EQuIP5

# ACHS EQuIP5: Quality Improvement Resource Tool for Non Government Drug and Alcohol Organisations

NADA
network of alcohol & other drugs agencies

THE AUSTRALIAN COUNCIL ON HEALTHCARE STANDARDS
ACHS

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## Clinical Function

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

1.1.1 Assessment ensures current and ongoing needs of the consumer / patient are identified.
1.1.2 Care is planned and delivered in collaboration 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, and they understand and provide consent for their health care.
1.1.4 Outcomes of clinical care are evaluated by healthcare providers and where appropriate are communicated to the consumer / patient and carer.
1.1.5 Processes for clinical handover, transfer of care and discharge 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 The care of dying and deceased consumers / patients is managed with dignity and comfort and family and carers are supported.
1.1.8 The health record ensures comprehensive and accurate information is collaboratively gathered, recorded and used in care delivery.

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

1.2.1 The community has information on health services appropriate to its needs.
1.2.2 Access and admission / entry to the system of care is prioritised according to healthcare needs.

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

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

1.4 The organisation provides care and services that achieve effective outcomes.

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

1.5 The organisation provides safe care and services.

1.5.1 Medications are managed to ensure safe and effective consumer / patient outcomes.
1.5.2 The infection control system supports safe practice and ensures a safe environment for consumers / patients and healthcare workers.
1.5.3 The incidence and impact of breaks in skin integrity, pressure ulcers and other non-surgical wounds are minimised through wound prevention and management programs.
1.5.4 The incidence of falls and fall injuries is minimised through a falls management program.
1.5.5 The system to manage sample collection, blood, blood components / blood products and patient blood management ensures safe and appropriate practice.
1.5.6 The organisation ensures that the correct consumer / patient receives the correct procedure on the correct site.
1.5.7 The organisation ensures that the nutritional needs of consumers / patients are met.

1.6 The governing body is committed to consumer participation.

1.6.1 Consumers / patients, carers and the community participate in the 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 meets the needs of consumers / patients and carers with diverse needs and from diverse backgrounds.

# Support Function

2.1 The governing body leads the organisation in its commitment to improving performance and ensures the effective management of corporate and clinical risks.

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 framework ensures that corporate and clinical risks are identified, minimised and managed.

2.1.3 Healthcare incidents are managed to ensure improvements to the systems of care.

2.1.4 Healthcare complaints and feedback are managed to ensure improvements to the systems of care.

2.2 Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff.

2.2.1 Workforce 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, meets 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.

2.3 Information management systems enable the organisation's goals to be met.

2.3.1 Health records management systems support the collection of information and meet the consumer / patient and organisation's needs.

2.3.2 Corporate records management systems support the collection of information and meet the organisation's needs.

2.3.3 Data and information are collected, stored and used for strategic, operational and service improvement purposes.

2.3.4 The organisation has an integrated approach to the planning, use and management of information and communication technology (I&CT).

2.4 The organisation promotes the health of the population.

2.4.1 Better health and wellbeing is promoted by the organisation for consumers / patients, staff, carers and the wider community.

2.5 The organisation encourages and adequately governs the conduct of health and medical research to improve the safety and quality of health care.

2.5.1 The organisation's research program develops the body of knowledge, protects staff and consumers / patients and has processes to appropriately manage the organisational risk associated with research.

# Corporate Function

3.1 The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services.

3.1.1 The organisation provides quality, safe health care and services 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 credentialing and defining the scope of clinical practice support safe, quality health care.

3.1.4 External service providers are managed to maximise quality, safe health care and service delivery.

3.1.5 Documented corporate and clinical policies and procedures assist the organisation to provide quality, safe health care.

3.2 The organisation maintains a safe environment for employees, consumers / patients and visitors.

3.2.1 Safety management systems ensure safety and wellbeing of consumers / patients, staff, visitors and contractors.

3.2.2 Buildings, signage, plant, medical devices, 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 and sustainable 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.

# Introduction

## Who are the ACHS?

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

## Who is NADA?

The Network of Alcohol and Drug Agencies (NADA) is the peak organisation for the non government drug and alcohol sector in NSW. NADA represents over 100 organisational members that provide a broad range of services including drug and alcohol health promotion, early intervention, treatment, and after-care programs. These community-based organisations operate throughout NSW. They comprise both large and small services that are diverse in their structure, philosophy and approach to drug and alcohol service delivery.

NADA's goal is *'to advance and support non government drug and alcohol organisations in NSW to reduce the drug and alcohol related harm to individuals, families and the community'.*

The NADA program consists of sector representation and advocacy, workforce development, information / data management, governance and management support and a range of capacity development initiatives. NADA is governed by a Board of Directors primarily elected from the NADA membership and holds accreditation with ACHS until 2014.

Further information about NADA and its programs is available on the NADA website at www.nada.org.au.

## What is the purpose of this EQuIP5 Quality Improvement Resource Tool?

The ACHS and NADA *EQuIP5 Quality Improvement Resource Tool for Non Government Drug and Alcohol Organisations* has been developed in partnership between ACHS and NADA to assist non government drug and alcohol organisations to understand and apply the EQuIP5 standards. This Resource Tool builds on the 2009 version by providing a current, accessible and easy-to-use resource relevant to the speciality of the non government drug and alcohol sector.

## What is quality improvement?

Quality improvement is the ongoing response to quality assessment data about a service in ways that improve the processes by which services are provided to consumers / patients.[1]

With a focus on outcome, process and people-based improvement; the objective is to improve the quality of care for consumers / patients by striving for best practice. This can be achieved when an organisation compares its performance with, or learns from, others and applies best-practice principles. Organisations might demonstrate their efforts through:

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

## What is continuous improvement?

Continuous improvement is striving for continual improvement in the quality of care an organisation / health service provides. Continuous improvement assists the organisation through:

- looking for ways to improve as an essential part of everyday practice
- consistently achieving and maintaining quality care that meets consumer / patient needs
- monitoring outcomes in consumer / patient care and seeking opportunities to improve both the care and its results.

## What is the role of an organisation's quality improvement coordinator?

[1] International Society for Quality in Health Care (ISQua). *The ISQua surveyor training standards programme.* Dublin IRL; ISQua; 2009.

The role of a quality improvement (QI) coordinator or quality officer is to provide leadership and support in quality improvement to all staff within the organisation, including the executive and management. The QI coordinator may:

- develop and implement a plan for continuous improvement within the organisation
- lead development and implementation of policies and procedures reflecting best practice
- manage risk, safety and compliance issues
- motivate and inspire organisational change
- support staff to become involved in QI
- prepare for pre-surveys, self assessments and organisation wide surveys by collating and preparing information and data as evidence of best practice, with the aim achieving accreditation.

The quality improvement coordinator or quality officer is not responsible for undertaking all quality and development activity - a whole of organisation approach is needed.

### What is accreditation?

Accreditation is public recognition by a healthcare accreditation body (such as ACHS) of the achievement of accreditation standards (such as EQuIP5) by a healthcare organisation such as your own. Accreditation signals to the community that the organisation is striving for best practice and has a quality improvement culture and effective quality management systems in place. Accreditation also sends a message that the organisation has a strong focus on consumer / patient needs and safety. Refer to *The ACHS EQuIP5 Guide – Book 1* pages 5 to 6 for more information about ACHS accreditation.

## EQuIP5 Overview

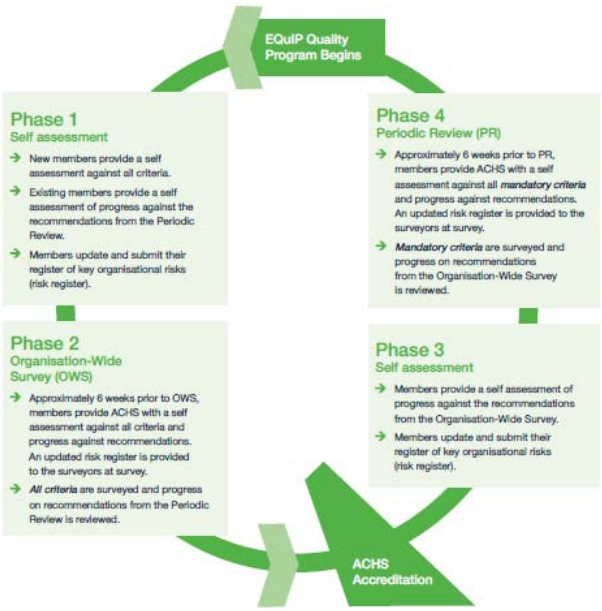
### What is EQuIP?

EQuIP is the Evaluation and Quality Improvement Program, developed and conducted by ACHS. It is a four-year quality assessment and improvement program for organisations / health services that supports excellence in consumer / patient care and services.

EQuIP is a quality management tool that can help organisations develop and maintain a systematic way of operating which is monitored and evaluated on a continuous basis with a view to the organisation becoming the best of its type. The emphasis of EQuIP is on continuous improvement and the measurement and reporting of achievements and outcomes.

### The EQuIP cycle

The 4 year EQuIP cycle requires organisations to submit at least one activity every year of their four- year EQuIP membership period. Refer to *The ACHS EQuIP5 Guide – Book 1* pages 7 to 9 for more information on the ACHS EQuIP cycle.



## The EQuIP5 rating scale

Each of the 47 EQuIP5 criteria has five levels of achievement:

| Awareness | Implementation | Evaluation | Excellence | Leadership |
|---|---|---|---|---|
| Awareness of basic requirements. Policy and legislative requirements are in place. | Systems have been developed and implemented. | Data are collected; evaluation of the systems occurs to ensure the system works effectively. Improvement efforts support better results. | Benchmarking and/or research and/or advanced implementation strategies and/or excellent outcomes are achieved. | The organisation is a peer leader in systems and outcomes. |
| LA<br>Little Achievement | SA<br>Some Achievement | MA<br>Marked Achievement | EA<br>Extensive Achievement | OA<br>Outstanding Achievement |
| LA elements | LA elements<br>plus SA elements | LA, SA elements<br>plus MA elements | LA, SA, MA elements<br>plus EA elements | This can only be rated by the surveyors at the survey |

Refer to *The ACHS EQuIP5 Guide – Book 1* page 24 for more information about achievement ratings.

## EQuIP5 mandatory criteria

Mandatory criteria are those where a rating of Marked 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. There are 15 mandatory criteria in EQuIP5. Refer to *The ACHS EQuIP5 Guide – Book 1* page 30 to 34 for more information about mandatory criteria:

### Clinical Function – 8 mandatory criteria

1.1.1 – Assessment ensures current and ongoing needs of the consumer / patient are identified.
1.1.2 – Care is planned and delivered in collaboration 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 and they understand and provide consent for their health care.
1.1.4 – Outcomes of clinical care are evaluated by healthcare providers and where appropriate are communicated to the consumer / patient and carer.
1.1.5 – Processes for clinical handover, transfer of care and discharge address the needs of the consumer / patient for ongoing care.
1.1.8 – The health record ensures comprehensive and accurate information is collaboratively gathered, recorded and used in care delivery.
1.5.1 – Medications are managed to ensure safe and effective consumer/patient outcomes.
1.5.2 – The infection control system supports safe practice and ensures a safe environment for consumers / patients and healthcare workers.

### Support Function – 3 mandatory criteria

2.1.1 – The organisation's continuous quality improvement system demonstrates commitment to improving the outcomes of care and service delivery.
2.1.2 – The integrated organisation-wide risk management framework ensures that corporate and clinical risks are identified, minimised and managed.
2.1.3 – Healthcare incidents are managed to ensure improvements to the system of care.

### Corporate Function – 4 mandatory criteria

3.1.3 – Processes for credentialling and defining the scope of clinical practice support safe, quality health care.
3.1.5 – Documented corporate and clinical policies and procedures assist the organisation to provide quality, safe health care.

3.2.1 – Safety management systems ensure safety and wellbeing of consumers / patients, staff, visitors and contractors.
3.2.4 – Emergency and disaster management supports safe practice and safe environment.

## Using this Resource Tool

This quality improvement resource should be used in conjunction with *The ACHS EQuIP5 Guide – Book 1 and Book 2.*

### Language

⇒ The term 'consumer / patient' as used in *The ACHS EQuIP5 Guide – Book 1 and Book 2* is not used in this Resource Tool except where exact wording of a standard or criterion is replicated. The term 'consumer / patient' will be replaced by 'client'. NADA acknowledges that this term may not be the preferred term by all organisations in the non government drug and alcohol sector, however it has been selected as the most representative term overall.

⇒ A glossary of terms and acronyms referred to throughout the *ACHS EQuIP5 Guide* is located at the back of both *Book 1* and *Book 2* of *The ACHS EQuIP5 Guide.*

### Layout of this Resource Tool is as follows:

⇒ Each of the three EQuIP5 functions and their related standards and criteria are in colour-coded sections.

| Clinical Function (green) | Support Function (purple) | Corporate Function (blue) |
|---|---|---|

⇒ Mandatory criteria are identified by *italicised text* as well as a mandatory criterion icon.

⇒ A summary of the intent of the criterion is provided along with page reference to the *ACHS EQuIP5 Guide – Book 1* or *Book 2* for further information and relationships with other criteria.

⇒ Evidence commonly presented within the standards are suggestions of evidence of achievement for that particular element within a criterion. Other evidence can be identified and listed by your organisation. Suggestions of evidence may include policies / procedures / supporting documents as included in the NADA Policy Tool Kit and the NADA Governance Toolkit.

⇒ Reference is made for each criterion to suggested performance measures in *The ACHS EQuIP5 Guide* as a source of data for evaluation and monitoring. While many of the suggested performance measures are applicable to non government drug and alcohol organisations, some may need modification or will not be relevant at all. Organisations may identify their own relevant performance measures.

⇒ Examples of key improvements and plans for improvement are provided for each criterion. These examples may suit your organisation or you may identify your own completed and planned quality and safety initiatives in the ACHS Electronic Assessment Tool (EAT). Refer to *The ACHS EQuIP5 Guide – Book 1* page 14 for more information about key improvements and plans for improvement.

### Important points

⇒ This Resource Tool does not address achievement beyond the Marked Achievement (MA) rating level. Organisations seeking an Extensive Achievement (EA) rating must demonstrate they have undertaken benchmarking and/or research and subsequent improvement, and/or demonstrate excellent outcomes relating to the relevant criterion. Organisations seeking an Outstanding Achievement (OA) rating must additionally demonstrate leadership relating to the relevant criterion. OA level achievement can only be rated by surveyors as a part of the organisation wide survey.

⇒ A useful feature of *The ACHS EQuIP5 Guide* is the 'prompt points' which are located throughout each criterion. The prompt points are intended to guide and 'prompt' organisations to consider their practice in relation to the criterion.

## Further information

For more information about ACHS accreditation, contact:

ACHS Customer Service Managers
The Australian Council on Healthcare Standards (ACHS)
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## EQuIP5 Quality Improvement Resource Tool feedback

The ACHS and NADA welcome feedback on this Resource Tool. Comments and suggestions can be forwarded to:

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Sector Development
Network of Alcohol and Drug Agencies (NADA)
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# Clinical Function

EQuIP5

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

### Criterion 1.1.1
*Assessment ensures current and ongoing needs of the consumer / patient are identified*


The intent of this criterion is to ensure the assessment system meets the needs of the client, carer and the organisation. The initial assessment phase should be a consultative, collaborative approach that actively involves the client.

Refer to *The ACHS EQuIP5 Guide – Book 1,* page 44 for further information, including the relationship 1.1.1 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) Guidelines are made available for staff to assess physical, spiritual, cultural, psychological and social needs, including the identification of 'at risk' consumers / patients.<br>The organisation provides guidelines for staff in assessing clients using a holistic approach, including identification of 'at risk' clients and their specific needs. | Client Intervention Policy and related procedures.<br>Staff's accessibility to guidelines. |
| | (b) Guidelines are available on the specific needs of self identified Aboriginal and Torres Strait Islander consumer / patients.<br>The organisation provides guidelines for staff in identifying specific needs of self identified Aboriginal and Torres Strait Islander consumer/patients. | Client Intervention Policy and related procedures.<br>Resources on Aboriginal and Torres Strait Islander cultural and health needs.<br>Client Diversity Policy and related procedures. |
| | (c) There is policy / guidelines to assess the consumer / patient's need for health promotion.<br>The organisation provides guidelines for staff in identifying where a client may need information and education that promotes better health and wellbeing. | Client Intervention Policy and related procedures. |
| | (d) Referral systems to other relevant service providers exist. | Client Intervention Policy and related procedures.<br>Referral procedures and resources – service provider list, documented processes. |
| Rating | Element | Evidence commonly presented |
| SA | (a) Assessment guidelines based on current professional standards and evidence based practice are implemented.<br>Client assessment processes are informed by known and documented evidenced based best practice, and | Client Intervention Policy and related procedures.<br>Evidence Based Practice Policy.<br>Client assessment documents / forms. |

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| undertaken according to staff skill, training and qualifications. | Reference to and compliance with evidence based practice. |
| (b) Assessments are conducted in a timely manner.<br>Client assessment processes are informed by best practice regarding when and where assessments should be undertaken, and when reassessment should occur. | Client Intervention Policy and related procedures.<br>Client records.<br>Electronic / other flags in client health records.<br>Results of client health record audits. |
| (c) The needs of 'at risk' consumers / patients are identified and managed.<br>The client assessment process identifies clients who may be at risk and systems are in place to respond to these clients needs. Specific risk assessments may be required, including:<br>- aged care assessment<br>- physical health assessment<br>- mental health assessment<br>- domestic violence assessment<br>- suicide / self-harm assessment<br>- nutritional needs assessment<br>- children at risk assessment<br>- potential for violence assessment.<br><br>To assist in managing needs of at risk clients, the organisation provides guidance for staff to ensure client and staff well being and safety. | Client Intervention Policy and related procedures.<br>Client Suicide and Self Harm Policy and related procedures.<br>Client Mental Health Management Policy and related procedures.<br>Other specific risk response guidelines.<br>Client health records.<br>At risk flags on client paper and electronic records.<br>Client behaviour agreements / contracts.<br>Client intervention / treatment plans. |
| (d) A support person / carer is involved in the assessment system where appropriate.<br>When appropriate, and with the client's informed consent, a support person / carer is involved in client assessment processes. | Client Intervention Policy and related procedures.<br>Family Inclusive Practice Policy.<br>Client consent / agreement. |
| (e) Information is provided to the consumer / patient on their health status.<br>Information on a client's health status / issues / needs is provided by appropriately skilled and qualified professionals. This may be done by a multidisciplinary team within the organisation, and/or include external service providers, e.g. general practitioner, counsellor, psychiatrist. | Client Intervention Policy and related procedures.<br>Skilled and qualified staff.<br>Relationships with external service providers.<br>Client accessible resources / information. |
| (f) Planning for discharge / transfer of care commences at assessment, is multidisciplinary where appropriate, and coordinated.<br>Planning for discharge / transfer of care begins at assessment, and a plan is in place once the client commences treatment with the service. Discharge / transfer of care plans may be updated throughout the intervention.<br><br>Planning for discharge / transfer of care is undertaken by a multidisciplinary team within the organisation and/or includes external service providers. Where appropriate, a carer or support person may be involved in the exit planning process.<br><br>Residential services should provide guidelines for unscheduled client exits, i.e. a client leaves or is discharged during | Client Intervention Policy and related procedures.<br>Skilled and qualified staff.<br>Family Inclusive Practice Policy.<br>Relationships with external service providers.<br>Client health records.<br>Client exit / discharge plans.<br>Client exit package. |

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| | the night or with short notice.<br><br>Client exit / discharge plans consider:<br>- distance and cost of client getting to exit destination<br>- homelessness and immediate accommodation needs (including costs) upon discharge<br>- high psychological needs<br>- age of client (under 18) or clients being discharged with children in their care<br>- who should be contacted once a client is discharged and/or an emergency contact<br>- ongoing care and referrals.<br><br>Client exit / discharge planning should include a basic exit package with referral pathways to other service providers and support information, e.g. resources, contact numbers. | |
| Rating | Element | Evidence commonly presented |
| MA | (a) The assessment process is evaluated and improved as required.<br>The organisation reviews and updates client assessment processes regularly to ensure alignment with best practice, and that they meet client and organisation needs. | Quality Improvement Policy review schedule.<br>Documented review and improvement activities.<br>Record / history of assessment processes over time. |
| | (b) Processes for assessing and managing 'at risk' consumers / patients are evaluated and improved as required.<br>The organisation reviews outcomes associated with the management of its identified 'at risk' clients and evaluates its processes for assessment of increased risk and for providing or facilitating appropriate services. | Quality Improvement Policy review schedule.<br>Documented review and improvement activities.<br>Review and improvement based on client and staff feedback. |
| | (c) Planning for discharge / transfer of care is evaluated to ensure it:<br>(i) consistently occurs<br>(ii) is multidisciplinary if appropriate<br>(iii) meets consumer / patient and carer needs.<br>The organisation evaluates its planning for the discharge / transfer of care of its clients to determine whether its processes are consistent, whether it is multidisciplinary where required, and whether the organisation's communication with external service providers is satisfactory. Client and carer feedback and satisfaction surveys are incorporated into the evaluation to ensure that processes for discharge / transfer of care meet client needs. | Documented review and improvement activities, i.e. client file audits.<br>Review and improvement based on client and carer feedback. |
| | (d) Referral systems are evaluated and improved, as required.<br>The organisation evaluates its systems for referral to external service providers, including referral pathways and support information such as its directory of providers and their contact details. There is consultation with staff to ensure that organisational resources are appropriate, and with providers to identify any deficiencies in process. Clients and carers are surveyed to assess their satisfaction with the referral system, and improvements are made as required. | Documented review and improvement activities, i.e. client, staff and external provider feedback. |

Performance measures

Suggested performance measures for this criterion are on page 50 of *The ACHS EQuIP5 Guide – Book 1.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Client Intake and Assessment Policy | Policy and assessment processes were reviewed and updated to identify clients at risk of domestic violence. | 100% of clients screened for risk of domestic violence, resulting in greater number of referrals to domestic violence specialists, improved client discharge planning, and improved client satisfaction ratings. |
| 2 | Client exit / discharge planning | Client exit / discharge planning form developed that clients and staff commence on admission and review throughout the intervention. | 100% of clients have individualised documented discharge plans in their health record, resulting in better planned, communicated and safer discharge from the service. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Update Client Intake and Assessment Policy and related procedures to include guidance on the identification of clients at risk of hepatitis infection. | Clinical team leader | March 2014 |
| 2 | Implement domestic violence identification training for all staff. | Clinical team leader | April 2014 |

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

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


The intent of this criterion is to ensure that care planning and delivery are responsive to client needs. This should be a consultative, collaborative approach that actively involves the client and his or her carer.

