evidence should demonstrate effective monitoring and evaluation of safety and quality data and actions taken to improve.
- Incidents, feedback and audit results should be centralised, trended and analysed.
- Improvements and projects should demonstrate that the change is effective, realizes benefits and reduces risk.
- Remove single points of contact. Have Standards lead and back-up lead, you will need to allow that key staff may be on leave for the SNAAP.
- Ensure high risks are on your risk register and managed or have an action plan.
- Other high-level improvements should be in your Quality Plan.
- Don’t forget your Hospitality, Maintenance/Biomed and administration teams

FINAL CONSIDERATIONS for SNAAPs continued….

- Quality data reported to committees, staff, consumers and is displayed.
- Educate and test staff on how to answer questions
- **POST SNAAP**
- After a mock or formal SNAAP ensure lessons learnt are captured, review SNAAP approach and implement any improvements needed.
- Communicate outcomes to staff, patients and stakeholders

Other factors for consideration

- NSQHS V2.0 has been in place for 5 years
- Systems, processes and policies should be in place and well embedded
- Legislative compliance should be demonstrated
- Focus is on continuous monitoring and evaluation of data and systems and taking action.
- All unwarranted data variation should link into the risk or quality improvement systems. Outcome data should inform your risks and approach.
- Consumer engagement in governance, linking the lived experiences of consumers into training and other communication systems
- Governance systems for clinical care standards and advisories
- Monitoring industry change to ensure best practice guidelines, protocols, decision tools

Clinical Care Standards (1.27)

- Ensure there is effective governance oversite of new/revised CC standards
- Determine applicability
- Allocate responsibility
- Review the quality statements, assess compliance/gaps – take action
- Link the quality statement outcomes and KPIs into quality, audit and risk systems
- Demonstrate how you meet the standards - *Response Statements*

Advisory Timeline compliance

- Should be well advanced, dates must be met
- Action plans in place and reviewed and updated regularly
- Demonstrate how you meet the advisory – *Response statements*

Incident Management

- Ensuring changes implemented are sustained, particularly for SAC 1, 2 ratings
- Clustering of SAC 3 to determine any emerging risks

1.16 Medical Records, 1.17-1.18 My health record and Standard 5 Comprehensive Care

Key points
Evidence should show you are working towards *an integrated record that everyone uses* and is available at the point of care.

My Health Record is being used for uploads of discharge summaries and to improve diagnostic capacity, capability.

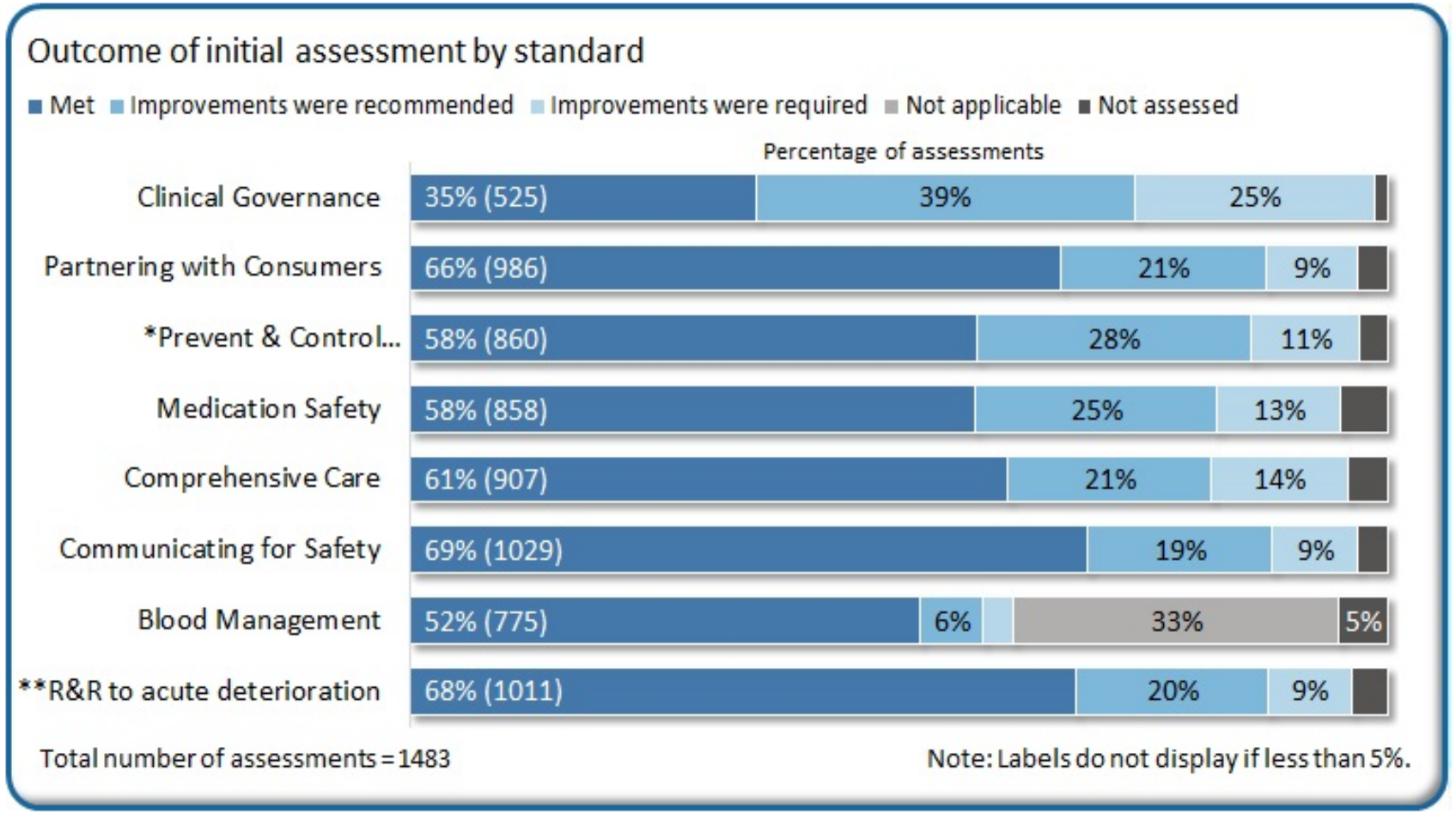
Examples of NOT METS 2022 GovPlus clients	
1.08	Quality Systems- evaluation of audit recommendations and quality improvements
1.12	Open Disclosure – action plan, evaluation of the system
1.16	Medical Records - Risk Assessment
1.20/1.22	Mandatory Training, Performance Review
2.01	Consumer Engagement – establish Advisory Committee, consumer representatives
2.11	Consumer Engagement in governance and service design
4.02	Medication Safety - Line Labelling
3.10	Hand Hygiene
5.29	Delirium/Cognitive Impairment
5.35	Restraint – authorisation and reporting – links with 1.30

All Not Mets and Met with Recommendations were identified at mock assessments and were not a surprise.