Refer to the *ACHS EQuIP5 Guide – Book 1,* page 54 for further information, including the relationship 1.1.2 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | | |

| | | |
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| | (a) Evidence-based guidelines on care planning and delivery are available.<br>The organisation ensures that its care and services are based upon the best available evidence, and that evidence-based guidelines are available to support the planning and delivery of care. | Client Intervention Policy and related procedures.<br>Guidelines are known by, and accessible to, all staff.<br>Staff resource library.<br>Staff access to journals and other clinical and practice reference material. |
| | (b) Care is provided in response to consumer / patient needs in a timely manner and in accordance with policy and procedures.<br>The organisation's Client Intake and Assessment Policy and Client Intervention Policy and their associated procedures define the parameters for client intake and the prioritisation of care. The organisation ensures that care is timely and delivered according to assessed client need. | Client Intervention Policy and related procedures.<br>Client health records – assessments, interview notes, treatment plans, etc. |
| | (c) Care planning reflects jurisdictional priorities for self identified Aboriginal and Torres Strait Islander consumers / patients.<br>The organisation has implemented policy and procedure for the planning and delivery of care to self-identified Aboriginal and/or Torres Strait Islander clients, which are in alignment with jurisdictional priorities for this client base. The organisation has increased its capacity to deliver appropriate care to Aboriginal and/or Torres Strait Islander clients by entering into partnerships with relevant external service providers. | Client Intervention Policy and related procedures.<br>Client Diversity Policy and related procedures.<br>Specific practices for working with Aboriginal and Torres Strait Islander clients.<br>Partnerships with relevant service providers to meet the needs of Aboriginal and Torres Strait Islander clients. |
| Rating | Element | Evidence commonly presented |
| SA | (a) Care planning and delivery are based on the assessment of consumer / patient needs, in collaboration with the consumer / patient and when appropriate their carer.<br>Intervention and treatment planning and delivery is informed by assessing client needs and is done in collaboration with the client and their carer where appropriate, ensuring the client is able to make decisions on the intervention and care to be provided. | Client Intervention Policy and related procedures.<br>Family Inclusive Practice Policy.<br>Client records – assessments, interview notes, treatment plans, etc. |
| | (b) Consumers / patients are informed of factors impacting on their health and a plan for promoting their individual wellbeing is discussed.<br>Clients are provided with information on how they can develop skills in managing self well being. This may be via a number of formats, including print and electronic material, DVD, group education sessions, individual planning sessions, specialist referral. | Skilled and qualified staff.<br>Client accessible resources / information.<br>Client health records – assessments, interview notes, treatment plans, etc.<br>Services provided, i.e. education groups, referral and linking with specialists. |
| | (c) Care planning decisions, actions and changes are documented in the consumer / patient health record.<br>All client intervention and care is clearly noted in the client health record and other organisation-identified areas, including where relevant, the electronic health record and register of actions. | Client Intervention Policy and related procedures.<br>Client health records – interview and file notes, treatment plans.<br>Electronic records. |
| | (d) Care is coordinated, planned and delivered by skilled and trained individuals within a multidisciplinary team with an identified team leader.<br>A range of skilled and trained individuals are involved in a client's care to ensure the client's needs are identified and | Organisation human resources chart.<br>Functions and responsibilities chart.<br>Employee position descriptions – skill, training and qualifications |

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| | responded to. Care planning and delivery includes handover between staff shifts, case reviews / conferencing, and referral to external service providers as required. | required.<br>Client health records – case notes, referral notes, external provider reports, case reviews / conferencing notes.<br>Staff handover meetings.<br>Client case reviews / conferencing. |
| | (e) Consumers / patients and when appropriate, carers are provided with information that allows them to understand their care and care delivery options and any variations to their care.<br>Clients and carers when appropriate are provided with information on the intervention / treatment options available within and external to the organisation. Clients and carers develop understanding of the procedures, activities, events, and timing of the care that will be provided, and when treatment may change. | Organisation / service / treatment information via brochure, website, etc.<br>Intervention / treatment schedule – group program, individual counselling, etc.<br>Client understanding and consent forms.<br>Client rights and responsibilities agreement.<br>Client orientation procedures.<br>Client records. |
| | (f) A system exists for the effective identification and management of a deteriorating consumer / patient.<br>The health, wellbeing and progress of the client is reviewed regularly through observation, client interview, case reviews / conferencing, handover between staff shifts, and carer involvement where appropriate. Client records are maintained with all required information noted by staff, including clients who have been identified as having specific risk factors.<br><br>Defined processes are known and followed for responding to client emergency situation, i.e. first aid, medical assistance, police assistance. | Client Intervention Policy and related procedures.<br>Client records – case notes, referral notes, external provider reports, case reviews / conferencing notes, at risk flag.<br>Staff handover meetings.<br>Client case reviews / conferencing. |
| Rating | Element | Evidence commonly presented |
| MA | (a) Policy and procedures for care delivery are evaluated.<br>Client intervention / treatment policies are regularly reviewed and evaluated to ensure they meet the needs of the client, staff and the organisation, and are informed by best practice. Evaluation includes feedback from clients, carers and staff. | Quality improvement policy review schedule.<br>Documented evaluation activities.<br>Record / history of client intervention / treatment policies and programs over time. |
| | (b) The care planning and delivery processes are evaluated and improved as required.<br>Client intervention / treatment is regularly reviewed, evaluated and improved to ensure it meets the needs of the client, staff and the organisation, and are informed by best practice. Evaluation includes feedback from clients, carers and staff. | Documented review and improvement activities.<br>Review and improvement based on client and staff feedback. |
| | (c) Multidisciplinary team processes for care delivery are evaluated and improved as required.<br>The team involved in providing client intervention / treatment is involved in review and improvement activities. This may include staff and external provider meetings and/or surveys as to how processes could be improved. | Documented review and improvement activities.<br>Review and improvement based on staff and external feedback.<br>Stakeholder surveys and reports.<br>Staff meetings. |
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| | (d) The system for the effective identification and management of a deteriorating patient is evaluated and improved as required.<br>The identification and response to clients identified as being at risk or where an emergency situation occurs is reviewed and improved on, based on feedback from those involved, those with expertise and informed by best practice. | Known and understood best practice for identification and management of clients at risk or an emergency situation.<br>Documented review and improvement activities.<br>Review and improvement based on staff and external feedback. |

Performance measures

Suggested performance measures for this criterion are on page 58 of *The ACHS EQuIP5 Guide – Book 1.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Client risk checklist. | A client risk checklist was developed for inclusion in all client records. | Clients at risk are easily identified and communicated between staff, so that monitoring and response is improved. |

Plans for improvement

| No. | Intended Improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | All clients identified as at-risk will have initial and follow-up case reviews / conferencing throughout treatment. | Clinical Director | April 2014 |

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

### Criterion 1.1.3

*Consumers / patients are informed of the consent process and they understand and provide consent for their healthcare*


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

Refer to *The ACHS EQuIP5 Guide – Book 1,* page 62 for further information, including the relationship 1.1.3 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | | |

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| | (a) There is policy / guidelines for consent that is consistent with jurisdictional legislative requirements.<br>The organisation provides guidelines for staff in obtaining intervention / treatment consent from the client, and where appropriate, their carer. The policy / guidelines addresses:<br>- procedure used to obtain consent<br>- aspects of care requiring client consent<br>- documentation in the client health record<br>- shared consent between other service providers<br>- surrogate decision maker providing consent<br>- use of interpreter service<br>- situations where consent may not be provided or required. | Client Intervention Policy and related procedures.<br>Privacy and Confidentiality Policy and related procedures. |
| | (b) Healthcare providers are advised of the consent policy / guidelines.<br>The organisation informs staff of the consent policy / guideline through new staff orientation processes. External providers are informed of the organisation's consent policy / guidelines when developing referral pathways and when making individual client referrals. | Staff Induction and Orientation Procedure.<br>Staff Induction and Orientation Checklist.<br>Privacy and Confidentiality Policy and related procedures. |
| | (c) Consumers / patients are provided with information on recommended investigations, treatment or procedures, and costs prior to providing consent for that health care.<br>The organisation provides information and discusses with clients, information about the intervention / treatment prior to obtaining client consent, including:<br>- specific procedures, activities and investigations<br>- possible benefits, risks, complications and side effects<br>- probability of achieving care and treatment goals<br>- associated costs<br>- limitations to confidentiality. | Client Intake and Assessment Policy and related procedures.<br>Organisation / service / treatment information via brochure, website, etc.<br>Information on specific procedures, activities and investigations – group program, counselling, mental health assessment, etc.<br>Privacy and Confidentiality Policy and related procedures. |
| Rating | Element | Evidence commonly presented |
| SA | (a) Consent is obtained for investigations, treatment or procedures and costs in accordance with the organisation's policy / guidelines.<br>A signed consent form is completed by all clients prior to intervention / treatment. The consent form may include details of agreed procedures, activities and investigations, including:<br>- supervised urinalysis and breath alcohol testing<br>- risks inherent in treatment, e.g. risks involved in drug and alcohol withdrawal / detoxification, or through the emergence of emotional states or sleep difficulties<br>- collection of health information and use of that information and/or disclosure by the organisation to third parties, e.g. use data for research / statistics<br>- financial responsibilities of the client, e.g. client contribution / fees, signing of Centrelink authority. | Client Consent Form.<br>Client records – authorised consent forms. |
| | (b) There is a process to manage consent where it is unable to be given at the appropriate time.<br>In the case where a client is unable to provide signed consent, such as a telephone assessment, documentation exists to | Client Intervention Policy and related procedures.<br>Client assessment documents. |

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| | enable the recording of verbal consent until a signed authority is obtained. | Client records – assessment documents and authorised consent forms. |
| | (c) There is a process to obtain consent for personal information to be communicated to healthcare workers outside the service, to carers or to other relevant persons when required.<br>Client consent is obtained as standard practice for occasions where external service providers and referrals are involved in a client's care. | Client Intervention Policy and related procedures.<br>Client Consent Form.<br>Client records – authorised consent forms. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The consent process is evaluated and improved as required.<br>The client consent process is regularly reviewed, evaluated and improved to ensure it meets the needs of the client, staff and the organisation, and is informed by best practice. Evaluation includes feedback from clients, carers and staff. | Documented review and improvement activities.<br>Review and improvement based on staff and external feedback. |
| | (b) Compliance with the consent process is evaluated and strategies for improvement are implemented as required.<br>The organisation undertakes client record audits to ensure client consent is obtained prior to intervention / treatment commencing. The process of obtaining client consent is evaluated and improved to ensure it is in line with current best practice. | Quality improvement review schedule.<br>Documented evaluation activities – client record audit findings and responses.<br>Review and improvement based on client and staff feedback. |

Performance measures

Suggested performance measures for this criterion are on page 72 of *The ACHS EQuIP5 Guide – Book 1.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Availability of organisation, service and treatment information for clients prior to care commencing. | Reviewed availability and accessibility of information for clients to ensure they are informed of the intervention / treatment prior to care commencing. Developed electronic and hard copy information and provided to stakeholders / referrers, as well as clients. | Clients receive detailed information about the service and service requirements prior to intake, giving the client opportunity to contact the service with any questions or concerns prior to commencement of treatment. |
| 2 | Discussion with clients regarding the limits of confidentiality. | Reviewed the procedure and content, developed hard copy agreement outlining limits of confidentiality and how client data may be used for service development. | Clients provided with opportunity to discuss confidentiality limits before agreement. Signed agreement obtained before treatment commences. Original agreement placed in client health record and copy provided to client. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Develop organisation / service website for improved provision of information to clients, families and stakeholders. | Service Manager | August 2014 |

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

### Criterion 1.1.4

*Outcomes of clinical care are evaluated by healthcare providers and where appropriate are communicated to the consumer / patient and carer*


The intent of this criterion is to ensure that organisations evaluate the outcomes of the care and the services they provide, on a case-by-case basis, as well as organisation-wide.

Refer to *The ACHS EQuIP5 Guide – Book 1*, page 68 for further information, including the relationship 1.1.4 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) Healthcare providers are aware of the organisation's systems for the evaluation of clinical care.<br>Staff are informed of the organisation's evaluation systems - this may be through new staff orientation, staff meetings, specific clinical and/or evaluation meetings. | Staff Induction and Orientation Procedure.<br>Staff Induction and Orientation Checklist.<br>Meeting minutes and action plans. |
| | (b) Policy / guidelines exist for providing feedback about clinical care to consumers / carers.<br>The organisation has policy / guidelines for staff in providing feedback to clients and carers about the intervention / treatment being provided. | Client Intervention Policy and related procedures. |
| | (c) Consumers / patients and when appropriate carers are enabled to provide feedback on the care provided.<br>Clients of the service and their carers are supported to give feedback on the intervention / treatment provided. Support is provided by informing clients and their carers that feedback is welcomed and by having mechanisms to give feedback. Mechanisms may include client satisfaction surveys, feedback and complaint forms, service suggestion forms / drop box, consultation / focus groups with clients, etc. | Client and carer rights and responsibilities.<br>Client and carer satisfaction surveys. Client feedback and complaint forms<br>Client service suggestion forms/drop box.<br>Client consultation/focus groups. |
| Rating | Element | Evidence commonly presented |
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| SA | (a) Formal processes are implemented across the organisation for the review of clinical care.<br>The organisation regularly reviews the intervention / treatment provided to clients, both individually and organisation / service-wide. Reviews of intervention / treatment may also include a focus on specific population groups, and/or specific intervention / treatments, and/or at risk clients. | Client Intervention Policy and related procedures.<br>Program Evaluation Policy and related procedures.<br>Client case reviews / conferencing.<br>Client and carer feedback reports and actions undertaken. |
| | (b) Prior to discharge, healthcare providers discuss the outcomes of care with the consumer / patient and when appropriate the carer, and this is documented.<br>In the lead up to and at exit from the intervention / treatment, staff review and discuss outcomes with individual clients in line with policy / guidelines. The findings and discussion are documented in the client's health record. | Client Intervention Policy and related procedures.<br>Individual client health records. |
| Rating | Element | Evidence commonly presented |
| MA | (a) Clinical audit is supported across the organisation and reviewed by the relevant clinician groups to evaluate and improve health care.<br>The organisation has policy / guidelines that outline the process for intervention / treatment evaluation, including when, what aspects and specific staff responsibilities and delegations. The organisation has systems in place for collating client intervention / treatment data for evaluation, i.e. health outcomes database, client feedback database. | Program Evaluation Policy and related procedures.<br>Program review reports and actions undertaken.<br>Health outcomes database – reports and actions undertaken.<br>Client feedback database – reports and actions undertaken. |
| | (b) Individual and group consumer / patient care and outcomes data (including 'at risk' patients) are evaluated and improved as required.<br>Client data are reviewed individually and as a whole and used to inform client intervention / treatment development. At risk client review may include those with mental health issues, those with poor physical health and those with poor support outside of the organisation's intervention / treatment. | Client Intervention Policy and related procedures.<br>Client Exit Policy and related procedures.<br>Program Evaluation Policy and related procedures.<br>Client treatment plans.<br>Client related databases with outcome data reports.<br>Program review reports and actions undertaken. |
| | (c) Data collected from the feedback of consumer / patients are used by the organisation in the evaluation of clinical care.<br>The organisation's processes for evaluation of its clinical care are informed the feedback obtained from clients and carers. A database of feedback is maintained and the information gathered is incorporated into the organisation's processes for evaluating its care and services. | Feedback and Complaints Policy and related procedures.<br>Client feedback database – reports and actions undertaken. |
| | (d) Consumers / patients and when appropriate, carers participate in the evaluation of care.<br>The organisation conducts consultations and focus groups, and incorporates comments from clients and their carers regarding the interventions / treatments provided by the organisation into the evaluation of its care and services. | Client Intervention Policy and related procedures.<br>Feedback and Complaints Policy and related procedures.<br>Client and carer consultation / focus groups and reports and actions undertaken. |

Performance measures

Suggested performance measures for this criterion are on page 72 of *The ACHS EQuIP5 Guide – Book 1.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Information provided to clients and carers regarding their feedback on care. | Reviewed the information provided to clients. Expanded pre-entry information pack and intake processes to include client and carer feedback opportunities. | Clients and carers more informed about how they can participate in feedback on the care provided by the organisation. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Client health outcome data collated and discussed at quarterly staff clinical meetings. | Clinical Manager | October 2014 |

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

### Criterion 1.1.5
*Processes for clinical handover, transfer of care and discharge address the needs of the consumer / patient for ongoing care*


The intent of this criterion is to ensure that clinical handover is effective and that organisations follow processes for safe transition of care at completion or when there is a change in clinical personnel.

Refer to *The ACHS EQuIP5 Guide – Book 1*, page 74 for further information, including the relationship 1.1.5 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) Guidelines for discharge and transfer of care are available.<br>The organisation has guidelines for managing client exit and transfers to other service providers. Guidelines exist for the handover of client care within the organisation from individual staff, teams and shifts. | Client Intervention Policy and related procedures.<br>Client Exit Policy and related procedures. |
| | (b) Arrangements with other service providers and, where appropriate, the carer, are made with consumer / patient consent and input, and confirmed prior to discharge or transfer of care.<br>Plans for when clients are to exit from the intervention / treatment are discussed and confirmed with the client prior to exit. Referral to other intervention / treatment and/or other service providers is discussed and agreed to with the client, and where appropriate the carer, before a referral is made. Agreement on exit plans and referral may be | Client Intervention Policy and related procedures.<br>Client Exit Policy and related procedures.<br>Family Inclusive Practice Policy and related procedures.<br>Client health records – signed exit plans and Consent to Release Information Forms. |

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| | provided on Client Exit Plan and Consent to Release Information Form. | |
| Rating | Element | Evidence commonly presented |
| SA | (a) There is an effective, organisation-wide system for discharge / transfer of care which ensures continuity of care and timely notification between referrers and providers.<br>The organisation's policy / guidelines on managing client exit and transfers to other service providers is applied consistently for all clients by all relevant staff and meets the needs of the client, the referring organisation and the external service provider. The policy / guidelines provide detail on when and how referral to external service providers is to be done. | Client Intake and Assessment Policy and related procedures.<br>Client Exit Policy and related procedures.<br>Client case reviews / conferencing.<br>Client health records – referrals.<br>Feedback from external service providers – reports and actions undertaken. |
| | (b) Clinical handover processes are utilised to ensure continuity of care.<br>The ongoing care of clients in the service are discussed between staff as part of shift handover and transfer of care between staff. | Client Intervention Policy and related procedures.<br>Shift handover meetings.<br>Client health record – transfer of care notes. |
| | (c) Results of investigations follow the consumer / patient through the referral system.<br>Relevant information regarding a client's intervention / treatment / investigation (i.e. mental health screening, physical examinations, and medications) is transferred to the ongoing service provider. | Client Intervention Policy and related procedures.<br>Client Exit Policy and related procedures.<br>Client health record – transfer of care notes. |
| | (d) There is evidence to demonstrate that service providers receive timely notification about consumer / patient discharge to their care.<br>External service providers report that the organisations referral and discharge processes provide sufficient notice of client referral / transfer. | Client Exit Policy and related procedures.<br>Feedback from external service providers – reports and actions undertaken. |
| | (e) Discharge information is discussed with the consumer / patient and a written discharge summary is provided.<br>Discussions are undertaken with clients regarding their exit from the service. All clients are provided with a discharge intervention / treatment report. | Client Exit Policy and related procedures.<br>Client health record – discharge intervention / treatment report. |
| | (f) Formalised follow-up occurs for 'at risk' consumers / patients.<br>The organisation identifies at-risk clients during the intervention / treatment and flagged for follow up once exited from the service. | Client Exit Policy and related procedures.<br>At-risk client follow-up register / flagging.<br>Client health record – discharge intervention / treatment report and follow-up notes. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The processes for discharge / transfer of care are evaluated, and improved as required.<br>The organisation reviews and improves the process of exiting and transferring clients. Client exits and transfers that do not proceed as planned are discussed at clinical / staff meetings with a view to improving policy and practice | Quality Improvement Policy review schedule.<br>Documented review and improvement activities.<br>Record / history of client exit and transfer processes over time.<br>Client, staff and external feedback – reports and action undertaken. |

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| | (b) Discharge and referral information for consumers / patients, other service providers and the systems for providing the information are evaluated and improved as required.<br>The organisation reviews and improves exit and referral information provided to clients and external service providers. | Quality Improvement Policy review schedule.<br>Documented review and improvement activities.<br>Record / history of exit and referral information over time.<br>Client, staff and external feedback – reports and action undertaken. |

Performance measures

Suggested performance measures for this criterion are on page 80 of *The ACHS EQuIP5 Guide – Book 1.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Exiting and referral of at risk clients. | Client exit checklist developed and applied with all clients to ensure that risks associated for individual clients were considered. | The needs of at risk clients better identified and appropriate action undertaken to ensure client safety and to meet the organisation's duty of care requirements. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Automatic client exit report query developed in client health outcomes database for all clients on exit and referral. | Clinical team leader | November 2014 |

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

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

The intent of this criterion is to ensure that all organisations and individuals involved in caring for clients contribute to a seamless continuum of care and fulfil their responsibilities for their part of this process.

Refer to *The ACHS EQuIP5 Guide – Book 1,* page 74 for further information, including the relationship 1.1.6 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) There are formal processes for coordinating ongoing care by multiple service providers in a timely manner.<br>The organisation has policy / guidelines to support the provision of interventions / treatment for clients who receive ongoing care from additional service providers. | Client Intervention Policy and related procedures.<br>Client Exit Policy and related procedures. |
| Rating | Element | Evidence commonly presented |
| SA | (a) Care coordination and/or case management is available for appropriate consumers / patients and their carer.<br>The organisation provides a case manager / coordinator for clients to support coordinated care, and seamless referrals, and to achieve improved health outcomes. | Client Intervention Policy and related procedures. |
| | (b) There are systems for screening, prioritisation and readmission of consumers / patients with chronic conditions.<br>The organisation may identify at risk clients for which priority access to assessment and admission is provided. At risk clients may be: pregnant women, parents as primary carers, clients with acute mental health issues. | Client Intervention Policy and related procedures.<br>Client Suicide and Self Harm Policy and related procedures.<br>Client Mental Health Management Policy and related procedures.<br>Other specific risk response guidelines. |
| | (c) Strategies are developed to reduce acute presentations and avoidable admissions of consumer / patients with chronic conditions.<br>The organisation implements programs / strategies / activities that support clients in managing their own well being to reduce preventable re-presentation. Programs / strategies / activities may include: drug and alcohol and mental health harm reduction and relapse prevention education; specific issue / illness care education; identifying and connecting the client with supports; coordination of client's care with other providers; and supportive aftercare and follow-up. | Client Intervention Policy and related procedures.<br>Client Mental Health Management Policy and related procedures.<br>Client Exit Policy and related procedures.<br>Client program schedule – group education, individual sessions, etc.<br>Information provided to clients. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The ongoing care process is evaluated and improvements are made to ensure better practice.<br>The organisation reviews the process of providing ongoing / aftercare so that it knows what practices are in place and identifies ways to improve. | Quality improvement policy review schedule.<br>Documented review and improvement activities.<br>Record / history of client care processes over time.<br>Client, staff and external feedback – reports and action undertaken. |
| | (b) Education provided for consumers / patients requiring ongoing care and where appropriate their carer, is evaluated, and improvements are made to ensure better practice.<br>The educational needs of clients and their carers are regularly reviewed, with input from clients and their carers, and consideration given to the current and changing client demographics. The organisation makes improvements to the education services it provides to ensure they meet client and carer needs and contribute to improved client outcomes. | Quality improvement policy review schedule.<br>Documented review and improvement activities.<br>Record / history of client education packages over time.<br>Client, staff and external feedback – reports and action undertaken. |

Performance measures

Suggested performance measures for this criterion are on page 89 of *The ACHS EQuIP5 Guide – Book 1.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Education provided to clients on Hepatitis B transmission. | Accessible print brochure on Hepatitis B prevention provided to all clients as part of their admission kit. Information expanded in the client 'Hepatitis Education' group. | All clients are provided with information about preventing and managing Hepatitis B. Opportunity for greater discussion in client group. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Seek feedback from clients, as part of the exit process, for suggestions on further education topics and format. | Clinical Manager and all clinical staff. | November 2013 |

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

### Criterion 1.1.7
### The care of dying and deceased consumers / patients is managed with dignity and comfort and family and carers are supported

The intent of this criterion is to ensure that organisations place a high priority on the care and management of consumers / patients at the end of life, and provide appropriate support services for families / carers.

Refer to *The ACHS EQuIP5 Guide – Book 1,* page 92 for further information, including the relationship 1.1.7 has with other criteria.