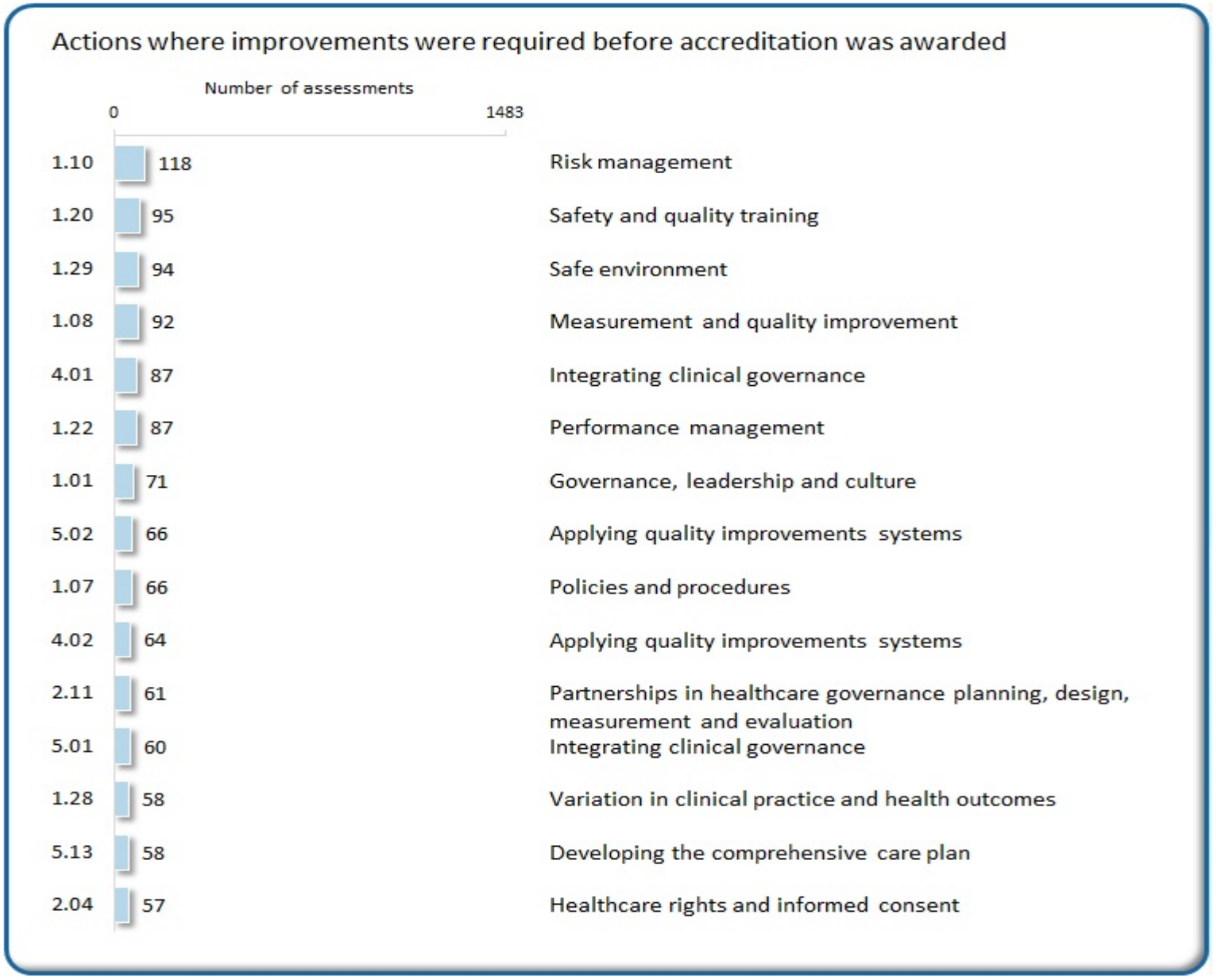
Examples of Met with Recommendations 2022 GovPlus clients	
Std 1	Overdue policies, Risk Register – accurate, Clinical Care Standards, Best practice tools/guidelines, test and tagging, Biomedical
Std 2	Evaluating consumer engagement processes, consumer feedback linked to workforce training and using lived experiences
Std 3	Governance oversight of Clinical Care Standards, PIVC, AMS usage reports, surgical prophylaxis, management and use of Invasive Devices, staff immunisation, AS 4187
Std 4	Staff medication safety training, compliance with Best Possible Medication History taken on admission, prescriber documentation legibility and indication, compliance with documenting VTE, adverse reactions, allergies.
Std 5	Delirium risk screening, assessment and monitoring, evidence of shared decision making, Advanced HealthCare Plans documented in medical record. Pressure injury prevention and wound management consistent with best practice guidelines, ensure clear policy on physical and chemical restraint, that this is authorised and reported to your governing body
Std 6	Patient identification – use of three identifiers in handovers
Std 7	Blood safe training compliance
Std 8	Evaluate escalation system to ensure its effective

Accreditation outcomes Australia wide (Ref ACSQHC)