*This criterion has limited, if any, application in non government drug and alcohol organisations. Contact your ACHS Customer Services Manager for further advice.*

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

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


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

Refer to the *ACHS EQuIP5 Guide – Book 1*, page 102 for further information, including the relationship 1.1.8 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) Every consumer / patient has a health record with a unique identifier.<br>Every client has a paper and/or electronic health record characterised by a unique identifier for that client. A central record of all client unique identifiers is maintained. | Client File Management Policy and related procedures.<br>Central record of client unique identifiers.<br>Client health records – paper and/or electronic. |
| | (b) Health record documentation policy and procedures are available for staff and meet relevant professional jurisdictional guidelines.<br>The organisation's Client File Management Policy and related procedures are available to staff, and are informed by relevant NSW and federal guidelines. Guidelines may include: NSW Ministry of Health Drug and Alcohol Treatment Guidelines for Residential Settings[i]; NSW Ministry of Health Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines Professional Practice Guidelines[ii]; WA Drug and Alcohol Office Counsellor's Guide to Working with Alcohol and Drug Users[iii]; specific guides from nursing, social work, psychology, and medical practitioner disciplines.<br><br>Health record policy and procedures address issues such as:<br>- health record forms (constructional requirements and physical characteristics, form identification/name, client identification, layout, fixing of loose forms, form design)<br>- dividers<br>- health record covers (size, design, information included)<br>- sectioning within the record<br>- order of filing within sections<br>- retention and disposal. | Location and staff access to Client File Management Policy and related procedures.<br>Client health records – paper and/or electronic. |
| | (c) Healthcare providers are aware of the organisation's systems for healthcare record creation and | Client File Management Policy and related procedures. |

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| | management.<br>Staff are aware of the organisation's policy and procedures for the creation and ongoing management of client health records. Awareness may be developed through new staff orientation processes, formal communication when policy and/or procedures are changed, targeted information / training sessions, and health record audits.<br><br>- | Staff orientation checklists.<br>Staff notices / emails / meetings demonstrating communication of policy / procedure change.<br>Record of information/training sessions.<br>Documented audits and feedback to staff.<br>Staff knowledge of health record creation and management. |
| | (d) Authorised internal and external health care providers have access to information about the consumer / patient in accordance with jurisdictional privacy legislation.<br>The organisation identifies those staff and external service providers who are entitled to access client health records, as well as when, how and what components they may access. Relevant policies and procedures are informed by and comply with privacy legislation, including the *National Privacy Act 1988* and the ten National Privacy Principles. | Client File Management Policy and related procedures.<br>Privacy and Confidentiality Policy and related procedures.<br>Health record storage and security. |
| | (e) Consumers / patients are given advice / written guidelines on how to access their health records.<br>Information about how clients can access their health record is made available to all clients. This may be done in writing on the organisation's website and brochures, and client intake / orientation documents, as well as verbally as part of the client intake process and when access is requested. | Client File Management Policy and related procedures.<br>Privacy and Confidentiality Policy and related procedures.<br>Organisation website and brochures.<br>Client intake / orientation procedure and documents. |
| Rating | Element | Evidence commonly presented |
| SA | (a) Healthcare providers use the health record to document and communicate all aspects of care delivery in accordance with the organisation's policy / guidelines.<br>The organisation's staff and relevant external service providers, adhere to the Client File Management Policy and related procedures, recording all aspects of care provided and scheduled.<br><br>Organisations may identify minimum requirements for creating and managing client health records, including:<br>- client identifier, name and date of birth on every page in every health record<br>- only blue or black pen is used, with the exception of allergy alerts which are be written in red pen or indicated by a label / sticker<br>- all notes and entries marked with the staff's name, signature and designation in block letters<br>- all notes and entries are dated and timed<br>- all notes and entries are objective and factual, and not presumptions or judgements<br>- all written notes and entries are legible<br>- only approved abbreviations are used<br>- no use of white-out / liquid paper<br>- entries written in error are ruled through with a single line and initialled by the staff making the entry<br>- student entries are countersigned<br>- all health records are compiled in a stipulated order to support consistent document location / filing. | Client File Management Policy and related procedures.<br>Staff knowledge of health record documentation.<br>Client health records – paper and/or electronic. |

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| | (b) Systems are implemented to monitor the legibility of the health record.<br>The organisation's Client File Management Policy and related procedures include guidelines for reviewing the legibility of all entries in client health records, and active review is undertaken. | Client File Management Policy and related procedures.<br>Schedule of client health record reviews/audits. |
| | (c) Results of reviews and clinical consultations are made available to healthcare providers.<br>Documentation of all client reviews, referrals, consultations, interventions and treatment is compiled in the client's health record and made available to relevant staff and service providers as required. | Client File Management Policy and related procedures.<br>Client health records – paper and/or electronic. |
| Rating | Element | Evidence commonly presented |
| MA | (a) Health records are evaluated to ensure they meet medico-legal requirements, professional documentation standards and jurisdictional health department guidelines.<br>The organisation reviews client health records to ensure practice aligns with the organisation's Client File Management Policy and related procedures, including privacy and minimum standard requirements. | Client File Management Policy and related procedures.<br>Schedule of client health record reviews / audits.<br>Documented review and improvement activities. |
| | (b) Health records are evaluated to ensure that the clinical content supports high quality care and improvements are made as required.<br>The organisation reviews client health records to ensure that client assessments, treatment / intervention plans, case notes and results are recorded and inform the care provided to clients. Where reviews identify areas for improvement in the documenting of clinical content, the organisation makes a record of the issues, action planned and implemented, and the results. | Client File Management Policy and related procedures.<br>Schedule of client health record reviews / audits.<br>Documented review and improvement activities. |
| | (c) Evaluation of legibility of the health record is addressed through the use of audits, and improvements are made as required.<br>The organisation reviews client health records to ensure that hand-written, faxed and scanned health record entries are able to be read by users of the health record. Where reviews identify areas for improvement in the legibility of health record entries, the organisation makes a record of the issues, action planned and implemented, and the results. | Client File Management Policy and related procedures.<br>Schedule of client health record reviews / audits.<br>Documented review and improvement activities. |
| | (d) Timeliness of inclusion of reports and information from reviews, tests and other clinical investigations into the health record is evaluated and improved, as required.<br>The organisation reviews client health records to ensure that health record entries are made within the stipulated time to ensure that users of the health record have access to the information when needed. Where reviews identify areas for improvement in the timeliness of health record entries, the organisation makes a record of the issues, action planned and implemented, and the results. | Client File Management Policy and related procedures.<br>Schedule of client health record reviews / audits.<br>Documented review and improvement activities. |

Performance measures

Suggested performance measures for this criterion are on page 109 of *The ACHS EQuIP5 Guide – Book 1.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Client identifiers for health records. | An electronic sticker / label template developed to print client stickers / labels that include client name, identifier and date of birth. | All pages in the client health record have the client sticker / label attached to ensure entries and documentation are correctly attributed to the correct client. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Organisation to dispose of white-out / liquid paper in the office and to distribute reminder notices to staff not to use in client health records. | Administration Officer | July 2013 |

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

### Criterion 1.2.1
### The community has information on health services appropriate to its needs

The intent of this criterion is to ensure that organisations provide information on their services appropriate to the needs of the community they serve.

Refer to *The ACHS EQuIP5 Guide – Book 1,* page 112 for further information, including the relationship 1.2.1 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) Information is gathered to define the needs of the community.<br>The organisation identifies the needs of the community it serves by defining who its community is, what the broad and specific issues are that this community informs and presents with, and by collating data about the community. Strategies to gather community needs information may include client and stakeholder feedback / surveys, client and community consultation forums, reviewing intake and assessment data, and gathering data from relevant research (internally and externally). | Organisation and service information available on brochures, website, referral documentation.<br>Organisation strategic plan.<br>Client intake, assessment and outcome data.<br>Target population and actual client demographics report.<br>External research data and actual client demographics report.<br>Client, staff and external feedback reports. |
| | (b) Information on the organisation's healthcare services is available to the community. | Organisation and service information available on brochures, |

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| | The organisation provides clear information to potential clients and the broader community about the services / treatments / interventions it provides, any associated costs or other requirements, location and access, and the process for intake / admission.<br><br>Information may be provided through:<br>- directories or lists of organisations / services<br>- brochures<br>- websites<br>- news and sector media – articles, advertising<br>- signage<br>- DVDs, social media tools<br>- forums and community events. | website and social media tools.<br>Articles and advertisements in news media and sector media.<br>Community and stakeholder forums and events. |
| | (c) Relevant external service providers are provided with information on the health service and are informed of referral and entry processes.<br>The organisation provides clear information to external service providers about the services / treatments / interventions it provides, access and admission processes, the referral process, and the transfer of client information. | Organisation and service information available on brochures, website and social media.<br>External Relationship Policy.<br>Referral procedures and forms.<br>Interagency visits and in-services.<br>Conference / forum attendance and presentation. |
| Rating | Element | Evidence commonly presented |
| SA | (a) Consumers / patients have information about the specific service they are using.<br>The organisation provides information to clients about the treatments / interventions available, as well as how the organisation will manage health information, what the inclusion and exclusion criteria are, client rights and responsibilities, relationships and collaborations with other service providers, the schedule of the program, and transport / parking information.<br><br>The information is provided to clients in an appropriate format and language. | Organisation and service information available on brochures, website and social media.<br>Preadmission letters / information provided to clients.<br>Client intake / orientation procedure and documents.<br>Client rights and responsibilities document.<br>Client program schedule. |
| | (b) Healthcare providers within the organisation have information on relevant external services.<br>Staff within the organisation have access to information on external services relevant to the organisation's client group. Information available includes treatment / interventions available, contact details, referral processes, and how the client could access the service independently. | External service list / folder.<br>Internet access.<br>Forum attendance and presentation. Interagency visits and in-services. |
| | (c) There is collaboration between the organisation, consumers / patients and where required, external service providers.<br>The organisation develops and maintains relationships with clients and external service providers to meet the needs of clients and the community. | External Relationship Policy and related procedures.<br>Forum attendance and presentation.<br>Interagency visits, in-services and meetings.<br>Memoranda of understanding / service agreements.<br>Client Intervention Policy and related procedures. |
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| Rating | Element | Evidence commonly presented |
|---|---|---|
| MA | (a) The organisation reviews and evaluates content and processes for dissemination of information on services, and makes improvements as required.<br>The organisation reviews service information that is provided to potential clients, clients, the broader community, and external service providers, as well as how that information is disseminated. Where reviews identify areas for improvement in the content and dissemination of information, there is a record of the issues, action planned and implemented, and the results. | Schedule of service information reviews.<br>Documented review and improvement activities.<br>Client, staff and external feedback – reports and action undertaken. |
| | (b) Collaboration between the organisation, consumers / patients, carers and external service providers is evaluated, and improvements are made as required.<br>The organisation reviews the relationships with clients, carers and external service providers. Where reviews identify areas for improvement in relationship development, communication and maintenance, there is a record of the issues, action planned and implemented, and the results. | Schedule of relationship reviews.<br>Documented review and improvement activities.<br>Client, staff and external feedback – reports and action undertaken.<br>External Relationship Policy development over time.<br>Grievance and Dispute Settling Policy development over time. |

Performance measures

Suggested performance measures for this criterion are on page 116 of *The ACHS EQuIP5 Guide – Book 1.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Organisation website development. | The website now has a referral page for external service providers. | Written and verbal feedback from external service providers indicates client eligibility, intake, assessment and referral process information and tools has improved their knowledge of the organisation and how to make appropriate referrals. |

Plans for improvement

| No | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Update content and format of the organisation's external provider list to include treatment / intervention available, contact details, referral processes, and how the client could access the service independently. | Client case managers | September 2013 |

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

### Criterion 1.2.2

## Access and admission / entry to the system of care is prioritised according to healthcare needs

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

Refer to *The ACHS EQuIP5 Guide – Book 1,* page 118 for further information, including the relationship 1.2.2 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) The organisation has documented processes on the prioritisation for admission / entry to services.<br>The organisation has policy / guidelines that identify priority intake, assessment and admission based on clients' risks, issues and other needs. The policy / guidelines may include reference to certain population groups (i.e. women with children), referral points (i.e. MERIT program where services are funded), or clinical need (i.e. already experiencing alcohol withdrawal). The organisation may have universal inclusion or it may have priority access based on providing appropriate care in the appropriate setting or due to external factors such as funding conditions. | Client Intervention Policy and related procedures - intake and assessment. |
| | (b) The organisation has clear inclusion and/or exclusion criteria for admission to the service.<br>The organisation has documented inclusion and exclusion criteria to assist in assessing client eligibility. These inclusion and exclusion criteria are available to potential clients, clients, the broader community, and external service providers. | Client Intervention Policy and related procedures - intake and assessment.<br>Organisation and service information available on brochures, website and social media. |
| **Rating** | **Element** | **Evidence commonly presented** |
| SA | (a) A system exists for prioritising care according to need.<br>The organisation has a documented system / process for prioritising clients according to needs.<br>The policy / guidelines may identify persons responsible for determining priority intake, assessment and admission, and stipulate the documentation required when determining priority. | Client Intervention Policy and related procedures - intake and assessment.<br>Position descriptions.<br>Client health records. |
| | (b) Admission / entry processes meet consumer / patient needs and minimise duplication.<br>The organisation's intake, assessment and admission procedures are efficient and make use of tools and practices that reduce duplication of information gathering, documenting and sharing.<br>A record is made of all client demographic data, eligibility, initial contact details, referral details, presenting issues, and waiting list contacts for future reference. | Organisation and service information available on brochures, website and social media.<br>Client Intervention Policy and related procedures - intake and assessment.<br>Client File Management Policy and related procedures.<br>Client database / health record system.<br>Client health records.<br>Client waiting list management procedure. |
| | (c) There are processes that ensure continuity of care between referrers and providers.<br>Necessary client information is collected, disseminated and transferred between relevant service providers so that all involved are aware of the client and their needs and what actions / interventions have occurred and are scheduled. This may occur prior, during and post-treatment / intervention, and adheres to the organisation's privacy and | Client Intervention Policy and related procedures - intake and assessment.<br>Client File Management Policy and related procedures.<br>Client Exit Policy and related procedures. |

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|---|---|---|
| | confidentially policies / guidelines. | Client health records.<br>External Relationship Policy.<br>Referral procedures and forms.<br>Client case reviews / conferencing. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The organisation evaluates the effectiveness of its prioritisation guidelines, and these are improved as required.<br>The organisation reviews client prioritisation and all related guidelines. Where reviews identify areas for improvement, particularly access barriers for priority groups, there is a record of the issues, action planned and implemented, and the results. Reviews may include analysing client data and feedback from clients, carers, staff and external service providers. | Schedule of priority guideline reviews. Documented review and improvement activities.<br>Client, staff and external feedback – reports and action undertaken. |
| | (b) The organisation evaluates the admission / entry processes, and makes improvements as required.<br>The organisation reviews the intake, assessment, and admission process and all related guidelines. Where reviews identify areas for improvement, there is a record of the issues, action planned and implemented, and the results. Reviews may include analysing the time, resources and location of intake, assessment, and admission processes, as well as feedback from clients, carers, staff and external service providers, and documentation. | Schedule of intake, assessment, and admission process reviews.<br>Documented review and improvement activities.<br>Client, staff and external feedback – reports and action undertaken.<br>Client Intake and Assessment Policy and related procedures. |

Performance measures

Suggested performance measures for this criterion are on page 123 of *The ACHS EQuIP5 Guide – Book 1.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | External Relationship Policy. | External Relationship Policy developed to guide the rationale, identification, development and maintenance of partnerships with external service providers. | All staff know and understand the purpose and process for engaging in external relationships that support clients and the organisation to achieve desired outcomes. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Provide clearer, step-by-step information to clients on the process for intake, assessment and admission to the service. | Clinical Manager | August 2013 |

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

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

The intent of this criterion is to ensure that clients receive appropriate and necessary care, interventions and services in the most appropriate setting. Appropriateness is about doing what is necessary, and not doing what is not necessary.

Refer to *The ACHS EQuIP5 Guide – Book 1,* page 126 for further information, including the relationship 1.3.1 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) Documented processes exist on how the organisation assesses the appropriateness of care.<br>The organisation provides written guidance on how to review the care provided to clients to ensure it is appropriate. Appropriate care is that which addresses client's expressed needs and in accordance with current best practice. Guidance may include the process for reviewing client health records for documented expressed needs and responding interventions provided / arranged by the organisation. Peer review and clinical supervision may be a mechanism for assessing appropriateness of care provided. | Evidence Based Practice Policy and related procedures.<br>Quality Improvement Policy and related procedures.<br>Clinical Supervision Policy and related procedures. |
| | (b) Policy / guidelines exist on how to assess the appropriateness of the setting in which care is provided.<br>The organisation provides written guidance on how to review the setting where client service delivery is undertaken to ensure that it is appropriate for the treatment / intervention delivered. The setting in which services are provided is appropriate for the specific client group and there is appropriate support. | Evidence Based Practice Policy and related procedures.<br>Client Intervention Policy and related procedures. |
| | (c) Clinical guidelines are used to guide appropriate care delivery.<br>The organisation's documented treatments and interventions are informed by clinical guidelines appropriate to the client's expressed needs and current best practice. | Evidence Based Practice Policy and related procedures.<br>Client Intervention Policy and related procedures.<br>Program Evaluation Policy and related procedures.<br>Treatment and intervention that aligns with best practice clinical guidelines. |
| Rating | Element | Evidence commonly presented |
| SA | (a) The organisation has a strategy to ensure the appropriate use of interventions and services.<br>The organisation has processes to ensure that appropriate services are provided according to best-practice guidelines. This includes whether the service is appropriate for all age groups, cultures, or physical locations. | Evidence Based Practice Policy and related procedures.<br>Client Intervention Policy and related procedures.<br>Program Evaluation Policy and related procedures. |

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| | Organisations should also review whether particular services should be provided if the literature considers them to be of little benefit or unnecessary, even when it is past practice or the client requests it. | Peer review meetings and documented outcomes and actions.<br>Clinical supervision. |
| | (b) Service planning includes an evaluation of the appropriateness of the services to be provided.<br>The organisation utilises data gathered from reviews of appropriate service delivery when developing new services and improving existing services. | Program Evaluation Policy and related procedures.<br>Service and organisation planning documentation. |
| | (c) The organisation collects a suite of key indicators relating to appropriateness of care.<br>Indicators are collected by the organisation showing how services are meeting internally or externally identified standards. Generally, the indicators selected will demonstrate clinical, health and social outcomes, and the data are used for continued improvement in delivering appropriate services. | Evidence Based Practice Policy and related procedures.<br>Program Evaluation Policy and related procedures.<br>Client outcomes system and how data have been utilised. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The system for assessing the appropriateness of care and services is evaluated by clinicians and management, and improved as required.<br>The organisation's clinical and management staff review how appropriate care is assessed. Review may include analysing current credentialing and scope of clinical practice relevant to specific staff's knowledge, competence and qualifications, as well as ongoing peer review meetings and clinical audits. Where reviews identify areas for improvement, there is a record of the issues, action planned and implemented, and the results. | Evidence Based Practice Policy and related procedures.<br>Program Evaluation Policy and related procedures.<br>Peer review meetings and documented outcomes and actions.<br>Documented review and improvement activities. |
| | (b) Healthcare providers, including clinicians and managers and/or consumers, are involved in the evaluation of appropriateness of care.<br>The organisation utilises the skills, knowledge and experiences of clinical staff, managers and clients in reviewing appropriate service delivery. | Evidence Based Practice Policy and related procedures.<br>Program Evaluation Policy and related procedures.<br>Documented review and improvement activities. |
| | (c) Indicators for appropriateness of care and services are evaluated and improvements are made as required.<br>The organisation reviews indicators for appropriateness of care. Where reviews identify areas for improvement, there is a record of the issues, action planned and implemented, and the results. Reviews may include analysing the indicators to ensure the information gathered provides sufficient information for individual client, program, service and organisation planning, as well as reporting requirements. | Schedule of reviews of appropriate care indicators.<br>Documented review and improvement activities.<br>Record of appropriate care indicators over time. |

Performance measures

Suggested performance measures for this criterion are on page 132 of *The ACHS EQuIP5 Guide – Book 1.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Review of appropriate care indicators. | The organisation's current appropriate care indicators were reviewed against newly developed sector indicators. | Appropriate care indicators were expanded to ensure all aspects of client clinical, health and social outcomes are measured and reported on. |

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| 2 | Increase input from clients in reviewing the appropriateness of services provided. | Clients are asked at exit from the service whether the treatment / intervention provided addressed their stated needs. | All clients are provided with the opportunity to give feedback on the appropriateness of services. An indicator was developed to measure client responses. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Guidelines for appropriate service delivery with young people incorporated into Client Intake and Assessment Policy and Client Intervention Policy. | Clinical Manager | September 2013 |

## Standard 1.4: The organisation provides care and services that achieve effective outcomes

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

The intent of this criterion is to ensure interventions provided are proven to be effective, based on best available evidence, and delivered in the most effective way possible.

Refer to *The ACHS EQuIP5 Guide – Book 1,* page 135 for further information, including the relationship 1.4.1 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) Documented processes exist for implementing best available evidence into clinical practice.<br>The organisation can demonstrate how the best available evidence is implemented into treatment and interventions provided. Processes for implementing best available evidence include how the organisation identifies best available evidence, developing and documenting treatment and interventions based on best available evidence, identifying staff roles and responsibilities, communicating and training with staff, reviewing available evidence regularly and continually improving practice. | Evidence Based Practice Policy and related procedures.<br>Program Evaluation Policy and related procedures.<br>Client Intervention Policy and related procedures.<br>Functions and delegations matrix – clinical roles identified.<br>Staff training schedule.<br>Documented review and improvement activities. |
| | (b) Policy / guidelines exist on how to manage and minimise risk to consumers / patients accommodated outside the speciality ward area. | *Not applicable.* |

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| | *Not applicable.* | |
| Rating | Element | Evidence commonly presented |
| SA | (a) The organisation supports healthcare providers in the implementation of evidence-based care.<br>Documented and communicated policy and practice guidelines exist to support staff in implementing treatment and interventions based on best available evidence. Staff are trained in understanding and applying evidence-based practice to ensure consistent, appropriate and effective interventions. The organisation provides time and resources for staff to develop their knowledge and skills in evidence-based practice, including supervision, attendance at forums/ workshops / conferences, in-services, professional organisation membership, internet access and sector relevant email subscriptions.<br><br>The organisation may also collate resources for staff to access, including professional practice guidelines, journals and sector relevant publications.<br><br>The national Clinical Practice Guidelines Portal is available at www.clinicalguidelines.gov.au. | Evidence Based Practice Policy and related procedures.<br>Program Evaluation Policy and related procedures.<br>Client Intervention Policy and related procedures.<br>Staff Performance and Development Policy and related procedures.<br>Staff supervision.<br>Staff induction and orientation procedures.<br>Professional organisation memberships and subscriptions.<br>Resource library – hard copy and electronic. |
| | (b) Care process mapping is documented and undertaken by a multidisciplinary team when applicable.<br>The organisation has documented guidance to support staff in implementing effective client interventions for known conditions and issues. Documentation may include a care map / flow chart that addresses various interventions along the intervention pathway. All relevant staff are involved in the documentation process. | Client Intervention Policy and related procedures.<br>Program Evaluation Policy and related procedures.<br>Client intervention reviews and improvements – documentation and staff involved. |
| | (c) Policy and procedures are implemented for the management of consumers / patients accommodated outside the speciality ward area to ensure care is safe and effective.<br>*Not applicable.* | *Not applicable.* |
| Rating | Element | Evidence commonly presented |
| MA | (a) Indicators are used to evaluate the use of evidence-based care and improvements are made as required.<br>The organisation collects data to measure indicators of client outcomes. The data are used to review whether treatment and intervention provided are appropriate and effective, and improvements are made when required. | Evidence Based Practice Policy and related procedures.<br>Program Evaluation Policy and related procedures.<br>Client outcomes system and how data have been utilised.<br>Record of indicators over time, and responding intervention improvements over time. |
| | (b) Processes for ensuring the use of effective care, services and practice are evaluated and improved as required.<br>The organisation reviews how effective treatment and interventions are assessed. Review may include analysing whether current treatment and interventions are informed by best available evidence, and that all staff apply consistent practice. Where reviews identify areas for improvement, there is a record of the issues, action planned and implemented, and the results. | Evidence Based Practice Policy and related procedures.<br>Peer review meetings and documented outcomes and actions.<br>Documented review and improvement activities. |
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| | (c) Processes for managing consumers / patients accommodated outside the speciality ward are evaluated and improved as required.<br>*Not applicable.* | *Not applicable.* |

Performance measures

Suggested performance measures for this criterion are on page 140 of *The ACHS EQuIP5 Guide – Book 1.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Organisation memberships and subscriptions. | A review of the organisation's memberships and subscriptions was undertaken – team identified ones that were no longer relevant and new memberships and subscriptions to support skill and knowledge development. | The organisation has committed resources to memberships and subscriptions that support staff in understanding and applying best practice. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Engage external professional to review current treatment and interventions for clients presenting with alcohol and depression issues against best practice. Findings to inform the development of improved policy / guidelines. | Clinical Director | November 2013 |

## Standard 1.5: The organisation provides safe care and services

### Criterion 1.5.1
*Medications are managed to ensure safe and effective consumer / patient outcomes*


The intent of this criterion is to ensure that medications are managed to reduce medication prescription, dispensing and administration errors, and to reduce harm by medication error.

Refer to *The ACHS EQuIP5 Guide – Book 1,* page 143 for further information, including the relationship 1.5.1 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) There is policy / guidelines for medication management that is consistent with the Australian Pharmaceutical Advisory Council (APAC) guidelines together with jurisdictional legislation.<br>The term 'medicine' includes prescription and non-prescription medicines, including complementary health-care products.<br>The organisation has policy and/or guidelines to support staff in medication prescription, dispensing and administration. The following documents provide guidance on administering, storing, and dispensing medicines, as well as managing risks: *'Guiding principles for medication management in the community'*[iv], '*Guiding principles to achieve continuity in medication management*'[v], and *'National strategy for quality use of medicines'*[vi]. | Client Medication Management Policy and related procedures. |
| | (b) A multidisciplinary body oversees the management of medication safety.<br>The organisation involves a range of staff and professionals in managing client medication at intake, during and post-treatment / intervention. External service providers may include general practitioners, pharmacists / pharmacies and community nurses. | Client Medication Management Policy and related procedures.<br>Functions and Delegations Matrix.<br>External Relationship Policy and related procedures. |
| | (c) Healthcare providers have access to published guidelines for medication management.<br>The organisation ensures all relevant staff have access to externally published guidelines for managing client medications. | Professional organisation memberships and subscriptions.<br>Resource library – hard and electronic.<br>Internet access. |
| | (d) A standardised list of approved abbreviations for medications is used throughout the organisation.<br>The organisation ensures that only approved and recognised abbreviations, as per professional guidelines, are used when referring to medications. This includes in policies, procedures and client health records. | Client Medication Management Policy and related procedures.<br>Client File Management Policy and related procedures. |
| | (e) Medication risks are identified, evaluated and acted upon with particular focus on high risk medications.<br>The organisation identifies, mitigates and responds to potential and actual medication risks through the implementation of a Client Medication Management Policy and related procedures. High risk medication is identified and additional strategies are in place to prevent incidents, including health record flagging / alerts and additional security measures. | Client Medication Management Policy and related procedures.<br>High risk medication list.<br>Client File Management Policy and related procedures.<br>Medication security practice – locked approved cabinets and double key access.<br>Record of review of incidents and actions implemented. |

| Rating | Element | Evidence commonly presented |
|---|---|---|
| SA | (a) Clinical staff are provided with orientation and ongoing education on the policy and procedures of safe medication management.<br>Relevant staff responsible for client medication management are identified and provided with training as part of their induction and orientation to the organisation, as well as ongoing education and professional development. | Client Medication Management Policy and related procedures.<br>Staff induction and orientation procedures.<br>Staff Performance and Development Policy and related procedures.<br>Record of staff in-services / training / professional development activities.<br>Staff meetings. |
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| | (b) Procedures are implemented to reduce the risk and number of medication errors.<br>Implemented procedures reduce the likelihood and actual number of medication errors. Issues such as storage, access, security, transport, staff responsibilities, ordering and dispensing are addressed. Staff education and training also supports the reduction of medication errors. | Client Medication Management Policy and related procedures.<br>Staff Performance and Development Policy and related procedures.<br>Record of staff in-services/training/professional development activities.<br>Medication management practice. |
| | (c) Medication documentation is standardised across the organisation.<br>The organisation ensures that all documentation relating to medication management is standardised and consistent. Where medications are prescribed, a common medication chart is used. | Client Medication Management Policy and related procedures.<br>Medication charts.<br>Client health records. |
| | (d) There is a system to report medication errors, near misses and adverse drug reactions and this is linked to the incident management system.<br>The organisation has procedures for reporting all medication incidents including documentation in the client health record and medication incident report register, health record audits, and review of incident reports. The organisation may convene medication incident review committees with relevant professionals as a quality improvement measure. | Client Medication Management Policy and related procedures.<br>Medication incident reports register.<br>Medication management review committee meetings, minutes and actions. |
| | (e) The orientation system is updated when new risks are identified.<br>As new medication risks are identified, staff orientation and ongoing education is updated. | Client Medication Management Policy and related procedures.<br>Record of staff in-services/training/professional development activities. |
| | (f) There is pharmacy involvement in the storage, transport and distribution system.<br>The organisation identifies when and what medications are to be stored, transported and distributed according to professional practice guidelines. Where and when possible, there is involvement from a pharmacy / pharmacist in developing storage, transport and distribution systems. | Client Medication Management Policy and related procedures.<br>Record of pharmacy / pharmacist involvement. |
| | (g) A system is implemented to ensure medication review of individual consumers / patients.<br>Treatment and interventions provided to clients are individually reviewed, including any medications prescribed or being taken by the client. Reviews include identifying if the current medication is appropriate and effective, and if there are any side effects or interactions. | Client Medication Management Policy and related procedures.<br>Client Intervention Policy and related procedures.<br>Client health record – medication charts, treatment plans. |
| | (h) Consumers / patients and carers are educated about prescribed medications to encourage ongoing safe use of medications and compliance after discharge.<br>Clients are provided with information about medications that have been prescribed. Information may be provided verbally by qualified professionals, and/or in print, and clients may be directed to where further information is available, such as the National Prescribing Service website: www.nps.org.au. | Client Medication Management Policy and related procedures.<br>Medication resources provided to clients.<br>Referrals to qualified professionals and other resources. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The system for safe medication management is evaluated and improved as required.<br>The organisation's medication management procedures are reviewed following medication incidents and/or on a regular schedule. Review may include analysing documentation, prescribing practices, security and access, information provided to clients, and incident responses. Where reviews identify areas for improvement, there is a record of the issues, action planned and implemented, and the results. | Client Medication Management Policy and related procedures.<br>Evidence Based Practice Policy and related procedures.<br>Policy review schedule.<br>Documented review and improvement activities. |

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| | (b) Medication errors, near misses and adverse drug reactions are reported, analysed and trended, and further strategies to reduce medication incidents are implemented.<br>All medication incidents are documented, reviewed and trended over time. Strategies to reduce medication incidents may include staff communication and discussion, updating policy and procedures, and staff training / education. External professionals may be utilised to ensure best practice implementation. | Client Medication Management Policy and related procedures.<br>Medication management review committee meetings, minutes and actions.<br>Staff / clinical meeting minutes, in-services, training.<br>Mapping of medication incident trends.<br>External professional input. |
| | (c) Medication storage, distribution and transport processes are evaluated and improved as required.<br>The organisation's medication storage, distribution and transport procedures are reviewed following an incident and/or on a regular schedule. Where reviews identify areas for improvement, there is a record of the issues, action planned and implemented, and the results. | Client Medication Management Policy and related procedures.<br>Policy review schedule.<br>Documented review and improvement activities. |

Performance measures

Suggested performance measures for this criterion are on page 150 of *The ACHS EQuIP5 Guide – Book 1.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Client Medication Management Policy and related procedures. | Developed template and examples for documenting prescribed and other medicines in client health records. | Staff know, understand and apply consistent documentation of prescribed and other medicines in client health records. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Pharmacist engaged to review storage, access and security of medicines against best practice. Findings to inform the development of improved policy / guidelines. | Clinical Director | November 2013 |

## Standard 1.5: The organisation provides safe care and services

### Criterion 1.5.2

*The infection control system supports safe practice and ensures a safe environment for consumers / patients and healthcare workers*

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

Refer to the *ACHS EQuIP5 Guide – Book 1,* page 156 for further information, including the relationship 1.5.2 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) There is an infection control policy / guidelines, including notifiable diseases, sterilisation and reprocessing where applicable, that is referenced to:<br>(i) Australian standards<br>(ii) jurisdictional legislation<br>(iii) codes of practice<br>(iv) industry guidelines.<br>The organisation has policy and procedures to support staff in managing infection control. The policy should cover only those issues relevant to non government drug and alcohol and related service provision. Issues may include: staff education, training and responsibilities; needlestick injury; blood exposure; notifiable diseases; staff immunisation requirements or recommendations; hand hygiene; linen management; food handling; and information for visitors and contractors.<br><br>The following documents provide guidance on infection control practice: *'Australian guidelines for the prevention and control of infection in healthcare'*[vii], *'A-Z of infectious diseases'*[viii], *'WHO guidelines on hand hygiene in health care'*[ix], and *'Infection control policy*[x]'. | Work Health and Safety Policy and related procedures.<br>Infection Control Policy and related procedures.<br>Site instructions / posters such as hand washing guide at wash basins. |
| | (b) The infection control management plan is approved, supported and resourced by the organisation's executive.<br>The organisation's governing body has approved policies, procedures and actions that support infection control management. Financial and other support is provided so that infection control management policies, procedures and actions can be implemented and maintained. | Work Health and Safety Policy and related procedures.<br>Infection Control Policy and related procedures.<br>Quality Improvement Action Plan – infection control activities scheduled and completed.<br>Board meeting minutes and endorsement of policy and actions.<br>Financial budgets and actuals for WHS activities.<br>Record of staff training / in-services.<br>WHS facilities on premises – sharps bins, additional wash basins, etc. |
| | (c) There is policy / guidelines for food handling that includes storage, preparation and distribution in accordance with jurisdictional regulations and/or standards.<br>Where the organisation provides clients with food and meals, there is a policy and procedures to support safe storage, preparation and distribution. Issues addressed in the policy include refrigeration requirements, designated food storage areas, safe reheating of foods, and family bringing of food to the service. Food Standards Australia New Zealand provides information on food safety. The www.haccp.com.au website provides details of their food handling training services. | Work Health and Safety Policy and related procedures.<br>Infection Control Policy and related procedures.<br>Site instructions / posters such as how to reheat food safely at microwaves. |
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| | (d) There is policy / guidelines for the collection of dirty linen, management, transport and storage of clean linen within the healthcare facility.<br>Residential facilities have policy and procedures to safely manage dirty and clean linen. Issues addressed in the policy include how clean and dirty linen is kept separated, the collection of dirty linen if external contractors are used, staff and client handling and cleaning of dirty linen, safe and clean storage of linen, and staff responsibilities for monitoring linen management practice. | Work Health and Safety Policy and related procedures.<br>Infection Control Policy and related procedures.<br>Site instructions / posters such as identifying dirty linen repositories, and reminders to use gloves when handling used / dirty linen. |
| | (e) Healthcare providers are educated and information is available on the risks of infection including their responsibilities in preventing infection.<br>The organisation provides or facilitates staff with training and information on infection prevention and management, and identifies all staff responsibilities. | Work Health and Safety Policy and related procedures.<br>Infection Control Policy and related procedures.<br>Staff in-service and training calendar – including mandatory WHS.<br>Site instructions / posters such as correct hand washing techniques and correct handling of sharps. |
| | (f) Healthcare providers are supplied with equipment and an environment that enables them to implement the infection control policy / guidelines.<br>The organisation provides resources for staff to use as part of their infection control responsibilities. Equipment may include: wash basins and hand washing liquid; disposable hand towels; latex gloves and other personal protective equipment; sharps tongs; sharps bins; spill kits; dishwashers; and cleaning and disinfectant products. | Work Health and Safety Policy and related procedures.<br>Infection Control Policy and related procedures.<br>WHS equipment.<br>Site instructions / posters on the correct use of infection control equipment. |
| | (g) External service providers, students, carers and visitors are advised of the organisation's infection control requirements.<br>The organisation provides information to external service providers, students, carers and visitors on infection control procedures and how this relates to their involvement with and in the organisation. Information may be provided in writing through pamphlets, included in contracts / agreements and on posters throughout the facility. | Work Health and Safety Policy and related procedures.<br>Infection Control Policy and related procedures.<br>Student Placement Policy and related procedures.<br>External Relationship Policy and related procedures.<br>Volunteer Policy and related procedures.<br>Information pamphlets.<br>WHS instructions / posters throughout the organisation's facilities. |
| Rating | Element | Evidence commonly presented |
| SA | (a) The infection control management plan is reviewed and adequate resources are provided to ensure implementation of the plan and related policies.<br>The organisation reviews scheduled and completed infection control activities to ensure that sufficient financial and other resources are available and utilised for ongoing infection control management. | Work Health and Safety Policy and related procedures.<br>Infection Control Policy and related procedures.<br>Policy review schedule.<br>Financial budgets and actuals for WHS activities.<br>Record of infection control activities – scheduled and completed. |
| | (b) Infection prevention strategies are integrated into all stages of healthcare planning, including health facility, construction and/or refurbishment.<br>The organisation identifies activities that support the prevention of infection, including the ability to isolate infectious persons and contain the spread of infectious diseases. Activities may include residential services reserving a single room for clients with influenza, rostering clients with Hepatitis A on duties other than food preparation, and adequate | Work Health and Safety Policy and related procedures.<br>Infection Control Policy and related procedures.<br>Service planning – record of WHS considerations.<br>Financial budgets and actuals for WHS activities.<br>Organisation facilities. |

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| | facilities for the collection and disposal of contaminated / blood spills. | |
| | (c) There is a documented program of continuous education for staff about infection control issues.<br>The organisation identifies relevant staff infection control training needs and provides or facilitates this on an ongoing basis. WHS is an agenda item for staff meetings. | Work Health and Safety Policy and related procedures.<br>Infection Control Policy and related procedures.<br>Staff induction and orientation procedures.<br>Staff in-service and training calendar – including infection control.<br>Staff meeting minutes and actions. |
| | (d) A standardised hand hygiene observation assessment tool is used throughout the organisation.<br>As part of the organisation's WHS auditing, hand hygiene practice is reviewed. Hand hygiene materials and information, including audit tools, are available from the Hand Hygiene Australia website www.hha.org.au. | Work Health and Safety Policy and related procedures.<br>Infection Control Policy and related procedures.<br>WHS audit reports. |
| | (e) The infection control system includes isolation and containment of infections when required.<br>The organisation implements activities that support the isolation and containment of infections, including residential services isolating infectious persons by reserving a single room for clients with influenza, rostering clients with Hepatitis A on duties other than food preparation, and adequate facilities for the collection and disposal of contaminated / blood spills. | Work Health and Safety Policy and related procedures.<br>Infection Control Policy and related procedures.<br>Client room facilities. |
| | (f) Policy / guidelines for collection of dirty linen, management, transport and storage of clean linen are implemented within the health facility.<br>Residential facilities' policy and procedures on safely managing dirty and clean linen is understood and complied with. | Work Health and Safety Policy and related procedures.<br>Infection Control Policy and related procedures.<br>Dirty linen collection points within the facility.<br>Clean linen storage points within the facility.<br>Transport of linen practices. |
| | (g) A system is implemented for appropriate use of antibiotics and antimicrobials.<br>*Not applicable.* | *Not applicable.* |
| | (h) An effective surveillance system is implemented to monitor healthcare associated infections.<br>The organisation identifies, records and reviews infections that are acquired within the organisation's facilities. | Work Health and Safety Policy and related procedures.<br>Infection Control Policy and related procedures.<br>WHS audit reports.<br>Infection incident reports. |
| | (i) The infection control system ensures effective communication of infection risks and managements to consumers / patients and their carers.<br>The organisation provides clients and carers with information on infection risks associated with treatment / intervention. This information may include the risks associated with clients with Hepatitis B serving food, and good hand and respiratory hygiene. | Work Health and Safety Policy and related procedures.<br>Infection Control Policy and related procedures.<br>Information provided to clients. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The infection control system is evaluated and improved as required. | Work Health and Safety Policy and related procedures. |

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| | The organisation's infection control procedures are reviewed following an infection incident and/or on a regular schedule. Review may include analysing documentation, control practices, information provided to clients and staff, and incident responses. Where reviews identify areas for improvement, there is a record of the issues, action planned and implemented, and the results. | Infection Control Policy and related procedures.<br>Policy review schedule.<br>Documented review and improvement activities. |
| | (b) The system for the reprocessing of medical devices demonstrably complies with:<br>(i) Australian Standards<br>(ii) jurisdictional requirements.<br>*Not applicable.* | *Not applicable.* |
| | (c) Hand hygiene practices are evaluated and improved as required.<br>The organisation's hand hygiene procedures are reviewed on a regular schedule. Review may include analysing documentation, hand hygiene practices, information provided to clients and staff, and equipment used to support safe hand hygiene practice. Where reviews identify areas for improvement, there is a record of the issues, action planned and implemented, and the results. | Work Health and Safety Policy and related procedures.<br>Infection Control Policy and related procedures.<br>Policy review schedule.<br>Documented review and improvement activities. |
| | (d) The appropriate use of antibiotics and antimicrobials is evaluated and improved as required.<br>*Not applicable.* | *Not applicable.* |

Performance measures

Suggested performance measures for this criterion are on page 162 of *The ACHS EQuIP5 Guide – Book 1.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Hand washing stations | Install a hand washing station and poster guidelines at entry to client dining area. | Clients have easy access to hand washing facilities before entering dining area, thereby increasing hand washing and hand hygiene practice. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Review of infection control resources / equipment to ensure current and available products are in use | Operations Manager | September 2013 |

## Standard 1.5: The organisation provides safe care and services

Criterion 1.5.3
The incidence and impact of breaks in skin integrity, pressure ulcers and other non-surgical wounds are minimised through wound prevention and management programs

The intent of this criterion is to ensure that the occurrence of healthcare-associated, non-surgical breaks in skin integrity is prevented whenever possible and minimised at all times.

Refer to *The ACHS EQuIP5 Guide – Book 1,* page 166 for further information, including the relationship 1.5.3 has with other criteria.

*This criterion has limited, if any, application in non government drug and alcohol organisations. Contact your ACHS Customer Services Manager for further advice.*

## Standard 1.5: The organisation provides safe care and services

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

The intent of this criterion is to prevent falls from occurring and to minimise injury from falls that could not be prevented.

Refer to *The ACHS EQuIP5 Guide – Book 1,* page 174, for further information, including the relationship 1.5.4 has with other criteria.

*This criterion has limited, if any, application in non government drug and alcohol organisations. WHS policies and related procedures should include provision for identification and management of general fall risks. Contact your ACHS Customer Services Manager for further advice.*

## Standard 1.5: The organisation provides safe care and services

Criterion 1.5.5
The system to manage sample collection, blood, blood components / blood products and patient blood management ensures safe and appropriate practice

The intent of this criterion is to ensure that healthcare organisations have effective systems for safe and appropriate blood management.

Refer to *The ACHS EQuIP5 Guide – Book 1,* page 182 for further information, including the relationship 1.5.5 has with other criteria.

*This criterion has limited, if any, application in non government drug and alcohol organisations. Contact your ACHS Customer Services Manager for further advice.*

## Standard 1.5: The organisation provides safe care and services

### Criterion 1.5.6
### The organisation ensures that the correct consumer / patient receives the correct procedure on the correct site

The intent of this criterion is to ensure that client identification procedures are implemented and adhered to throughout the organisation.

Refer to the *ACHS EQuIP5 Guide – Book 1,* page 192 for further information, including the relationship 1.5.6 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) Policy and procedures for ensuring correct patient, correct procedure and correct site identification prior to any clinical intervention are consistent with international and jurisdictional policy / guidelines.<br>The organisation has processes in place to ensure that the client is correctly identified prior to receiving the treatment / intervention planned for that person. Practical activities may include cross checking a client's name, date of birth and consent with the client, against appointment bookings, against the electronic and paper client records, confirming with the client the agreed treatment / intervention, and visually identifying a client with a recorded name and date of birth.<br><br>A search for previous contact with the service may also be undertaken.<br>Clients with similar or identical names are flagged in the paper and electronic health record. | Client Intervention Policy and related procedures.<br>Client File Management Policy and related procedures.<br>Client health records – flagged files.<br>Client handover meetings. |
| | (b) Information on consumer / patient identification and correct procedure, correct site policy / guidelines is provided to healthcare providers and to consumers / patients and carers.<br>Staff are aware of the processes in place to ensure that the client is correctly identified prior to receiving the treatment / intervention planned for that person. Information is provided as part of new staff orientation processes, as well as when there are changes to the policy and/or related procedures. | Staff induction and orientation processes.<br>Staff meeting minutes.<br>Staff notices. |
| Rating | Element | Evidence commonly presented |
| SA | (a) The consumer / patient identification and correct procedure, correct site policy / guidelines and | Client health records. |

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| | documentation are implemented throughout the organisation by staff / teams involved in healthcare interventions.<br>Staff involved in treatment / intervention provision as well as administration of client information understand and implement processes to ensure the correct treatment / intervention is provided to the correct client. Activities may include client handover meetings where the client is identified against the health record, staff / client introductions by another staff member, and photo identification retained in the client health record. | Client handover meetings.<br>Client health records – photo identification. |
| | (b) Staff are educated on the consumer / patient identification and correct procedure, correct site policy and procedures.<br>Staff are aware of the processes in place to ensure that the client is correctly identified prior to receiving the treatment / intervention planned for that person. Information is provided as part of new staff orientation processes, as well as when there are changes to the policy and/or related procedures. | Staff induction and orientation processes.<br>Staff meeting minutes.<br>Staff notices. |
| | (c) Consumers / patients and carers are involved in ensuring correct patient, correct procedure and correct site.<br>Clients and carers are informed of the need to correctly identify the correct client prior to and during treatment / intervention provision, and how they may be asked throughout treatment / intervention to confirm their name, date of birth, etc. | Client orientation procedures<br>Client rights and responsibilities agreement. |
| | (d) A system to report near misses and errors in consumer / patient identification is implemented, and is linked to the incident management system.<br>The process for identifying, responding and reviewing 'near misses' in client identification and treatment / intervention provision is documented and followed. This may include reporting the incident to the team leader / manager, lodging an incident form, and discussing at staff and/or clinical review meetings. | Incident reports.<br>Staff meetings. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The organisation implements standard consumer / patient identification processes that correspond with national specifications.<br>Staff involved in treatment / intervention provision as well as administration of client information understand and implement processes to ensure the correct treatment / intervention is provided to the correct client. | Client Intervention Policy and related procedures.<br>Client File Management Policy and related procedures.<br>Client health records – flagged files.<br>Client handover meetings.<br>Incident reports.<br>Staff meetings. |
| | (b) Compliance with policy and procedures on consumer / patient identification, correct procedure and correct site is evaluated, and improved as required.<br>The organisation reviews processes to ensure compliance and make improvements as required. This may be done through audits of health record documentation, staff handover meetings and observation of practice with clients. | Policy review schedule.<br>Documented review and improvement activities. |
| | (c) Any confirmed incident of wrong patient, wrong procedure or wrong site investigated, and strategies implemented as required.<br>Where an incident has occurred, there are documented details and a review of current processes is undertaken, with | Incident reports.<br>Documented review and improvement activities. |

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| | improvements made as required. | |

Performance measures
Suggested performance measures for this criterion are on page 196 of *The ACHS EQuIP5 Guide – Book 1.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Client consent forms updated. | Client consent forms have tick boxes that list treatment / intervention options where the client marks their agreed treatment / interventions and prints their name, signature and date. | Confirmation of correct client and correct treatment / intervention is made prior to treatment / intervention commencing. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | As part of staff handover between shifts, all staff confirm they can visually identify all residential clients. If necessary, other staff introduce the staff to the client. | Team Leader and all staff | November 2013 |

## Standard 1.5: The organisation provides safe care and services

### Criterion 1.5.7
### The organisation ensures that the nutritional needs of consumers / patients are met

The intent of this criterion is to ensure that the nutritional needs of clients are met during their healthcare journey.