1318 Assessments Jan 2019 – April 23- Public, Private and Day Surgery Hospitals



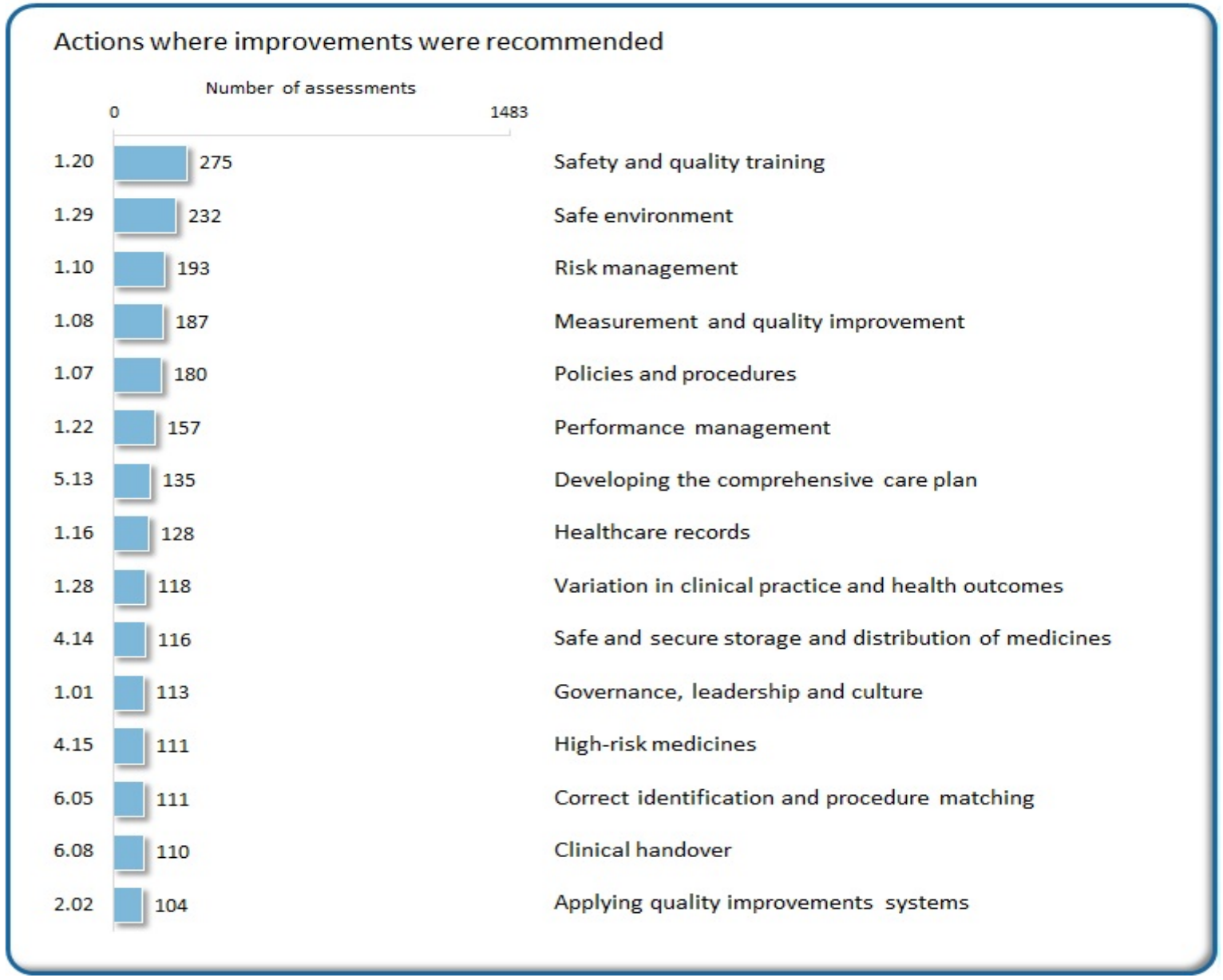
Total Not Mets – Jan 2019 to April 23 (ACSQHC)



Some interesting facts for NMs between Aug 22 and April 23

Standard 1 37% - 39%
Standard 3 25% - 28%
Standard 4 21% - 25%
Standard 5 18% - 21%
Standard 8 18% - 20%

Total Met with Rec's – Jan 2019 to April 23 (ACSQHC)



Key messages

- 75% or more time will be spent in clinical areas
- Commence being accreditation ready every day
- Reduce the risk of Not Mets in basic areas such as mandatory training, performance reviews
- Ensure evidence systems are easily accessible and can be maintained
- Review audits and audit tools, focus on patient journey and effectiveness audits
- Understand the benefits of a mix of efficiency, compliance and effectiveness audit tools
- Provide direction and training on auditing and quality improvements

QUESTIONS

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