Refer to *The ACHS EQuIP5 Guide – Book 1,* page 198 for further information, including the relationship 1.5.7 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) Policy / guidelines exist for the delivery of nutritional care consistent with jurisdictional guidelines.<br>Where an organisation is responsible for the provision of meals and food as part of client's treatment / intervention | Specific policy or guideline for client meal planning and delivery.<br>Client Intervention Policy and related procedures. |

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| | program, policy or guidelines are developed to address the client's nutritional needs. The policy / guideline addresses client assessment / screening / ongoing review of overall physical health, including their food and nutritional status. Where a client may be at risk of poor nutrition (i.e. homelessness, eating disorder) this is identified and addressed and/or referral is made. Additionally, the policy / guidelines includes information to be provided to clients and staff on health, nutrition, diet, meal planning, etc.<br><br>Nutrition Australia website (www.nutritionaustralia.org) has resources such as fact sheets, posters, and cookbooks on preventative health through good nutrition.<br><br>The Dietitians Association of Australia website (www.daa.asn.au) has resources about healthy eating, nutrition fact sheets and recipes.<br><br>The National Health and Medical Research Council (NHMRC) website (www.nhmrc.gov.au) has information about the five food groups, potion sizes, and other dietary guidelines.<br><br>Where the organisation provides lunch/snack/tea as a non residential intervention, the organisation is not responsible for the clients' nutritional well-being. However, where appropriate, the organisation may consider overall physical health, including food and nutritional status, as part of standard client assessment processes, and make referrals as necessary. | |
| | (b) A multidisciplinary team oversees the organisation's nutrition management strategy to ensure the provision of food and fluid to consumers / patients consistent with good nutritional care.<br>The organisation includes relevant skilled and knowledgeable staff and external providers when developing policies and practice guides related to client nutrition and meal provision. Personnel such as nursing, meal preparation / serving staff, management, dieticians, medical practitioners, and child professionals may provide valuable input into establishing client nutrition screening, assessment, referral, and menu planning. | Specific policy or guideline for client meal planning and delivery.<br>Consultation meetings with relevant service providers. |
| | (c) Relevant healthcare providers are educated, and aware of their role in delivering good nutritional care and preventing malnutrition.<br>Staff responsible for planning and preparing client meals and food are adequately qualified, skilled and/or trained in responding to the nutritional needs of clients presenting to drug and alcohol services. Other client-contact staff, including case workers and counsellors, have an understanding of the benefits of good nutrition and how this can support client health and recovery. | Staff induction and orientation processes.<br>Staff in-service and training calendar – nutrition and food health.<br>Staff meeting minutes.<br>Staff notices. |
| | (d) Relevant healthcare providers use a validated nutrition risk screening tool to assess consumers / patients<br>(i) on admission<br>(ii) following a change of health status<br>(iii) weekly thereafter.<br>As part of standard client intake and assessment processes, staff screen clients for overall physical health issues and may ask clients if there are any health issues that do or may impact on their nutrition and food intake. Special consideration may need to be given to pregnant or lactating women, clients with eating disorders, clients with | Client Intervention Policy and related procedures.<br>Client health records – treatment plans. |

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| | hepatitis, clients reporting little food intake over recent or long term periods of time. | |
| | (e) Nutritional care is incorporated into the consumer / patient care plan.<br>Particularly where a nutrition or food intake issue has been identified, the client's care / treatment plan includes actions to address the issue. Such actions may include focusing on eating balanced meals from the five food groups, special diets to respond to physical issues, referral to nutritionist / dietition, developing basic meal preparation, cooking skills, etc. | Client Intervention Policy and related procedures.<br>Client health records – treatment plans.<br>Client education – individual or group.<br>Client living skills training / program. |
| Rating | Element | Evidence commonly presented |
| SA | (a) The organisation has a strategic and coordinated approach to delivering consumer / patient-centred nutritional risk screening and care for those with malnutrition.<br>The organisation provides client intake, assessment and intervention in a standard way across the organisation by all relevant staff. All clients are supported to participate in activities that improve their own nutrition intake and health. Referrals to specialist services are made as required. | Client Intervention Policy and related procedures.<br>Client living skills training / program. |
| | (b) The nutrition policy / guidelines are adapted to local needs and implemented across the organisation.<br>Policy or guidelines that address the client's nutritional needs consider those individuals with particular needs including pregnant or lactating women, clients with eating disorders, clients with hepatitis, clients reporting little food intake over recent or long term periods of time. | Client Intervention Policy and related procedures.<br>Client health records – treatment plans.<br>Specific policy or guideline for client meal planning and delivery. |
| | (c) Roles and responsibilities of relevant healthcare providers in the delivery of the nutrition management strategy are clearly defined.<br>The organisation documents and communicates the expected roles of all staff responsible for contributing to the client's nutrition intake and health. This may include in position descriptions, function and delegations register, daily rosters, and policies and procedures. | Staff position descriptions.<br>Functions and delegations matrix / register.<br>Client Intervention Policy and related procedures.<br>Staff rosters.<br>Client program implementation guide. |
| | (d) Food, fluid and nutritional care is considered as part of an intervention and medical treatment plan.<br>As part of standard client intake, assessment intervention processes for residential services, staff screen clients for overall physical health issues and may ask clients if there are any health issues that do or may impact on their nutrition and food intake. Where appropriate, specific interventions are included in a client's treatment plan to address nutrition and food intake care.<br>The organisation's client menus and meal plans are developed with drug and alcohol clients in mind and possible nutrition and food intake issues they may present with. | Client Intervention Policy and related procedures.<br>Client health records – treatment plans.<br>Specific policy or guideline for client meal planning and delivery.<br>Client menus and meal plans. |
| | (e) Referrals to nutrition-related services occur in a timely manner.<br>Where a client has been identified as requiring additional care relating to their nutrition and food intake, contact with and/or referral to an external provider with nutritional expertise is made. | Client Intervention Policy and related procedures.<br>External referral procedures.<br>Client health records – referral to external providers. |
| Rating | Element | Evidence commonly presented |
| MA | | |

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| | (a) Nutritional care is evaluated and improved as required.<br>The organisation's nutrition and food care is reviewed as part of a regular schedule. Review may include: seeking feedback from clients and staff; analysing procedures for screening, assessment and referral; reviewing food menus and meal plans; obtaining external expertise in client nutrition and food care planning. Where reviews identify areas for improvement, there is a record of the issues, action planned and implemented, and the results. | Policy review schedule.<br>Quality improvement action plan.<br>Documented review and improvement activities.<br>Client and staff feedback. |
| | (b) Education programs on nutritional care and malnutrition are evaluated and improved as required.<br>As part of the organisation's nutrition and food care review, education provided to staff and clients is assessed and improved as required. | Quality improvement action plan.<br>Documented review and improvement activities. |
| | (c) Reporting of incidents contributing to deterioration in consumer / patient nutritional status is analysed and trended, and improvements are made to the nutritional policy / guideline as required.<br>Where poor client nutrition is not identified at screening / assessment, or where client poor nutrition and food care is not addressed, a review of incidents is undertaken to identify areas for improvement. Where practice can be improved, changes are made to the relevant policies and procedures. | Quality improvement action plan.<br>Documented review and improvement activities. |

Performance measures

Suggested performance measures for this criterion are on page 203 of *The ACHS EQuIP5 Guide – Book 1.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Identifying and responding to client nutrition and food needs. | Client intake and assessment forms and processes amended to include two questions about client health and nutrition status, and treatment plans now include nutrition and food care elements. | All clients have a basic screening for nutrition and food care, and actions identified in treatment / intervention plans. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Client menu, meal plans and recipes to be reviewed by an external nutritionist or dietician to ensure suitability for this client group and their varying presenting issues. | Operations Manager and Clinical Manager | November 2013 |

## Standard 1.6: The governing body is committed to consumer participation

## Criterion 1.6.1
## Consumers / patients, carers and the community participate in the planning, delivery and evaluation of the health service

The intent of this criterion is to ensure that organisations recognise and act upon the importance of client, carer and community participation in health care.

Refer to *The ACHS EQuIP5 Guide – Book 1,* page 208 for further information, including the relationship 1.6.1 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) Management's commitment to consumer / patient, carer and community participation is demonstrable.<br>The organisation has policies and procedures in place that identify how clients, carers and the community are involved in different levels of practice, including management decision making, program development and individual client care. Different types of participation may include information provision, consultation, delegation, partnership and control.<br><br>Examples of where clients, carers and the community may be involved in management decision making include: clients / carers / community members as part of strategic planning and/or clients / carers / community members resourced to attend planning and review events (i.e. travel expenses).<br>Examples of where clients, carers and community may be involved in program development include: seeking feedback from clients / carers / community members on program / clinical guidelines and/or involved in developing a client / carer / community participation policy.<br>Examples of where clients and carers may be involved in individual client care include: providing accessible information to clients and carers about drug and alcohol use and treatment, developing an intervention / treatment plan together, and promote the rights and responsibilities of clients and carers. | Client Participation Policy and related procedures.<br>Client Intervention Policy and related procedures.<br>Family Inclusive Practice Policy and related procedures.<br>External Relationship Policy and related procedures.<br>Feedback and Complaints Policy and related procedures.<br>Strategic planning attendance by clients / carers / community members.<br>Client health records – treatment plans.<br>Client rights and responsibilities and related procedures. |
| | (b) The organisation has identified its community and main consumer groups.<br>The organisation identifies who it provides services for and with, including: geographic region covered; types of drug and alcohol and related issues clients may have; age; and their cultural, linguistic, gender and sexuality diversity. | Client Intervention Policy and related procedures.<br>Client Participation Policy and related procedures.<br>Client Diversity Policy and related procedures.<br>Organisation / service information through website, brochures, etc. |
| | (c) The organisation has policy / guidelines that address consumer / patient, carer and community participation and a documented process to manage this.<br>The organisation's policies and procedures inform staff, clients, carers and community members about how the organisation engages clients, carers and community in the organisation and program development and service delivery. Specific activities addressed include: unsolicited feedback and complaints processes; solicited feedback; carer information / support sessions; consultation forums / meetings / discussion papers; partnerships through client and carer committees; governance roles; and individual client case consultation with client and carer involvement.<br><br>Resources that may support client, carer and community participation policy development include *'Treatment* | Client Participation Policy and related procedures.<br>Family Inclusive Practice Policy and related procedures.<br>External Relationship Policy and related procedures.<br>Board governance policies and procedures – client, carer, community member positions.<br>Record of formal consultation forums, meetings, discussion papers.<br>Carer information / support groups.<br>Client advisory group – terms of reference, minutes, etc. |

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| | *Services User Project: Final Report'*[xi] and *'Voices on choices: Working towards consumer-led alcohol and drug treatment'*[xii]. | |
| | (d) Consumers / patients, carers and the community are advised of the organisation's code of conduct.<br>Clients, potential clients, carers and community members are informed of the organisation's code of conduct and the expectation on staff of behaviour and service delivery. The code of conduct details how the organisation's staff interact with clients and carers and how privacy and confidentiality are maintained. | Staff code of conduct.<br>Client and carer program / service orientation.<br>Organisation / service information through website, brochures, etc. |
| Rating | Element | Evidence commonly presented |
| SA | (a) Consumers and consumer groups are consulted about effective ways of participating with the organisation and partnerships are established.<br>The organisation's seeks feedback from clients and client representative groups on how clients can participate effectively in the planning, delivery and evaluation of services. | Feedback and Complaints Policy and related procedures.<br>Record of Client Participation Policy development and how clients were involved.<br>Client Exit Policy and related procedures. |
| | (b) Relevant staff are trained in how to implement and evaluate consumer / patient, carer and community group participation strategies.<br>The organisation develops staff knowledge, attitudes and skills to better engage client, carer and community participation. This can be done through resource dissemination, in-house or external training, or in-services from external client representative groups or other experts. | Availability, understanding and use of client, carer and community participation resources by staff.<br>Staff training calendar.<br>Staff training records.<br>Record of staff in-services. |
| | (c) Consumers / patients and, when relevant, carers are involved in policy / guideline development and health services planning.<br>The organisation involves clients and, where relevant, carers in the organisation's planning, policy development / implementation, and program development / implementation to ensure client and carer needs and perspectives are considered.<br>Consumers / clients are involved through their input via planning day attendance, evaluations, suggestions and focus groups. | Board governance policies and procedures – client, carer, community member positions.<br>Record of formal consultation forums, meetings, discussion papers.<br>Client advisory group – terms of reference, minutes, etc.<br>Organisation planning sessions – record of client and carer participation.<br>Record of formal consultation forums, meetings, discussion papers. |
| | (d) Consumers / patients and, when relevant, carers sign confidentiality agreements when appointed to committees, and as otherwise appropriate.<br>When a client or carer participates in organisational committees such as a Board committee or client representative group, they are informed of their responsibilities regarding client and organisational confidentiality and demonstrate understanding of this by signing a confidentiality agreement. | Client and Carer Confidentiality Agreement.<br>Record of signed confidentiality agreements. |
| | (e) The organisation implements relevant training for interested consumers / patients and carers.<br>The organisation supports clients and carers to participate in organisational development by building their knowledge and skill through training and mentoring. | Client Participation Policy and related procedures.<br>Record of client and carer training, support and mentoring provided. |
| Rating | Element | Evidence commonly presented |
| MA | | |

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|---|---|---|
| | (a) The consumer / patient and carer participation program is evaluated and consumers / patients and carers are involved in this evaluation and improvements are made as required.<br>The organisation's client and carer participation practices are reviewed on a regular schedule with clients and carers. Areas for improvement are identified, and there is a record of the issues, action planned and implemented, and the results. | Client Participation Policy and related procedures.<br>Quality improvement policy review schedule.<br>Documented review and improvement activities.<br>Record / history of client and carer participation over time.<br>Client and carer feedback – reports and action undertaken. |
| | (b) Feedback on consumer / patient and carer participation is provided to the community and the organisation.<br>The organisation documents and distributes information on how clients and carers have participated with the organisation and how they have contributed to organisational development. | Annual reports – client and carer participation roles and contributions.<br>Information sessions provided to the community.<br>Presentations to client and carer advisory groups.<br>Organisation / service information through website, brochures, etc. |

Performance measures

Suggested performance measures for this criterion are on page 213 of *The ACHS EQuIP5 Guide – Book 1.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Client participation in-services for staff | Several in-services were arranged for staff that addressed strategies for client participation. | Staff were better informed on how they could engage client participation. There is now a client feedback meeting held weekly with all current clients welcome to attend to provide feedback and suggestions on organisation and service improvements. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Developed Client Participation Policy with previous and current client involvement to guide staff and clients in how clients can contribute to organisational development. | Manager | December 2013 |

## Standard 1.6: The governing body is committed to consumer participation

### Criterion 1.6.2
### Consumers / patients are informed of their rights and responsibilities

The intent of this criterion is to support organisations in meeting their obligations to inform clients of their rights and responsibilities.

Refer to *The ACHS EQuIP5 Guide – Book 1,* page 216 for further information, including the relationship 1.6.2 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) A consumer / patient rights and responsibilities document exists.<br>The organisation has a document that details client's rights about what they can expect and demand from the organisation and service, and what the organisation is obligated to provide to the client, and when appropriate their carer. The document also details client's responsibilities regarding their honesty, compliance and conduct which facilitate the organisation's provision of safe, high quality health care. Reference is made to the Australian Charter of Healthcare Rights.[xiii] (www.safetyandquality.gov.au) | Client rights and responsibilities. |
| | (b) A confidentiality and privacy policy / guideline is in place.<br>The organisation has processes in place to guide staff and clients in managing personal, health and medical information. These processes are informed by and meet legislation, codes of professional ethics, and accepted standards. | Privacy and Confidentiality Policy and related procedures.<br>Client rights and responsibilities and related procedures.<br>Client and Carer Confidentiality Agreement.<br>Volunteer Policy and related procedures.<br>Client File Management Policy and related procedures. |
| | (c) The organisation provides information on how consumers / patients and carers when relevant, can access advocacy and support services.<br>Clients and carers are informed of how to contact external advocacy and support services. General information on where such services are, their role and how to make contact can be provided throughout a client's intervention / treatment through brochures, information / education sessions, facilitating meetings, other printed materials, and referrals. | Client and carer information sessions.<br>External advocacy and support service material / information provided to clients and carers. |
| | (d) The procedure for consumer access to their health records is documented and communicated to consumers / patients and when appropriate, their carers.<br>The organisation documents the process for staff and clients by which a client may access their own health record. Clients and when appropriate carers are informed of their right to access their own health record and the process involved in doing so. Consideration is given to the format and language needs of clients and carers. | Privacy and Confidentiality Policy and related procedures.<br>Client and carer program / service orientation.<br>Client rights and responsibilities and related procedures.<br>Client File Management Policy and related procedures. |
| Rating | Element | Evidence commonly presented |
| SA | (a) Consumers / patients and when appropriate, carers receive a copy of the rights and responsibilities document.<br>All clients and, when appropriate, carers are provided with information about client rights and responsibilities while a client of the service. This may be provided at the time of intake / assessment and throughout the intervention / treatment. Information may be made available through the organisation's website, brochures, client orientation procedures, as posters throughout the facility, and verbally discussed with the client. | Client Intervention Policy and related procedures.<br>Client and carer program / service orientation.<br>Client rights and responsibilities and related procedures.<br>Organisation website, brochures, etc. |
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| | (b) Staff discuss rights and responsibilities with the consumer / patient and when appropriate, their carer.<br>Staff members discuss rights and responsibilities with clients during intake/assessment. Further discussion may occur following a breach of rights or responsibilities on the organisation's or client's behalf. | Client Intervention Policy and related procedures.<br>Client and carer program / service orientation. |
| | (c) The organisation implements policy and procedures to ensure that personal health-related information is managed in accordance with jurisdictional privacy legislation.<br>The organisation has processes in place to guide staff and clients in managing clients' personal, health and medical information. These processes are informed by and meet legislation, codes of professional ethics, and accepted standards. Staff have or develop knowledge and practice in managing clients' personal, health and medical information through training and education supported by the organisation. | Privacy and Confidentiality Policy and related procedures.<br>Volunteer Policy and related procedures.<br>Client File Management Policy and related procedures.<br>Staff training and education – in-services, courses, etc. |
| | (d) Staff and volunteers sign confidentiality agreements.<br>Staff and volunteers are educated and trained in managing client confidentiality and sign confidentiality agreements to demonstrate their understanding and agreement with relevant confidentiality policies. | Privacy and Confidentiality Policy and related procedures.<br>Volunteer Policy and related procedures.<br>Staff Code of Conduct.<br>Client and Carer Confidentiality Agreement.<br>Staff personnel records – signed Confidentiality Agreements. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The system to inform consumer / patient rights and responsibilities is evaluated, and improvements to documents and practices are made as required.<br>The organisation's client rights and responsibilities processes are reviewed on a regular schedule. Where areas for improvement are identified, there is a record of the issues, action planned and implemented, and the results. | Quality improvement policy review schedule.<br>Documented review and improvement activities.<br>Record / history of client rights and responsibilities processes over time. |

Performance measures

Suggested performance measures for this criterion are on page 221 of *The ACHS EQuIP5 Guide – Book 1.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Communication of client rights and responsibilities. | Information on client's rights and responsibilities was made more widely available by posting on the organisations website, and being included in the intake / information pack provided to potential clients, in program brochures and in posters throughout the facility. | A greater emphasis on rights and responsibilities has provided clients with clearer understanding of their rights and responsibilities, and supported staff to implement responses to breaches of client responsibilities. |

Plans for improvement

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| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Develop a culturally appropriate poster to communicate client rights and responsibilities to Aboriginal and Torres Strait Islander people. | Team Leader | December 2013 |

## Standard 1.6: The governing body is committed to consumer participation

### Criterion 1.6.3
### The organisation meets the needs of consumers / patients and carers with diverse needs and from diverse backgrounds

The intent of this criterion is to ensure that the organisation provides for the diversity of the community it serves.

Refer to *The ACHS EQuIP5 Guide – Book 1,* page 222 for further information, including the relationship 1.6.3 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) The organisation identifies the diverse needs and diverse backgrounds of its consumers / patients and their carers, to improve its cultural competence, awareness and safety.<br>The organisation recognises varying qualities in individuals and across society, creating a culture of equality of care for all clients. Identification of diversity may be represented through policies and procedures, staff diversity education / training, recruitment of staff representing diversity, consultation and partnerships with services representing client diversity, and service delivery adapted to meet client diversity. | Client Diversity Policy and related procedures. |
| | (b) Policy / guidelines are written to ensure that services are provided appropriate to consumers / patients and carers with diverse needs and from diverse backgrounds.<br>The organisation's policies and procedures that relate to client service delivery consider and respond to the varying needs of client diversity, including age, race, ethnicity, language, gender, sexual orientation, religion, ability / disability, socio-economic level, and culture.<br>Where the organisation has identified particular client diversities that need to be responded to, specific guidelines are implemented to improve client outcomes.<br><br>Resources that may support client diversity policy development include *'Well proud: A guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services'*[xiv], *'National Cultural Competency Tool (NCCT) for Mental Health Services'*[xv], *'Guidelines for working with interpreters for counselling & health care staff working with refugees'*[xvi], and *'Guidelines on the management of co-occurring mental health conditions in alcohol and* | Client Diversity Policy and related procedures.<br>Diversity Competence Checklist – report and actions undertaken.<br>Specific diversity guidelines – i.e. Working with GLBT Clients, Supporting Clients with Literacy Barriers. |

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| | *other drug (AOD) treatment settings'*[xvii].<br><br>The following websites may provide information on specific client diversity:<br>- ACON www.acon.org.au<br>- Aboriginal Health and Medical Research Council www.ahmrc.org.au<br>- Community Restorative Centre www.crcnsw.org.au<br>- Disability Council of NSW www.disabilitycouncil.nsw.gov.au<br>- Drug and Alcohol Multicultural Education Centre www.damec.org.au<br>- No Bars www.nobars.org.au<br>- Pride in Diversity www.prideindiversity.com.au | |
| | (c) The organisation meets legislative requirements that are relevant to consumers / patients and carers with diverse needs and from diverse backgrounds.<br>The organisation's policies and procedures that relate to client service delivery align with legislation including: *Disability Discrimination Act 1992 (Commonwealth), Human Rights and Equal Opportunity Commission Act 1996 (Commonwealth), Racial Discrimination Act 1975 (Commonwealth).* | Client Diversity Policy and related procedures. |
| Rating | Element | Evidence commonly presented |
| SA | (a) The organisation collects demographic data in relation to the diverse population it serves.<br>The organisation has a standard and consistent process to collect client demographic data such as age, gender, living arrangements, etc. Data collection may include the Alcohol and Other Drug Treatment Services National Minimum Data Set as well as specific items identified by the organisation. | Client Intervention Policy and related procedures.<br>Client File Management Policy and related procedures.<br>Minimum Data Set collection forms.<br>Minimum Data Set database. |
| | (b) Staff are informed about and have access to information and resources regarding consumers / patients and carers with diverse needs and from diverse backgrounds.<br>The organisation collates resources and links, and provides access to, further information on working with a diverse client base. This may be done through subscriptions (newsletters, journals), providing internet access, developing a hard / electronic library, staff in-services, inter-agency visits, specific diversity education / training. | Subscriptions.<br>Resource libraries.<br>Internet access.<br>Schedule and record of staff in-services, training, education, conference attendance. |
| | (c) Staff are provided with the opportunity for training to enhance their skills in planning and delivery of appropriate services to consumers / patients and carers with diverse needs and from diverse backgrounds.<br>The organisation facilitates staff developing their knowledge, attitudes and skills in working with a diverse client base by providing staff in-services, funding and time for education and training, and/or supervision and mentoring. | Staff Performance and Development Policy and related procedures.<br>Schedule and record of staff in-services, training, education, conference attendance.<br>Staff supervision and/or mentoring. |
| | (d) Food, services, care and consideration for spiritual needs are provided in a manner that is appropriate to consumers / patients with diverse needs and from diverse backgrounds.<br>The organisation's policies, procedures, and client service delivery is appropriate for a diversity of clients, and adapts where possible to the meal/food and spiritual needs of a range of clients. | Client intervention / treatment program – demonstrating flexibility to meet client diversity.<br>Menu plans and variables. |
| | (e) Translated information is developed appropriate to the diverse needs and diverse backgrounds of | Organisation brochures, posters and client program information in a |

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| | consumers / patients.<br>The organisation identifies diversity and provides information about the service/program in culturally specific ways. This may be done by having service brochures, posters and client program information presented in varying languages, and for different literacy levels, or for the visually- or hearing-impaired. | range of culturally appropriate formats. |
| | (f) Trained interpreters are available and staff / consumers / patients are informed of the availability.<br>The organisation details the process for accessing trained interpreters and all staff, clients and carers are aware of the process. | Client Intake and Assessment Policy and related procedures.<br>Staff induction and orientation procedures.<br>Client and carer program / service orientation.<br>Organisation brochures, posters and client program information in a range of culturally appropriate formats. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The organisation demonstrates partnerships with relevant local organisations, to support the diverse needs and diverse backgrounds of consumers / patients and their carers.<br>The organisation develops and maintains relationships with external service providers to support improved client outcomes by addressing client diversity and associated needs. This may be relevant at an organisational, planning, program or individual client level. | External Partnership Policy and related procedures.<br>Board membership – representing diversity.<br>Organisation subcommittees/working groups to address diversity with external expertise.<br>Inter-agency meetings / forums / in-services.<br>Clinical review meetings with external expertise in specific client diversity. |
| | (b) Data on utilisation of the service by people with diverse needs and from diverse backgrounds are collected, and maintained to monitor access, which is improved as required.<br>The organisation analyses client diversity data and improves service delivery and programs accordingly. | Minimum Data Set collection forms.<br>Minimum Data Set database.<br>Client data reports trended over time.<br>Record of client service / program improvements over time regarding diversity and access. |
| | (c) The organisation evaluates whether consumers / patients and their carers' diverse needs are met, and strategies for improvement are implemented as required.<br>The organisations reviews and improves services and programs regularly, with consideration of the diverse needs of clients. Specific activities may include utilising client feedback and conducting consultation with clients, carers and professionals on diverse needs. | Quality improvement policy review schedule.<br>Documented review and improvement activities.<br>Record / history of client services and programs over time. |

Performance measures

Suggested performance measures for this criterion are on page 227 of *The ACHS EQuIP5 Guide – Book 1.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Client's literacy access. | A question regarding client's ability to | A 2009 review of client evaluation data demonstrated that 30% of clients had some difficulty reading and |

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| | . | read and understand program material was included in the client evaluation. | understanding program materials. A subsequent review and update of the program material ensured information was more accessible and additional support was provided to clients with low literacy. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | In partnership with external expertise, review organisation, services and programs to ensure GLBT accessible and welcoming. | Service Manager | December 2013 |

# Support Function

EQuIP5

## 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

### Criterion 2.1.1

*The organisation's continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery*


The intent of this criterion is to ensure the organisation understands the importance of developing an improvement culture and system, and this can be demonstrated in all aspects of care and service delivery.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 252 for further information, including the relationship 2.1.1 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) The governing body is committed to continuous quality improvement.<br>The governing body understands, supports and implements quality improvement (QI) throughout the organisation by:<br>- defining Board, staff and others' QI roles and responsibilities<br>- discussing QI at Board meetings<br>- Board members being directly involved in QI committees, policy review and other activities<br>- endorsing the QI framework of the organisation<br>- ensuring QI is built into strategic and operational planning and budgets<br>- establishing QI indicators and measuring performance. | Quality Improvement Action Plan.<br>Policy Development Policy and related procedures.<br>Board orientation processes.<br>Board meeting agendas and minutes.<br>Functions and Delegations Matrix.s<br>Strategic and operational plans.<br>Budgets allowing for QI activities.<br>Engagement with QI program provider. |
| | (b) A framework for continuous quality improvement exists.<br>The organisation embeds QI throughout the organisation by:<br>- defining Board, staff and others' QI roles and responsibilities<br>- implementing a QI Action Plan outlining policy review schedule, new QI activities to be undertaken, and QI achievements<br>- establishing incident reporting and review processes<br>- establishing program / project / activity evaluation processes<br>- providing and facilitating QI education and training<br>- including budget line items for QI activity. | Quality Improvement Policy and related procedures.<br>Quality Improvement Action Plan.<br>Policy Development Policy and related procedures.<br>Functions and Delegations Matrix.<br>Staff position descriptions.<br>Program Evaluation Policy and related procedures.<br>Incident reporting and review processes. |
| Rating | Element | Evidence commonly presented |
| SA | (a) Quality improvement is planned, continuous and linked to the risk management system, education, and the | Quality Improvement Policy and related procedures. |

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| | strategic plan.<br>The organisation's QI program is planned with activities, milestones and timeframes clearly outlined. Continuous quality improvement and risk management are demonstrated by a schedule of review and improvement of policies, processes, activities and service delivery. Out of schedule review and improvement forms part of incident management practice to ensure risks are identified and addressed. Workforce professional development planning includes orientation, training, and resource allocation for quality improvement. The organisation incorporates quality improvement into the strategic plan, with QI outcomes and indicators established. | Quality Improvement Action Plan.<br>Staff orientation procedures.<br>Records of staff QI training / in-services – completed and scheduled.<br>Organisation strategic plan.<br>Organisation operational plans – workforce development, work health and safety (WHS).<br>Risk Management Policy and related procedures. |
| | (b) Staff are supported and participate in ongoing improvement in care and service delivery.<br>The organisation facilitates staff involvement in improving client care and service delivery by providing:<br>- QI orientation, education, training and/or mentoring<br>- allocation of resources and time for review activities<br>- resources and time to develop and implement improvements<br>- recognition and reward of improvement achievements – performance and development reviews, formal acknowledgement, public notices<br>- involvement in decision making through staff meetings, planning sessions, presentations to Board, leadership and involvement of improvement teams. | Quality Improvement Policy and related procedures.<br>Quality Improvement Action Plan – responsibilities and achievements.<br>Records of staff QI training / in-services – completed and scheduled.<br>Staff performance and development reviews.<br>Staff meeting agendas and minutes.<br>Record of quality working groups.<br>Record of planning sessions – quality, operational, strategic or activity.<br>Record of staff recognition and reward. |
| | (c) Leaders in quality improvement are identified and developed across the organisation and supported to drive the improvement.<br>The organisation identifies a QI leader(s) within the organisation as their primary role or as a part of their existing responsibilities. Organisational support is provided for these positions by ensuring formal recognition of the role, as well as providing training, resources, and supervision, facilitating Board and other staff engagement, and responding to QI recommendations. | Quality Improvement Action Plan.<br>Staff position descriptions.<br>Record of formal recognition of QI leaders.<br>QI working group minutes. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The effectiveness of the improvement framework and its component activities is evaluated and improved as required.<br>The organisation ensures that the quality improvement framework is regularly reviewed and improved as part of the organisation's quality improvement program. As the organisation's experience in implementing a QI program develops, the system will need to be amended to ensure continuous improvement. This will require the involvement of QI leaders, other staff, and Board members. | Current and previous Quality Improvement Action Plan.<br>Current and previous Quality Improvement Policy.<br>Record of QI system / policy review meetings.<br>Record of external review of QI system, including ACHS surveyor comments from assessments and surveys. |
| | (b) Qualitative and quantitative data are collected, analysed and used to plan and drive improvement.<br>The organisation collects and utilises relevant data to support planning and improvement of operations and service delivery. Data types may include: service delivery outputs (i.e. number of clients assessed, bed days, counselling sessions), service delivery outcomes (i.e. client's quality-of-life rating, risk-taking behaviour scores), operational outcomes (i.e. expenditure against budget, water and electricity consumption), and qualitative data (i.e. client satisfaction feedback, reasons for staff resignations, survey of stakeholders regarding quality of relationship). | Quality Improvement Policy and related procedures.<br>Program Evaluation Policy and related procedures.<br>Reports from review of client, staff and stakeholder consultation, surveys, and feedback.<br>Reports from review of staff resignations and exit interviews.<br>Client minimum data set (MDS) and health outcome reports.<br>Reports from reviews of performance against operational / strategic |

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| | | plan indicators.<br>Current and previous Quality Improvement Action Plans. |
| | (c) Clinicians are involved in the evaluation of the quality improvement system.<br>All staff contribute to reviewing and improving the organisation's quality improvement framework and systems, including direct client workers such as case managers, counsellors, psychologists, nurses, and medical practitioners. | Quality Improvement Policy and related procedures.<br>Record of QI review working group – participants, actions, responsibilities, outcomes.<br>Report on feedback from staff questionnaire regarding QI systems and processes.<br>Staff meeting minutes. |

Performance measures

Suggested performance measures for this criterion are on page 257 of *The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Review QI administrative support needs. | A review of administrative support needs led to the allocation of an administration officer 2 days per week for 6 months, and then 1 day per week for a further 12 months. | Completion of planned QI activity has increased from 50% to 75% in the first 4 months.<br><br>Staff report greater confidence and capacity in the organisation being able to complete all planned QI activities. |
| 2 | Further embed QI in the organisations' operations. | Quality improvement is included as a standing agenda item at staff and Board meetings.<br>Quality improvement is included in Board orientation processes and Governance Policy.<br>Quality improvement is included in position descriptions and staff performance and development reviews as a performance indicator. | 100% of Board members receive orientation to the organisation's quality improvement program.<br><br>Staff report a greater understanding of their responsibilities and interest in the organisation's QI program. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Engage an external consultant to review and report on the organisation's quality improvement processes and culture. | Business Manager and QI Coordinator | July 2015 |

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| 2 | Develop a bi-monthly internal quality and safety newsletter for staff and Board members, with the aim of developing understanding and engagement in the QI program. | QI Coordinator | March 2014 |

## 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.

### Criterion 2.1.2

*The integrated organisation-wide risk management framework ensures that corporate and clinical risks are identified, minimised and managed.*


The intent of this criterion is to ensure that the organisation identifies, minimises and manages corporate and clinical risks.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 260 for further information, including the relationship 2.1.2 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) There is an organisation-wide risk management policy / guideline for corporate and clinical risks that identifies specific strategies for managing risks and is available to clinicians, managers and other staff.<br>The organisation has a risk management policy that guides the identification, analysis, response, monitoring and communication of corporate and clinical risks specific to the organisation. Corporate risks relate to financial management, human resources, information management, work health and safety (WHS), environment and assets, sustainability, and reputation. Clinical risks relate to client intervention and services provided, client outcomes, and confidentiality / privacy. | Risk Management Policy and related procedures.<br>Risk Review Template.<br>Risk register.<br>Access to electronic and hard copy policies and related procedures. |
| | (b) Clinicians, managers and other staff are informed about their responsibilities for identifying and managing risks.<br>All staff are provided with information and, where relevant, training, on their responsibilities for identifying and managing risks. Initial instruction is provided at orientation, with ongoing information provided when there are changes to identified risks, their rating and/or the appropriate response. All staff have ready access to guidance on responding to specific corporate and clinical risks. | Risk Management Policy and related procedures.<br>Staff position descriptions.<br>Staff access to risk register.<br>Staff orientation procedures.<br>Staff orientation checklist.<br>Staff meeting agendas and minutes – risk management discussions. |
| Rating | Element | Evidence commonly presented |
| SA | (a) There is integration between quality improvement, risk management and strategic planning within the | Risk Management Policy and related procedures. |

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| | organisation.<br>The organisation's risk management processes are incorporated into the QI program and are an integral part of strategic planning. Strategic plans include risk management outcomes and indicators, providing direction and performance achievement. The organisation's QI program provides a mechanism for addressing risk, and is demonstrated by scheduled review and improvement of policies, processes, activities and service delivery, as well as out-of-schedule review and improvement following incidents. | Quality Improvement Action Plan.<br>Quality Improvement Policy and related procedures.<br>Organisation Strategic Plan. |
| | (b) An integrated, organisation-wide risk management framework addressing corporate and clinical risks is developed, documented and implemented.<br>The organisation's risk management process / framework, addressing both corporate and clinical risk, is clearly documented and applied across the whole organisation. The risk management process / framework may include policies, procedures, assessment tools, internal and external review, and staff education and training. | Risk Management Policy and related procedures.<br>Risk register.<br>Risk Review Template.<br>Quality Improvement Action Plan.<br>Staff orientation, education and training on risk management. |
| | (c) Systems are implemented to ensure clinicians, managers and staff can initiate action to prevent and/or reduce the impact of risks.<br>Staff's capacity to identify and respond to corporate and clinical risks may be developed through:<br>- orientation, education and training<br>- clearly detailing responsibilities<br>- developing policies, procedures and tools<br>- incorporating risk management into all projects, activities and service delivery<br>- supporting leadership in risk management<br>- providing time and resources to develop risk management strategies<br>- recognising risk management achievements<br>- reporting on organisation-wide risk management status. | Risk Management Policy and related procedures.<br>Risk register.<br>Risk Review Template.<br>Quality Improvement Action Plan.<br>Staff orientation, education and training on risk management.<br>Staff position descriptions.<br>Functions and Delegations Matrix.<br>WHS Policy and related procedures.<br>Staff meeting agenda and minutes – risk management items.<br>Risk management working groups. |
| | (d) A risk management approach is used when considering and developing new and modified services.<br>In considering and developing new or modified services, programs or activities, the organisation considers potential implications, likelihood of these occurring and the consequences. The development and implementation of new or modified services, programs or activities should also include consideration as to the effectiveness for clients and any related advantages, known risks and management strategies for them, communication with clients, staff education and training requirements, costs and cost benefits, monitoring and review, and data required for evaluation. | Risk Management Policy and related procedures.<br>Client Intervention Policy and related procedures.<br>Program Evaluation Policy and related procedures.<br>Evidence Based Practice Policy and related procedures.<br>Project Planning Policy and related procedures.<br>Record of planning for new / modified service, program or activity.<br>Evaluation reports from new / modified service, program or activity. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The corporate and clinical risk management framework is evaluated and improved as required.<br>The organisation reviews how corporate and clinical risks are managed, and implements risk identification and response improvements. | Current and previous Quality Improvement Policy and related procedures.<br>Current and previous Risk Management Policy and related procedures.<br>Current and previous Client Treatment Policy and related procedures.<br>Current and previous Program Evaluation Policy and related |

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| | | procedures.<br>Current and previous WHS Policy and related procedures.<br>Quality Improvement Action Plan and progress reports.<br>Record of feedback and meetings from staff consultation and involvement. |
| | (b) Risk identification and risk analysis are undertaken using qualitative and quantitative data.<br>The organisation utilises a range of information to identify and analyse risk within the organisation, including statistical data, financial details, and narrative descriptions and assessments. | Risk Review Template.<br>Risk review reports.<br>Record of planning for new / modified service, program or activity. |
| | (c) Data from risk management processes are provided to clinicians, managers and other staff and improvements to care and services are planned and implemented.<br>The organisation uses facilitated incident reporting to manage avoided risks and critical incident reporting to manage risks that have occurred. Data collected from these occurrences are provided and utilised by staff and the Board for improved risk management strategies. | Record of communication with staff and Board – emails, newsletters, monthly reports, etc.<br>Incident review reports and action plans distributed to staff and Board.<br>Staff and Board meeting minutes.<br>Current and previous risk register. |

Performance measures

Suggested performance measures for this criterion are on page 265 *of The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Staff involvement in risk management. | Risk management working group established including management, administrative and clinical staff members. Group responsible for leading risk management processes and facilitating engagement from other staff. | New Risk Management Policy developed in consultation with staff and Board, better outlining responsibilities, risk types, risk assessment and risk response strategies and controls.<br><br>Staff report having a better understanding of how to manage risks unique to their organisation. |
| 2 | Incorporate risk management activities into Quality Improvement Action Plan review schedules. | All risk management strategies are included in the 2 yearly review schedule along with policies and procedures. | The review of risk management strategies and controls has commenced, with 10% completed in the first 4 months, compared to 0% over the previous 2 years. |

Plans for improvement

| No. | Intended Improvement | Responsibility | Timeframe |
|---|---|---|---|

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| 1 | Complete a risk assessment and report on all external client activities (shopping, day leave, gym visits). | Team Leader and Client Support Worker | September 2013 |
| 2 | Develop and apply risk assessment matrix for all client interventions. | Program Manager and Team Leader | August 2013 |

## 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

### Criterion 2.1.3
*Healthcare incidents are managed to ensure improvements to the systems of care*


The intent of this criterion is to ensure that organisations have effective systems for managing healthcare incidents and near misses.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 268 for further information, including the relationship 2.1.3 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) The organisation has a process to effectively identify and manage incidents in an integrated manner, including serious incidents.<br>An incident is an event or circumstance that results in, or could have resulted in, unintended or unnecessary harm to a person and/or a complaint, loss or damage. A near miss is an incident that did not cause harm, loss or damage, but had the potential to do so.<br><br>The organisation has processes for integrated incident management including:<br>- identification of incidents and near misses<br>- notification of incidents – through established pathways<br>- prioritisation and categorisation – measuring severity<br>- investigation – internal and where appropriate external<br>- classification – capturing and documenting incident information<br>- analysis and action – how and why the incident occurred and prevention strategies<br>- feedback – including changes made and the resulting improvements.<br><br>An integrated process ensures incidents are managed consistently across the organisation, and trends and patterns are able to be identified. Integration also means that all related policies and procedures align and describe a | Incident Management Policy and related procedures.<br>WHS Policy and related procedures.<br>Incident Report Template.<br>Incident register.<br>Risk Management Policy and related procedures.<br>Risk register.<br>Incident review reports and action plans.<br>Quality Improvement Action Plan. |

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| | common process. | |
| | (b) The organisation is aware of the principles for open disclosure.<br>Open disclosure refers to frank and transparent discussion of incidents that have resulted in harm to a client while receiving health care. The following national standards[xviii] for open disclosure are incorporated into the organisation's incident response policies and procedures:<br>- open and timely communication<br>- acknowledgement of the event<br>- expression of regret<br>- recognition of reasonable expectations of clients and their support persons<br>- staff support<br>- integrated risk management and systems improvement<br>- good governance<br>- confidentiality. | Incident Management Policy and related procedures.<br>Feedback and Complaints Policy and related procedures.<br>WHS Policy and related procedures. |
| | (c) Incident management and open disclosure policy / guidelines exist and are communicated to staff.<br>The organisation's incident management policies and procedures, including open disclosure, are communicated to staff at orientation, as part of the policy / procedure review and update, and throughout and following an incident. | Incident Management Policy and related procedures.<br>WHS Policy and related procedures.<br>Staff orientation processes.<br>Incident review reports. |
| | (d) Consumers / patients are provided with information about incident management processes.<br>The organisation provides clients with relevant information about how incidents are managed by the organisation. This may occur as part of client admission and orientation processes, and should be accessible at any time by the client, and reiterated following an incident. | General safety and care information available publicly – website, brochures, posters throughout the facility.<br>Client admission and orientation processes – checklist, manual, rights and responsibilities, feedback and complaints, etc.<br>Feedback and Complaint Management Policy and related procedures. |
| Rating | Element | Evidence commonly presented |
| SA | (a) Incidents are systematically managed in accordance with jurisdictional policy / legislation and Australian standards including:<br>(i) identification<br>(ii) review<br>(iii) action on incidents<br>(iv) communication<br>(v) levels of responsibility for incident management<br>(vi) support for consumers / patients and staff involved in incidents<br>(vii) in-depth investigations for serious incidents / sentinel events.<br>The organisation's policies and procedures that guide incident management are informed by, and compliant with, relevant jurisdictional policies and legislation, such as WHS and privacy legislation. All staff and Board members act in accordance with incident management guidelines, which specifically address the actions listed above. | Incident Management Policy and related procedures.<br>WHS Policy and related procedures.<br>Incident Report Template.<br>Incident register.<br>Risk Management Policy and related procedures.<br>Risk register.<br>Incident review reports and action plans.<br>Functions and Delegations Matrix.<br>Legal and Regulatory Policy and related procedures.<br>Examples of incident responses including staff debriefing sessions, practice change, communications. |
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| | (b) Clinicians, managers and staff are orientated / trained in incident management and open disclosure.<br>The organisation orientates staff to incident management and open disclosure through formal orientation processes and through engaging staff in incident management review and improvement. Additional education and training may be provided through staff in-services, funding and time for education and training, and/or supervision and mentoring. | Incident Management Policy and related procedures.<br>WHS Policy and related procedures.<br>Staff orientation procedures.<br>Staff orientation checklist.<br>Record of staff training / in-services relating to incident management, open disclosure and WHS. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The incident management system is evaluated and improved as required.<br>The organisation reviews how incidents are managed, including identification and response, and implements improvements. | Current and previous Incident Management Policy and related procedures.<br>Current and previous risk registers.<br>Quality Improvement Action Plan.<br>Review and report of incidents – including improvement actions. |
| | (b) The principles of open disclosure are evident in the system to manage incidents.<br>The organisation's incident management policies and procedures incorporate open disclosure principles to ensure a transparent and well managed response to incidents. | Incident Management Policy and related procedures.<br>Feedback and Complaints Policy and related procedures.<br>WHS Policy and related procedures.<br>Staff orientation procedures.<br>Staff orientation checklist. |
| | (c) Incidents are trended, risks are identified, and improvements are made as required.<br>The organisation collates incident data to map trends, identify actual and potential risks, and inform improvement strategies. Incident management improvement strategies aim to reduce the likelihood and/or severity of incidents. | Incident Management Policy and related procedures.<br>WHS Policy and related procedures.<br>Quality Improvement Action Plan.<br>Review and report of incidents – including data, trends and improvement actions. |
| | (d) Improvement strategies are evaluated, communicated and implemented across the organisation to ensure the organisation is providing safe practice and a safe environment.<br>Incident management improvement strategies are communicated to staff and other relevant personnel as part of the implementation process. All incident management improvement strategies are evaluated to ensure they are effective and contribute to overall safety improvement. | Incident Management Policy and related procedures.<br>Quality Improvement Action Plan.<br>Review and report of incidents and improvement strategies.<br>External incident and incident improvement review reports.<br>Record of minutes from staff, QI and WHS meetings – incident management and improvements. |
| | (e) The support provided for consumers / patients and staff involved in incidents is evaluated, and improved as required.<br>The organisation reviews the support provided to clients and staff following an incident event. The review will address improvements to be made regarding communication, responding to complaints, and services provided and/or facilitated. | Incident Management Policy and related procedures.<br>Quality Improvement Action Plan.<br>Review and report of incidents and improvement strategies.<br>Review of feedback from clients and staff.<br>Current and previous support for clients and staff involved in an incident. |

Performance measures

Suggested performance measures for this criterion are on page 272 of *The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Feedback and Complaints Policy. | Client orientation processes now include information on how to provide feedback and make a complaint, and how clients can expect the complaint to be managed. | The 2013 Client Feedback Survey Report indicates an increase in client satisfaction with how the organisation manages complaints - from 67% in 2010 to 90% in 2013.<br><br>A review of client complaints received during 2012/13 indicates 97% were managed within the specified time frame. Strategies were identified to maintain and improve future response times. |
| 2 | Review incident management policies and procedures. | Risk Management Policy and Incident Management Policy reviewed and updated to better align with each other and with the QI Policy, and clearer guidance provided on reviewing incidents and implementing improvements. | Staff report greater understanding of incident review processes. Since July 2012 there have been 3 incidents reported, all of which have been reviewed to inform incident management improvement. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Improve the communication of the organisation's open disclosure practices by adding information:<br>- on the website and in brochures<br>- in client admission processes<br>- in the Feedback and Complaints Policy<br>- in the brochure *'Information for Clients: How to Make a Complaint'* | QI Coordinator | December 2013 |

## 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

### Criterion 2.1.4

## Healthcare complaints and feedback are managed to ensure improvements to the systems of care

The intent of this criterion is to ensure the organisation has effective systems for managing client feedback and complaints, so that this information can be used to drive quality improvement while also identifying what the organisation does well.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 274 for further information, including the relationship 2.1.4 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) The organisation has a process for managing complaints and feedback, that is communicated to staff.<br>The organisation provides guidance to staff on how to manage feedback and complaints from clients and stakeholders. Guidance is communicated to staff through a number of mechanisms, including:<br>- orientation<br>- position descriptions and role designations<br>- specific policies and procedures<br>- agenda items at staff meetings<br>- in-services and education sessions<br>- formal training<br>- feedback and complaints response teams. | Feedback and Complaints Policy and related procedures.<br>Feedback and complaints record form.<br>Feedback and complaints register.<br>Staff orientation processes. |
| | (b) The organisation has a process for risk rating complaints.<br>The organisation's complaints management process includes an assessment or initial judgement of the severity of the incident and the related risk. Considered risks may include safety and welfare of staff, clients and stakeholders, financial and other resourcing impacts, service delivery impacts, implications for relationships / partnerships, and the organisation's reputation. | Feedback and Complaints Policy and related procedures.<br>Feedback and complaints record form – risk rating. |
| | (c) Consumers / patients and carers are informed of the process for making a complaint and providing feedback.<br>Clients and carers are provided with information on how they are able to provide feedback and make a complaint. This information is made available through the organisation's website, brochures and posters throughout the facility, and on initial client engagement and/or client admission. | Feedback and Complaints Policy and related procedures.<br>Client Treatment Policy and related procedures.<br>Client rights and responsibilities brochure.<br>Brochures and posters throughout the facility. |
| **Rating** | **Element** | **Evidence commonly presented** |
| SA | (a) Complaints and feedback are managed in accordance with jurisdictional policy / legislation and Australian standards.<br>The organisation's complaints management process is informed by policy, legislation and standards, including the NSW Ministry of Health's 'Complaints Management Guidelines' (2006) and Standards Australia's 'Handbook: The why and how of complaints handling' (2006). | Feedback and Complaints Policy and related procedures.<br>Responses to actual complaints. |
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| | (b) The complaint management system includes:<br>(i) registration of the complaint<br>(ii) review, including formal review of serious complaints<br>(iii) response in a timely manner<br>(iv) support and/or advocacy for consumers / patients, carers and staff involved in complaints<br>(v) communication of outcomes.<br>The organisation has a multi-step complaints management process in which the complaint is:<br>- received – verbally, in writing or on-line<br>- registered within the organisation's incident management system and acknowledgement provided to the complainant that this has occurred<br>- assessed – determining the severity of the incident<br>- investigated – internally and/or by external authorities<br>- analysed and reviewed – to determine a course of action<br>- responded to – acting on recommendations<br>- resolved – in the event of a valid complaint, formal acknowledgement is made to the complainant, and documentation finalised.<br><br>The organisation pre-determines appropriate complaint response timeframes, those responsible for leading responses, and the options for staff, clients and carer support. | Feedback and Complaints Policy and related procedures.<br>Complaints register.<br>Functions and Delegations Matrix. |
| | (c) Clinicians, managers and staff are orientated / trained in complaint management and open disclosure.<br>The organisation orientates staff to complaint management and open disclosure through formal orientation processes and through engaging staff in complaint management review and improvement. Additional education and training may be provided through staff in-services, funding and time for education and training, and/or supervision and mentoring. | Feedback and Complaints Policy and related procedures.<br>Staff orientation procedures.<br>Staff orientation checklist.<br>Record of staff training / in-services relating to complaint management and open disclosure. |
| | (d) Staff are trained in relevant methods of conflict and complaints resolution.<br>The organisation identifies designated staff to receive, report and investigate complaints, however any staff member may receive a complaint at any time. Therefore all staff are to be aware of the organisation's complaint management processes at orientation and throughout their employment period. Staff in direct contact with clients are also provided with training in conflict and complaint resolution. | Feedback and Complaints Policy and related procedures.<br>Incident Management Policy and related procedures.<br>Staff orientation processes.<br>Record of staff training / in-services relating to complaint management and conflict resolution. |
| | (e) Feedback about care and service is communicated to staff, consumers / patients and management.<br>Mechanisms are in place for communicating positive and negative feedback to staff, clients and management. For staff and management this may be done through general staff meetings, individual staff meetings, quality improvement meetings, distribution of feedback summary reports, newsletters, and an annual report of complaints and feedback. For clients this may be done through meeting with the complainant, written feedback, annual reports, newsletters, brochures and posters, and client satisfaction report distribution. | Feedback and Complaints Policy and related procedures.<br>Client feedback / satisfaction survey reports.<br>Staff meeting minutes.<br>Quality improvement meeting minutes.<br>Organisation newsletters, brochures and posters.<br>Annual reports. |
| | (f) There is a system to implement the recommendations from reviews of serious complaints.<br>Complaints and incident management processes incorporate how the organisation implements recommendations | Feedback and Complaints Policy and related procedures.<br>Incident Management Policy and related procedures. |

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| | coming from reviews of serious complaint. Consideration is given to staff responsibilities; communication with staff, clients and stakeholders; policy, procedure and practice change; resources required; and review actions. | Quality Improvement Action Plan. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The principles of open disclosure of an adverse event are evident in the system to manage complaints.<br>The organisation's incident and complaint management policies and procedures incorporate open disclosure principles to ensure a transparent and well-managed response to incidents and complaints. | Feedback and Complaints Policy and related procedures.<br>Incident Management Policy and related procedures.<br>Complaint review reports demonstrating open disclosure practice. |
| | (b) Consumers / patients and carers are involved in the evaluation of the complaint management process.<br>The organisation's review of complaint management processes incorporates feedback and other input from clients and carers, including that provided from individual complaints and that provided as part of a broader policy and procedure review and improvement schedule. | Feedback and Complaints Policy and related procedures.<br>Quality Improvement Policy and related procedures.<br>Individual complaint feedback.<br>Summary report of complaint feedback.<br>Record of client and carer consultations on complaint management. |
| | (c) Complaints are trended, risks are identified, and improvements are made as required.<br>The organisation collates complaint data to map trends, identify risks, and inform improvement strategies. Complaint management improvement strategies aim to identify areas of organisation and service practice that may be improved, thus reducing the likelihood of complaints and facilitating better responses to complaint incidences. | Feedback and Complaints Policy and related procedures.<br>Quality Improvement Policy and related procedures.<br>Review and report of complaints – including data, trends and improvement actions. |
| | (d) The support and access to advocacy provided for consumers / patients, carers and staff involved in complaints is evaluated, and improved as required.<br>The organisation reviews and improves the support provided to clients, carers and staff involved in a complaint. Activities may include consultation with clients, carers and staff following a complaint, and seeking feedback on what and how support information was provided, and the adequacy of actual support provided. | Feedback and Complaints Policy and related procedures.<br>Quality Improvement Policy and related procedures.<br>Review and report of consultations with clients, carers and staff.<br>Review of the employee assistant program (EAP). |

Performance measures

Suggested performance measures for this criterion are on page 279 of *The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Information provided to clients on the feedback and complaints process. | Client intake processes and client orientation manual updated to include more information on how clients can provide feedback and make a complaint, and how they can expect the complaint to be managed. | 100% of clients are provided with accessible information on the feedback and complaints process. |

Plans for improvement

| No | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Improve the process for reviewing client feedback provided anonymously through the 'suggestion box', by implementing a schedule of checking the box, collating feedback and communicating this to the staff, management and quality improvement teams. | Team Leader | December 2013 |
| 2 | Implement an annual review of all complaints received in order to identify improvement strategies. | Program Manager | December 2013 |

## Standard 2.2: Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff.

### Criterion 2.2.1
### Workforce planning supports the organisation's current and future ability to address needs.

The intent of this criterion is to ensure that the organisation plans to meet current and future workforce needs.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 282 for further information, including the relationship 2.2.1 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) Systems exist to ensure that the skill mix of clinical and support staff meets consumer / patient needs.<br>The organisation identifies the mix of positions, grades or occupations required to safely and effectively respond to the needs of clients, considering the knowledge, experience and limitations of each of these positions, grades or occupations. Workforce strategies are implemented accordingly. | Human Resources Management Policy and related procedures.<br>Position descriptions.<br>Client needs profile and report.<br>Current staff profile report.<br>Future staff needs report. |
| | (b) Documented policy and procedures for workforce planning and management are available to staff.<br>The organisation's workforce planning and management policies and procedures include activities such as scheduled reviews of existing systems, staff profiles, client needs, and external factors that may impact on the workforce (such as minimum qualification requirements, Award changes, etc.). These policies and procedures are accessible to staff responsible for organisation and service planning and staff recruitment and management. | Human Resources Management Policy and related procedures.<br>Current staff profile reports.<br>Workforce plans.<br>Business / operational plans. |
| | (c) Policy / guidelines for safe working hours exist.<br>The organisation addresses safe working hours for staff through the Human Resources Management Policy and related procedures and the WHS Policy and related procedures. Issues such as maximum shift length, number of | Human Resources Management Policy and related procedures.<br>WHS Policy and related procedures.<br>Flexible work practices agreements. |

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| | consecutive shifts, scheduled breaks, access to food, water and dining facilities, workload, away-from-office work activity, travel, and fatigue are assessed and risk management strategies identified. | |
| | (d) Strategies are in place to ensure safe, quality treatment and care if prescribed levels of skill mix of clinical and support staff are not available.<br>The Human Resources Management Policy includes strategies for responding to short-term workforce shortages (i.e. the next shift or the next few weeks' shifts), including the use of approved temporary / casual staff, reprioritising tasks, allocating tasks to other staff and/or temporarily reducing non-essential service delivery.<br><br>Ongoing skill shortages are addressed through other strategies such as broader advertising and recruitment processes, improving the attractiveness of positions (through remuneration, benefits, flexible work practices), increasing workforce development for existing staff, engaging in trainee uptake, reviewing and improving workplace culture and relationships, and collaborating with other organisations for staff sharing and development. | Human Resources Management Policy and related procedures.<br>Staff Performance and Development Policy and related procedures.<br>Procedure for utilising temporary / casual staff.<br>Workforce plans.<br>Workforce development activities – education, training, etc. |
| Rating | Element | Evidence commonly presented |
| SA | (a) The workforce strategic plan is clearly linked to the organisation's strategic direction and goals.<br>The organisation's strategic direction and goals are supported by a workforce plan to ensure the employment of sufficient qualified and skilled staff, and that these staff roles and responsibilities directly link to the organisation's direction and goals. | Strategic Plan.<br>Workforce plans.<br>Recruitment strategies. |
| | (b) The organisation's workforce planning reflects current and future needs of consumers / patients and staff.<br>The organisation identifies current and future needs of clients and staff, with consideration given to the number and types of service provision; clinical staff skill, qualification, and experience; administrative staff skill, qualification, and experience; staffing numbers over time; workforce development, training and support needs; emergency and temporary staffing; flexible work practices; and funding and other resource requirements. | Human Resources Management Policy and related procedures.<br>Workforce plans.<br>Service delivery and project plans – identifying staff resources required. |
| | (c) Workforce management functions and responsibilities are clearly identified.<br>Responsibilities for human resource management are identified and communicated throughout the organisation, including positions and staff that lead or participate in:<br>- identifying and approving position creation<br>- recruitment and induction<br>- professional development<br>- performance management and supervision<br>- team building and leadership<br>- policy development, implementation and monitoring<br>- health and safety.<br><br>These responsibilities may be demonstrated in an organisation's human resources structure, Functions and Delegations Matrix, individual position descriptions, performance and development review templates, and employment contracts. | Human Resources Management Policy and related procedures.<br>Recruitment advertisements.<br>Position descriptions.<br>Employment contracts.<br>Functions and Delegations Matrix.<br>Organisation human resources structure. |

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| | (d) Fatigue prevention and management strategies are implemented.<br>The organisation recognises fatigue as a potential health and safety risk and thus implements strategies, in partnership with staff, to prevent and manage fatigue for staff, volunteers, students and trainees. Prevention strategies may include policies around staff rostering (maximum shift length and number of consecutive shifts), scheduled breaks, and safe motor vehicle use. Management strategies may include auditing and responding to staff's hours worked, adjusting work activities or workloads, and having back-up service delivery plans for when staff are fatigued. | Human Resources Management Policy and related procedures.<br>WHS Policy and related procedures.<br>Flexible Work Practices Procedure.<br>Staff rosters. |
| | (e) Staff members are advised of, and have access to, workforce policies and procedures.<br>Staff are provided with information and access to workforce policies and procedures through initial orientation, open access to relevant electronic and hard copy documents, communication following an incident or policy change, and involvement in policy review and development. | Human Resources Management Policy and related procedures.<br>Staff orientation processes.<br>Electronic and hard copy access to relevant policies and procedures.<br>Communication distribution – emails, newsletters, formal letters, etc. |
| | (f) There are contingency plans to manage workforce shortages.<br>As for LA (d) above.<br><br>The Human Resources Management Policy, Client Treatment Policy, WHS Policy and Risk Management Policy are aligned to ensure that client care is not compromised by staff shortages. | Human Resources Management Policy and related procedures.<br>Procedure for utilising temporary / casual staff.<br>Workforce plans.<br>Functions and Delegations Matrix.<br>Client Treatment Policy and related procedures.<br>WHS Policy and related procedures.<br>Risk Management Policy and related procedures.<br>Client service delivery / program timetabling. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The workforce policy, plan, goals and strategic direction are regularly reviewed, evaluated and improvements are made as required.<br>The organisation collates data to measure performance against workforce plans. These data, including staff turnover, recruitment achievements, staff satisfaction, client and service delivery needs, inform the review and improvement of workforce policies and planning. | Current and previous Human Resources Management Policy and related procedures.<br>Current and previous workforce plans.<br>Current and previous strategic plans.<br>Quality Improvement Action Plan.<br>Review and report of workforce planning, achievement and recommendations. |
| | (b) Performance measures are used on a regular basis to evaluate employee fatigue and improvements are made as required.<br>The organisation collates data to measure effectiveness of existing fatigue prevention and management strategies. Data collection may include audits of staff rostering practices, staff satisfaction with existing strategies, and review of incidents. | Current and previous Human Resources Management Policy and related procedures.<br>Review and report of staff rostering practices.<br>Staff satisfaction reports.<br>Report from staff consultations.<br>Review and report of staff related incidents.<br>Current and previous WHS Policy and related procedures.<br>Quality Improvement Action Plan. |

Performance measures

Suggested performance measures related to this criterion are on page 288 of *The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Staff recruitment guidelines. | Human Resources Management Policy updated to better identify process and staff positions responsible for recruitment activities. | Guidelines for staff recruitment describe expectations and responsibilities. All staff report improved understanding of the process, and staff designated for recruitment activities understand their roles and responsibilities.<br><br>Since the Policy was updated 12 months ago, 100% of positions have been recruited in accordance with the Policy. |
| 2 | Staff fatigue management strategies. | Implemented a maximum number of shifts / hours a staff member can work within a two-week roster period. | A review of staff shifts and hours worked compared with rosters over the past 6 months indicates there have been 2 instances where staff have worked above the maximum number of shifts, compared with the previous 6 months where there were 9 instances. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Develop a workforce plan to align with the 2014-2017 strategic plan; identifying staff skill mix needs and associated resourcing. | Executive Director, Program Managers and Finance Officer | February 2014 |
| 2 | Implement guidelines for managing instances of short-term staff shortages to ensure continued service delivery that is effective and safe for staff and clients. | Executive Director and Program Managers | July 2014 |

## Standard 2.2: Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff.

### Criterion 2.2.2
### The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meets the needs of the organisation

The intent of this criterion is to ensure that all aspects of recruitment, selection and appointment meet the needs of the organisation.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 290 for further information, including the relationship 2.2.2 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) Recruitment, selection and appointment are undertaken in accordance with legislative requirements, jurisdictional policy / regulations and organisational policy / guidelines.<br>Staff employment policy and practice is informed by, and complies with, Commonwealth and State Acts and Regulations covering fair work and work relations, WHS, working with children, privacy, anti-discrimination, and record keeping.<br><br>Relevant Commonwealth legislation includes:<br>- *Disability Discrimination Act* 1992<br>- *Racial Discrimination Act* 1975<br>- *Sex Discrimination Act* 1984<br>- *Fair Work Act* 2009<br>- *National Employment Standards*<br>- *Social, Community Home Care and Disability Services (SCHADS) (Modern) Award*<br><br>Relevant NSW legislation includes:<br>- *Industrial Relations Act* 1996<br>- *Work Health and Safety Act* 2011<br><br>Further information available from:<br>- Fair Work Australia www.fwa.gov.au<br>- NSW Industrial Relations www.industrialrelations.nsw.gov.au<br>- WorkCover Authority of NSW www.workcover.nsw.gov.au<br>- NSW Department of Family and Community Services *'It's Your Business: Chapter 8 Probity in Employment'*.<br>- NSW Commission for Children and Young People for working with children checks. | Human Resources Management Policy and related procedures.<br>Staff Recruitment Procedure.<br>Recruitment Advertisement Template.<br>Staff Induction and Orientation Procedure.<br>Position Descriptions. |
| | (b) Recruitment processes ensure staff and volunteers have the necessary licences, registration, qualifications, skills and experience to perform their work.<br>The organisation's recruitment process includes screening and verifying stated qualifications and experience. Screening includes conducting working with children checks (WWCCs) and national criminal record checks (NCRCs) for certain positions. Verifying academic and professional qualifications may be done by checking with the appropriate university / college / training institute and relevant registration body such as the Australian Health Practitioner Regulation Agency (AHPRA), www.ahpra.gov.au. Skills and experience may be confirmed through questioning at employment interview(s), conducting referee checks, viewing samples of work, and skill testing. | Human Resources Management Policy and related procedures.<br>Staff Recruitment Procedure.<br>Volunteer Policy and related procedures.<br>Record of staff qualifications and registrations.<br>Record of staff and volunteer referee checks.<br>Record of staff WWCCs and NCRCs. |
| Rating | Element | Evidence commonly presented |

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|---|---|---|
| SA | (a) The recruitment system ensures an adequate number and skill mix of staff to provide the organisation's services.<br>Staff recruitment aligns with the identified current and future service delivery and operational needs (refer to criterion 2.2.1) to ensure the organisation's goals are met. | Human Resources Management Policy and related procedures.<br>Workforce plans.<br>Strategic plan.<br>Operations plan.<br>Procedure for utilising temporary / casual staff. |
| | (b) All departments / units comply with the organisation's recruitment, selection and appointment requirements.<br>The organisation's human resources management policies and procedures are implemented across all sections and sites, and by all staff identified with such responsibilities. | Human Resources Management Policy and related procedures.<br>Record of staff recruitment – personnel files.<br>Report of staff recruitment audits. |
| | (c) The volunteer recruitment system ensures an adequate number and mix of volunteers to provide applicable services.<br>The organisation identifies an appropriate number of volunteers to be engaged at any given, as well as their qualifications, experience and the roles to be undertaken. This may be outlined in formal volunteer policies and procedures as well as workforce and operational plans, and complies with relevant workplace legislation. | Human Resources Management Policy and related procedures.<br>Volunteer Policy and related procedures.<br>Workforce plans.<br>Documented roles and responsibilities of volunteers. |
| | (d) There is a system and program for the orientation and integration of all staff and volunteers.<br>All staff and volunteers are provided with an orientation to the organisation, including:<br>- vision, mission and values<br>- code of conduct<br>- rights and responsibilities<br>- administration and operations<br>- work health and safety<br>- role and performance expectations<br>- introduction to other staff and volunteers.<br><br>An orientation checklist which is signed by both parties ensures consistent orientation is provided, and that staff and volunteers are prepared for their role and responsibilities. | Human Resources Management Policy and related procedures.<br>Volunteer Policy and related procedures.<br>Staff Induction and Orientation Procedure.<br>Staff Induction and Orientation Checklist.<br>Volunteer Placement Procedure.<br>Staff Orientation Manual.<br>Volunteer Orientation Manual.<br>Record of staff and volunteer orientation – personnel files. |
| Rating | Element | Evidence commonly presented |
| MA | (a) Performance measures are used to evaluate and improve recruitment, selection, and appointment systems and adapt them to changing service requirements, where required.<br>The organisation collates data to measure the effectiveness of recruitment, selection, and appointment systems. Data collection may include audits of recruitment practice (i.e. number of staff receiving formal orientation within required timeframe); number of vacancies filled within a set timeframe; length of staff's employment; staff satisfaction and feedback with the recruitment process; and review of qualifications and experience needed for positions and roles. Information gathered is used to inform improvements to the recruitment, selection, and appointment system. | Current and previous Human Resources Management Policy and related procedures.<br>Current and previous Volunteer Policy and related procedures.<br>Review and report on recruitment audits.<br>Quality Improvement Action Plan. |
| | (b) The orientation and integration system is evaluated and improved on a regular basis. | Current and previous Human Resources Management Policy and |

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| | The organisation collates data to measure the effectiveness of staff and volunteer orientation processes. Data collection may include audits of orientation practice, feedback from staff and volunteers, and review of relevant legislation. | related procedures.<br>Current and previous Volunteer Policy and related procedures.<br>Induction and Orientation Feedback Form.<br>Review and report on orientation audits.<br>Quality Improvement Action Plan. |

Performance measures

Suggested performance measures related to this criterion are on page 295 of *The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Human resource legislation compliance. | A review of relevant human resources legislation was undertaken which informed the update of the Human Resources Policy to ensure compliance. An action plan was developed to implement policy changes. Operations Manager joined several employer mailing lists to ensure up-to-date knowledge is maintained and distributed to relevant staff. | Human Resources Policy and related procedures are 100% compliant with current legislation.<br><br>The new system of maintaining knowledge of new or amended legislation ensures the organisation and staff are aware of their human resources responsibilities. |
| 2 | Staff and volunteer orientation procedures reviewed and updated. | Specific procedure developed to guide orientation of staff and volunteers. Additional resources developed: orientation checklist, manual, and feedback form. | Since the new procedures were implemented 12 months ago, 100% of new staff (n = 6) and volunteers (n = 2) have been provided with a standard orientation to the organisation.<br><br>100% of new staff and volunteers report the orientation process provided them with adequate orientation to enable them to commence their role. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Indicators developed to measure and improve the organisation's recruitment process. | Executive Director and Operations Manager | June 2014 |
| 3 | Review the organisation's volunteer program, including how volunteers are utilised, skills required, roles to be undertaken, and reward practices. | Operations Manager and Program Manager | November 2013 |

## Standard 2.2: Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff.

### Criterion 2.2.3
### The continuing employment and performance development system ensures the competence of staff and volunteers.

The intent of this criterion is to ensure that the organisation and staff take responsibility for maintaining the skills, performance and competence required to provide quality care.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 298 for further information, including the relationship 2.2.3 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) Staff and volunteers are provided with a written position description outlining their role, responsibilities and accountabilities.<br>All staff are provided with a written, dated and current position description prior to and at commencement of employment. Position descriptions outline responsibilities, accountabilities, functions, activities and performance review processes. | Human Resources Management Policy and related procedures.<br>Volunteer Policy and related procedures.<br>Position descriptions.<br>Record of signed and dated position descriptions - personnel files.<br>Interviews with staff. |
| | (b) Staff and volunteers are provided with appropriate supervision by experienced, trained and qualified staff.<br>Supervision is provided relevant to the position, skill, experience and professional development needs of staff and volunteers, with those responsible clearly identified and sufficiently skilled. Supervision may include regular work plan review meetings, general oversight of activities, clinical practice review and development provided by internal or external personnel (individual or group), manager's meetings, mentoring, and regular and/or post incident debriefings. | Human Resources Management Policy and related procedures.<br>Volunteer Policy and related procedures.<br>Staff Performance and Development Policy and related procedures.<br>Clinical Supervision Policy and related procedures.<br>Position descriptions.<br>Functions and Delegations Matrix.<br>Records of group and/or individual supervision activities.<br>Records of work plan reviews and meetings. |
| | (c) Performance of staff, including contracted staff and volunteers, is reviewed in accordance with organisation-wide requirements.<br>Staff and volunteer performance reviews are undertaken at three months after initial employment and then on a regular schedule, perhaps annually and as agreed in the employment / volunteer contract. Performance review processes are transparent, based on the position description, consistent across the organisation, follow up on issues from previous reviews, identify strengths and areas for development, establish performance goals, identify support and training requirements, and include participation from the manager and staff member. | Human Resources Management Policy and related procedures.<br>Volunteer Policy and related procedures.<br>Staff Performance and Development Policy and related procedures.<br>Performance and Development Review Template.<br>Staff performance and development review schedule.<br>Records of performance and development reviews.<br>Human resources calendar – schedule of reviews. |

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| | (d) Accurate and complete personnel records, including training records, are maintained and kept confidential.<br>The organisation's Human Resources Management Policy provides guidance on maintaining personnel records in line with the National Privacy Principles and details the information to be collected, access and security, responsibilities for maintenance, and disclosure circumstances. | Human Resources Management Policy and related procedures.<br>Sample personnel record.<br>Personnel records. |
| | (e) The organisation has policy / guidelines for the process of managing a complaint or concern about a clinician.<br>The organisation's Feedback and Complaints Policy provides guidance for managing complaints or concerns coming from outside the organisation in relation to a staff member providing direct services to clients. Concerns or complaints identified from with the organisation are managed according to the Grievance Management Policy and/or Performance and Development Policy. Steps for managing a complaint or concern include:<br>- identification of the complaint<br>- notification to relevant managers / stakeholders<br>- investigation<br>- actions responding to the performance issues<br>- reporting outcomes to internal or external parties.<br><br>Policies also outline how the organisation manages threats or intimidation towards the complainant. Complaints regarding registered health practitioners should be referred to the relevant professional board. | Feedback and Complaints Policy and related procedures.<br>Grievance Management Policy and related procedures.<br>Performance and Development Policy and related procedures.<br>Employee Code of Conduct.<br>Complaints Record Form.<br>Client brochure: *'Information for Clients: How to Make a Complaint'*. |
| | (f) The organisation has policy / guidelines for the process of managing a complaint or concern about a member of staff, including contracted staff and volunteers.<br>As for LA (e) above. | As above. |
| Rating | Element | Evidence commonly presented |
| SA | (a) There is a performance development system that ensures:<br>(i) clinical, non-clinical staff and volunteers are competent and accountable for their work<br>(ii) there is active participation of both the manager and employee in performance review<br>(iii) areas for improvement and additional educational and development needs are identified.<br>The organisation demonstrates its commitment to organisational and professional development through performance development processes, ensuring staff and volunteers fulfil their roles competently. In addition to item LA (c) above, evidence of staff and manager participation may include written contribution by each party to all fields covered in the performance review. Performance development also includes identifying and implementing strategies in response to performance, knowledge or skill gaps. | Human Resources Management Policy and related procedures.<br>Volunteer Policy and related procedures.<br>Staff Performance and Development Policy and related procedures.<br>Performance and Development Review Template.<br>Staff performance and development review schedule.<br>Records of performance and development reviews.<br>Interview with staff.<br>Human resources calendar – schedule of reviews. |
| | (b) There is a system that ensures professional and other licensed staff provide verified documentary evidence to demonstrate their continuing registration with the relevant professional regulatory body.<br>The organisation has processes in place to ensure licensed staff (i.e. medical practitioners, nurses, psychologists, social workers) provide evidence of continued registration. Organisations can confirm staff professional registration | Human Resources Management Policy and related procedures.<br>Records of staff professional registration -personnel files.<br>Human resources calendar – schedule of staff registration renewal. |

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| | through the AHPRA www.ahpra.gov.au. A record of current registration should be kept in personnel records. | |
| | (c) Staff comply with published codes of professional practice, relevant to their professional role.<br>The organisation is aware of and monitors codes of professional practice for relevant positions and staff. Relevant professional practice may be incorporated into position descriptions, codes of conduct, performance monitoring and professional development plans. Staff are responsible for understanding and adhering to their relevant code of professional practice and for maintaining registration. | Human Resources Management Policy and related procedures.<br>Staff Performance and Development Policy and related procedures.<br>Employee Code of Conduct agreed and signed in personnel records.<br>Position descriptions – inclusion of relevant codes of professional practice. |
| | (d) Position descriptions, including accountabilities and responsibilities, are regularly reviewed.<br>The organisation has a system for ensuring position descriptions are current and reflect changes to duties and responsibilities. Activities may include: regular schedule for review (perhaps every two years) or following a change in service / program delivery; feedback from staff during performance and development reviews or targeted consultations; external / independent review; review of organisation performance and resources required. | Current and previous position descriptions.<br>Current and previous Functions and Delegations Matrix<br>Quality Improvement Action Plan.<br>Human resources calendar – schedule of position description review.<br>Review and report of staff feedback on position descriptions.<br>Staff Performance and Development Review Template.<br>Workforce plans and staff profiles. |
| | (e) There is a process for managing a complaint or a concern about a clinician.<br>As for LA (e) above. | As for LA (e) above. |
| | (f) There is a process for managing a complaint or concern about a member of staff, including contracted staff and volunteers.<br>As for LA (e) above. | As for LA (e) above. |

| Rating | Element | Evidence commonly presented |
|---|---|---|
| MA | (a) The performance development system is integrated with any relevant service plans or changing service requirements.<br>Performance development, position descriptions and operational / service / program plans are aligned to ensure progress towards the organisation's goals and outcomes. Staff education, training and other professional development activities support individual and organisational performance achievements. Operational / service / program plans include performance development and staffing requirements. | Human Resources Management Policy and related procedures.<br>Staff Performance and Development Policy and related procedures.<br>Operational / service / program plans.<br>Workforce skills audit / profile and action plan.<br>Workforce development plans. |
| | (b) Evaluation is undertaken to ensure staff, including contracted staff, and when appropriate volunteers, have participated in performance review and development.<br>The organisation's human resources management policies and procedures include mechanisms for ensuring staff and relevant volunteers participate in scheduled performance and development reviews. | Human Resources Management Policy and related procedures.<br>Staff Performance and Development Policy and related procedures.<br>Human resources calendar – schedule of performance and development reviews.<br>Quality Improvement Action Plan.<br>Record of performance and development review audit. |
| | (c) Performance measures are used to evaluate and improve the performance development system. | Human Resources Management Policy and related procedures. |

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| | The organisation collates data to measure the effectiveness of the performance development system. Data collection may include audits of performance development practice (i.e. number of staff receiving formal performance and development reviews), staff satisfaction and feedback with the performance and development process; review and report against external standards and guidelines; review of planned and implemented performance development activities (training events, mentoring program, etc.). Information gathered is used to inform improvements to the performance development system. | Staff Performance and Development Policy and related procedures.<br>Strategic Plan.<br>Review and report on human resources management performance – annual report, progress reports, etc.<br>Record of performance and development review audit.<br>Review and report on implementation of workforce development plans.<br>Review and report on staff satisfaction and feedback. |
| | (d) Staff participate in evaluating the performance development system.<br>The organisation involves staff in reviewing the effectiveness of the performance and development system by seeking feedback through consultations or questionnaires and involving staff on review working groups. | Staff Performance and Development Policy and related procedures.<br>Quality Improvement Action Plan.<br>Record and report of consultations with staff.<br>Record of staff working groups on performance and development review.<br>Quality Improvement Policy and related procedures. |
| | (e) The process for managing a complaint or concern about a clinician is evaluated, and improved as required.<br>The organisation collates data to measure the effectiveness of the feedback and complaint process. Data collection may include audits of the formal concerns and complaints management practice (i.e. number of complaints responded to within required timeframe); client, stakeholder and staff satisfaction with the process; review and report against external standards and guidelines; review of planned and implemented activities (complaints management training, communication to clients on complaint process, etc.). Information gathered is used to inform improvements to the feedback and complaint management system. | Current and previous Feedback and Complaint Policy and related procedures.<br>Current and previous Grievance and Dispute Settling Policy and related procedures.<br>Quality Improvement Action Plan.<br>Record and report of consultations with clients, stakeholders and staff.<br>External review reports and action plan. |

Performance measures

Suggested performance measures related to this criterion are on page 305 of *The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Confirmation of position descriptions, roles and responsibilities. | Annual performance and development reviews now include a review of the position description to ensure accuracy, relevancy, and that staff understand their roles, responsibilities and expected performance. | 100% of staff have a current position description signed by the staff member and their supervisor / manager.<br><br>Staff are provided with a formal opportunity to provide feedback on the accuracy and relevancy of their position description and offer recommendations for improvement. |
| 2 | Feedback and Complaints Management | Feedback and Complaints | Board members and staff report a better understanding of the process for managing concerns and complaints |

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| | Policy. | Management Policy updated to include how complaints regarding clinical / registered staff are to be managed. | towards clinical / registered staff.<br><br>Clients and stakeholders are better informed of the complaint management process and what their expectations may be. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Implement an annual audit of personnel files to measure practice against policy regarding position descriptions and performance and development reviews. | Operations Manager and Service Manager | December 2013 and then annually. |

## Standard 2.2: Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff.

### Criterion 2.2.4
### The learning and development system ensures the skill and competence of staff and volunteers

The intent of this criterion is to ensure the organisation's learning and development system for staff and volunteers is structured, planned and comprehensive.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 308 for further information, including the relationship 2.2.4 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) The organisation provides training in accordance with legislative and policy requirements.<br>Mandatory training is provided to staff in relation to fire and emergency management, first aid, other WHS issues and child protection. Additional training in records management, human resources management, the organisation's systems, programs, equipment use, administration, governance and quality improvement may also be provided at an organisation-wide, team or individual level. | Human Resources Management Policy and related procedures.<br>Staff Performance and Development Policy and related procedures.<br>Staff training register.<br>Staff orientation checklist.<br>Staff personnel files – training certificates, completed orientation checklists. |
| | (b) Staff and volunteers are consulted about their learning and development needs.<br>Staff and volunteer learning and development needs are identified through consultation, including as part of the performance review and development processes. Consultation may also be undertaken through staff surveys, team | Human Resources Management Policy and related procedures.<br>Staff Performance and Development Policy and related procedures.<br>Records of staff surveys. |

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| | meetings and supervision sessions. | Staff personnel files – records of completed performance and development reviews.<br>Staff interview. |
| Rating | Element | Evidence commonly presented |
| SA | (a) There is a planned and documented staff development program.<br>The organisation identifies staff development needs and responds with a documented plan or program, which is incorporated into relevant policies and procedures. The staff development plan / program may be both individual and whole-of-organisation, including, for example, individual staff performance review and development plans, and a schedule of planned group training sessions. Policies and procedures include reference to any staff training required to understand and apply the policy. | Human Resources Management Policy and related procedures.<br>Staff Performance and Development Policy and related procedures.<br>Staff personnel files – records of completed performance and development reviews and plans.<br>Schedule of planned staff development activities.<br>Staff interviews. |
| | (b) There is an evidence-based learning and development system available to staff and volunteers that:<br>(i) identifies both the needs of the organisation and the staff<br>(ii) is linked to the performance development system.<br>(iii) ensures staff remain competent to perform their work.<br>The organisation's staff development plan is based on the needs of staff (i.e. to progress professionally, competency training to maintain standards, address identified performance gaps) as well as the needs of the organisation (i.e. mandatory training, knowledge and skills to maintain best practice, knowledge and skills to achieve organisation goals).<br><br>For example, if the organisation aims to become recognised as capable of responding to clients with both drug and alcohol and mental health issues, the staff development plan is to include strategies for developing that capacity within staff. | Human Resources Management Policy and related procedures.<br>Staff Performance and Development Policy and related procedures.<br>Staff personnel files – records of completed performance and development reviews and plans.<br>Schedule of planned staff development activities.<br>Current strategic plan. |
| | (c) There is a process to identify mandatory training for staff and volunteers.<br>Mandatory training requirements are identified through processes such as regular review of legislation (as part of the review and update of organisation policies), being informed through membership of expert and professional bodies, receiving updates from relevant organisations, and understanding funding agreement requirements. | Human Resources Management Policy and related procedures.<br>Quality Improvement Policy and related procedures.<br>Policy review schedule.<br>Schedule of planned mandatory staff development activities.<br>Memberships of relevant professional and expert bodies.<br>Communications from professional and expert bodies – newsletters, email updates, etc. |
| | (d) The organisation provides adequate resources for learning and development.<br>Financial resources are allocated for mandatory training and additional professional development activities. Financial resources may cover direct costs such as course attendance fees, trainer's fees, and conference fees; and indirect costs such as travel, venue hire and wages for covering staff backfill. Learning and development costs may be incorporated or covered by other budget items such as internet access for online research and learning, subscriptions to journals and sector newsletters, and resource purchases. | Human Resource Management Policy and related procedures.<br>Current organisational budget – training, subscriptions, IT, consultant and travel line items.<br>Schedule of planned staff development activities.<br>Completed staff development activities.<br>Resources – journals, books, newsletters, subscriptions. |
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| | (e) Staff contribute to the teaching and supervision of students where relevant.<br>The organisation is clear on whether students are offered placements, and if so what the roles and responsibilities of staff are. Where possible and appropriate, staff provide student support, which may be through direct workplace supervision, mentoring and specific skill training sessions. | Human Resources Management Policy and related procedures.<br>Student Placement Policy and related procedures.<br>Previous and current student learning agreements.<br>Staff position descriptions.<br>Interviews with staff and students. |
| Rating | Element | Evidence commonly presented |
| MA | (a) Performance measures are used to evaluate learning and development systems and the systems are improved as required.<br>The organisation collates data to measure the effectiveness of learning and development systems. Data collection may include evaluation and feedback from staff participating in training sessions, assessment of staff and organisation capability following learning and development activities, and staff surveys. Information gathered is used to inform improvements to the learning and development system. | Human Resources Management Policy and related procedures.<br>Staff Performance and Development Policy and related procedures.<br>Staff survey reports and action plans relating to performance review and development practice.<br>Training session evaluation and feedback from staff.<br>Reviews of learning and development systems and activities.<br>Previous and current learning and development plans.<br>Organisation performance reports – annual report, report against performance indicators. |
| | (b) The student teaching and supervision program is evaluated and improved as required.<br>The organisation collates data to measure the effectiveness of the student teaching and supervision program. Data collection may include evaluation and feedback from staff and students participating in student placements, feedback from academic institutions involved in student placements, feedback from clients, and review of any adverse incidents involving students. Information gathered is used to inform improvements to the student teaching and supervision program. | Human Resources Management Policy and related procedures.<br>Student Placement Policy and related procedures – current and previous.<br>Student exit surveys.<br>Feedback from students' academic institution. |

Performance measures

Suggested performance measures related to this criterion are on page 314 of *The ACHS EQuIP5 Guide – Book 2*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Staff Performance and Development Policy reviewed and updated. | The Policy was updated to address equitable access to professional development opportunities for all staff, as well as the types of opportunities available and how staff can access them. | Staff are better informed of learning and development opportunities.<br><br>100% of staff have participated in a non-mandatory learning and development activity throughout 2013, compared to 60% in 2012. |
| 2 | Student Placement Policy developed. | In consultation with staff, students and students' academic | Staff and students are better informed of the process for managing student placements. |

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| | | institution(s), this policy was developed to guide the management of student placements within the organisation, including student eligibility and the responsibilities of all participants. | 100% of students have an identified work place supervisor and a learning agreement. |

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Register of mandatory training requirements developed and monitored by Service Manager. | Service Manager | June 2014 |
| 2 | Annual staff professional development day scheduled. Activities include both mandatory and requested training sessions. | CEO and Service Manager | October 2014 |

## Standard 2.2: Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff

### Criterion 2.2.5
### Employee support systems and workplace relations assist the organisation to achieve its goals

The intent of this criterion is to ensure a structured, planned and comprehensive system for managing workplace relations and to ensure 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.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 316 for further information, including the relationship 2.2.5 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) The workplace rights and responsibilities of management and staff are clearly defined, communicated and respected.<br>The organisation has policies and guidelines that ensure the rights and responsibilities of management and staff are clearly defined, communicated and adhered to. Rights and responsibilities include those outlined in legislation relating to employment and working conditions, privacy and WHS. Minimum employment conditions for employees | Human Resources Management Policy and related procedures.<br>Staff orientation documentation and procedures.<br>Employee Code of Conduct<br>Employment agreements.<br>Employee position descriptions. |

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| | are outlined in the National Employment Standards (NES). Rights and responsibilities are communicated through employment agreements, position descriptions, orientation, staff meetings, performance and development reviews, and access to organisational policies. | Staff Performance and Development Policy and related procedures.<br>Access to organisational policies. |
| | (b) Staff are consulted about industrial relations and support services in their workplace.<br>The organisation consults with staff about industrial relations and support services through staff meetings, satisfaction surveys, individual performance and development reviews, policy development, and following a workplace incident where support services may be required. | Human Resources Management Policy and related procedures.<br>Quality Improvement Action Plan – activities and achievements.<br>Performance and Development Review Template.<br>Completed Performance and Development Reviews.<br>Reports and actions from workplace incidents.<br>Information provided to staff regarding available support services.<br>Staff satisfaction survey reports.<br>Staff meeting minutes.<br>Staff interview. |
| | (c) Managers have the skills to identify 'at risk' staff behaviour.<br>Managers are skilled in identifying staff actions and reactions that put client care and safety at risk. 'At risk' behaviour may include that which contravenes the organisation's Code of Conduct, or that which does not comply with specific healthcare professional standards. | Human Resources Management Policy – recruitment and orientation processes.<br>Position descriptions for managers.<br>Employee personnel files – managers' experience and qualification records.<br>Staff Performance and Development Policy and related procedures.<br>Records of completed manager development activities.<br>Staff interview. |
| | (d) Staff know how to access employee support services.<br>Staff of the organisation have access to information about support services available to them, which may include Industrial Relations support, Employee Assistance Programs and internal support and referral services. Staff are educated about these services at orientation and know how to access them and what their rights are with respect to them, including confidentiality. They have ongoing access to this information through posters, information folders and the like. | Human Resources Management Policy and related procedures.<br>Staff orientation documentation and procedures.<br>Employee assistance program information<br>Staff satisfaction survey.<br>Feedback from EAP provider.<br>Staff interview. |
| | (e) Management and staff have access to information about grievance processes.<br>The organisation has a Grievance Policy and implemented processes to manage the resolution of grievances, which meet all pertinent legislative requirements and are understood by both management and staff. Staff are oriented to the grievance policy and processes on commencement of employment and have ongoing access to relevant information through policy manuals, rights posters and the like. | Grievance and Dispute Settling Policy and related procedures.<br>Grievance policy and procedures are available to staff.<br>Staff interview.<br>Records of grievance resolution.<br>Human Resources Management Policy.<br>Orientation and Induction checklist and feedback. |
| Rating | Element | Evidence commonly presented |
| SA | (a) Management and staff work cooperatively to achieve effective workplace relations. | Human Resources Management Policy and related procedures. |

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| | 'Workplace relations' is a system to balance the needs of employees and employers; the goal is to achieve optimal performance with respect to productivity, morale and the retention of quality staff. The organisation has a culture whereby management and staff work cooperatively to achieve effective workplace relations through monitoring of compliance with policy, distribution of information about rights and responsibilities, and processes to facilitate discussion and dispute resolution. | Staff Performance and Development Policy and related procedures.<br>Staff interview.<br>Staff meeting minutes.<br>Records of formal negotiations regarding workplace relations.<br>Incident monitoring identifying workplace issues. |
| | (b) The organisation supports flexible work practices to sustain work-life balance.<br>The organisation offers staff flexible work arrangements to promote the work-life balance. These include such measures as a reduction in hours worked, flexible start and finish times, split shifts, job sharing, time in lieu, flexible work locations and flexible leave arrangements. Flexible work arrangements assist with allowing staff time for study, to provide necessary care for children and other family members, to maintain activities in the community or to prepare for retirement. Flexible arrangements also provide time for community service commitments such as safety and emergency training. | Human Resource Management Policy and related procedures.<br>Staff contracts.<br>Staff Interviews. |
| | (c) There is a system that motivates staff and identifies the value of staff through appropriate acknowledgement.<br>The organisation has a system that seeks to meet the three staff goals of equity, achievement and camaraderie. The system ensures that staff are renumerated fairly and have fair job security (equity), are recognised for their own achievements and are informed of achievements made by the organisation (achievement) and work within an organisational culture that facilitates positive working relationships with fellow staff (camaraderie). | Human Resource Management Policy and related procedures.<br>Staff Performance and Development Policy and related procedures.<br>Formal and informal awards and rewards.<br>Team building and social events.<br>Staff interviews. |
| | (d) Managers facilitate staff access to industrial relations and employee support services.<br>The organisation and its manager(s) support staff to seek assistance, whether with personal and work related problems through an EAP provider or with industrial problems through industrial support such as unions. Managers make sure staff are aware of what supports are available to them and that they receive assistance to access these supports through flexible work arrangements, paid time off or other provisions. | Human Resources Management Policy and related procedures.<br>Staff Performance Development Policy and related procedures.<br>Record of staff performance development interview.<br>Record of leave arrangements.<br>Staff interviews.<br>Staff contracts.<br>EAP and other staff support service information. |
| | (e) An employee assistance program is implemented.<br>The organisation implements or facilitates access to an employee assistance program that supports staff in dealing with personal and work-related issues which may affect work performance, and where required can provide counselling services and/or early intervention mechanisms to prevent the escalation of existing issues. Staff are aware that an employee assistance program is available and know how to access its services. | Human Resources Management Policy and related procedures.<br>Staff contracts.<br>Staff Performance and Development Policy and related procedures.<br>EAP information available in the workplace.<br>Confidential usage reports from EAP providers.<br>Staff interviews. |
| | (f) There is a consultative and transparent system to identify, manage and resolve workplace relations issues.<br>The organisation has a system to manage effective workplace relations and resolve issues before they become disputes. This system often involves incident monitoring, providing clear and relevant information to staff on such issues as code of conduct, harassment, discrimination, WHS and industrial relations information, formal training for managers in industrial relations and formal mechanisms for staff input and grievance with industrial relations in the | Human Resources Management Policy and related procedures.<br>Grievance and Dispute Settling Policy and related procedures.<br>Quality Improvement Action Plan and progress reports.<br>Staff interviews.<br>Minutes of industrial meetings / consultation with staff. |

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| | organisation. The system is consistently monitored to identify problems and needs for improvement and to ensure the system is compliant with the most recent and relevant jurisdictional legislation and direction. | Incident audits. |
| | (g) Workplace relations are coordinated with relevant external groups.<br>Staff and management know how to access external support groups such as unions and relevant professional bodies, as appropriate. When industrial relations issues are dealt with, employees are represented by individuals who have been elected, and who have access to professional advice on the relevant issues. | Human Resources Management Policy and related procedures.<br>Evidence of contact resources for external supports.<br>Minutes of industrial meetings / consultation with staff.<br>Staff Interview. |
| Rating | Element | Evidence commonly presented |
| MA | (a) Performance measures are used on a regular basis to evaluate workplace relations, and improvements are made as required.<br>The organisation has measures in place to enable the regular evaluation of the workplace relations system. A set of indicators selected according to organisational need (for example, related to time lost to disputes or number or staff in industrial relations training) are used to monitor performance in this area and the outcomes are used to implement improvements, where required. | Quality Improvement Action Plan and progress reports.<br>Minutes of industrial meetings with staff.<br>Staff satisfaction survey.<br>Workplace relations audit. |
| | (b) Performance measures are used on a regular basis to evaluate staff support services and improvements are made as required.<br>The organisation has measures in place to enable the regular evaluation of the staff support services that it provides. A set of indicators selected according to organisational need (for example, related to the usage rates of the EAP or staff satisfaction with support services) are used to monitor performance in this area and the outcomes are used to implement improvements, where required.<br><br>The organisation has measures in place to continually evaluate the staff support services and make improvements where required. The organisation determines a set of indicators to be collected (such as number of times staff support has been accessed, staff satisfaction with staff support) and these are evaluated regularly and changes made where indicators indicate that they are required. | Quality Improvement Action Plan and progress reports.<br>Staff satisfaction survey.<br>Staff support services audit. |

Performance measures

Suggested performance measures related to this criterion are on pages 321 to 322 of *The ACHS EQuIP5 Guide – Book 2*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Orientation manual updated | An 'employee support' section was added to the orientation manual to ensure staff awareness of how to access support, and the types of support which the organisation | All staff informed of update through staff meeting minutes and access to policy. Staff satisfaction surveys indicate a 23% increase in awareness of support options. |

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| | | provides. | |
| 2 | Develop team cohesion and support | Quarterly 'social' team building events. Annual 'formal' team building day with external facilitator. | Over a 12 month period from July 2011, staff satisfaction surveys indicate improved satisfaction with work environment, support from co-workers and support from management. Additionally, there has been a decrease in the average number of staff sick days from 3 per month to just over 1 per month. |

Plans for Improvement

| No. | Intended Improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Training to be held on worker care to outline the responsibilities of the individual and the organisation with respect to support of colleagues and the workforce. | Service Manager | July 2013 |
| 2 | Introduction of a 'Manager Assist' program, an advisory service for managers and team leaders to assist with decision making regarding employee support or industrial issues. | Operations Officer | July 2013 |
| 3 | Re-write Employee Assistance Program policy and associated procedures to clarify for managers and staff the procedure for utilising this program, include new posters and information on staff office notice-board. | Operations Officer / Managers | July 2013 |

## Standard 2.3: Information management systems enable the organisation's goals to be met.

### Criterion 2.3.1
### Health records management systems support the collection of information and meet the consumer / patient and organisation's needs

The intent of this criterion is to ensure that the organisation's health records management system facilitates the provision of care. A key purpose of health records is to support continuity of care. Health records must therefore be managed so that all records are kept complete, up-to-date and available to relevant clinicians in a timely manner. An organisation should ensure the integrity, safety and security of all records.

Refer to the *ACHS EQuIP5 Guide – Book 2,* page 324 for further information, including the relationship 2.3.1 has with other criteria.

| Rating | Element | Evidence commonly presented |
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| LA | (a) There is a health records management policy and system that ensures:<br>(i) the secure, safe and systematic storage of data and records<br>(ii) timely and accurate retrieval of records stored on or off site<br>(iii) consumer / patient privacy when information is communicated<br>(iv) retention and destruction<br>according to all relevant standards / legislation / policy / guidelines.<br>The organisation has a system, including implemented policy and procedures, to govern its health records management, which ensures that staff and management are aware of all relevant procedures, and understand the necessity for systematic storage and handling of records and their responsibilities with respect to client privacy. The system includes a retention and destruction schedule that is compliant with relevant legislation and appropriate to the nature and form of the records (for example, shredding of paper records, wiping of electronic records). | Client File Management Policy and related procedures.<br>Client file access procedures.<br>Client file storage systems.<br>Client file example.<br>Privacy and Confidentiality Policy and related procedures. |
| | (b) Each consumer / patient is allocated an organisation-wide unique identifier.<br>The organisation allocates each client with a unique identifier, which is used to identify that client during all of his or her interactions with the organisation, including when there are multiple admissions. The unique identifier helps to ensure accurate record keeping and to maintain continuity of care. | Client File Management Policy and related procedures.<br>Client file example.<br>Central unique identifier registry. |
| | (c) Where multiple records for the consumer / patient exist they are cross-referenced.<br>The organisation has a system for ensuring that when a client has multiple health records, or a record containing information in different formats, all parts of the record are linked so that all current information is available. This system facilitates accurate record keeping where files are part-paper based and part-electronic, when part of a large file must be kept in storage, where multiple admissions result in multiple files, or where the file includes information in a variety of media (for example, x-rays, video footage). | Client File Management Policy and related procedures.<br>Client file examples, including a multiple-record client files. |
| | (d) Clinical classification is undertaken for all inpatient admissions in accordance with jurisdictional standards, where available, or guidelines.<br>*Not applicable.* | *Not applicable.* |
| | (e) Documented guidelines are available for consumers / patients on how to access their health records<br>The organisation has guidelines to inform its clients of the process to follow when they wish to access their own health records, which what they need to do to access their own records. An informational brochure is available to inform clients of their rights with respect to health record access. | Client File Management Policy and related procedures.<br>Client file access procedures.<br>*'What if I want to see my file'* information sheet for clients. |
| Rating | Element | Evidence commonly presented |
| SA | (a) The records management system is managed with reference to any relevant standards, codes of practice, and industry guidelines.<br>The organisation's health records management system ensures that all client files are created, stored and handled according to current jurisdictional legislation and all relevant standards and codes of practice. The system is monitored to ensure compliance with legislative requirements and the associated policy and procedures are regularly evaluated. | Client File Management Policy and related procedures.<br>Quality Improvement Action Plan and progress reports.<br>Legal and Regulatory Policy. |

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| | (b) There is a system to support the allocation and maintenance of the unique identifier.<br>The organisation has an implemented system to govern the creation and allocation of a unique identifier for each client, which is associated with that client in all episodes of treatment and for all admissions. All relevant staff are trained in the creation and allocation of the unique identifier, and the system is monitored for accuracy and compliance. | Client File Management Policy and related procedures.<br>Central unique identifier registry. |
| | (c) A central index of identifiers is maintained.<br>The organisation's system for managing unique client identifiers includes a central index, which is maintained as described within the Client File Management Policy and helps to ensure the accuracy and currency of client information. | Client File Management Policy and related procedures.<br>Central unique identifier registry.<br>Electronic client database. |
| | (d) The health record is linked to other health information systems using the unique identifier.<br>The organisation's system for managing the unique client identifier allows all information associated with that client across all of his or her interactions with the organisation to be linked, so as to maintain accurate record keeping and to facilitate continuity of care. | Client file management system.<br>Central unique identifier registry.<br>Client file / records. |
| | (e) All components of the record are accounted for at a central point and are monitored.<br>The organisation has a central registry through which the location of all client files, and all components of client files that are stored or handled separately, may be monitored during use, storage and/or transport. The registry records where all files, and parts of files, may be found. | Client file management system.<br>Central unique identifier registry.<br>Client file / records. |
| | (f) Training on health record keeping and records management is available for relevant staff.<br>The organisation ensures that all necessary training is provided for staff in the creation, maintenance, storage and accessing of client files, appropriate to the differing needs of administrative and clinical staff and according to staff position descriptions. The training also encompasses the unique identifier system and the organisation's responsibility to assist clients to access their own health records, upon request. | Client file management system.<br>Staff training records.<br>Staff Performance and Development Policy and related procedures. |
| | (g) Coding and reporting time frames meet internal and external requirements.<br>*Not applicable.* | *Not applicable.* |
| | (h) Healthcare workers participate in the analysis of data including clinical classification information.<br>*Not applicable.* | *Not applicable.* |
| | (i) Requests by consumer / patients for access to health records are met within a set period in accordance with jurisdictional policy / legislation.<br>The organisation ensures through an audit or similar process that all client requests for access to their health records are met within the time period designated in relevant jurisdictional legislation and/or according to organisational policy. | Client File Management Policy and related procedures.<br>Client file access requests and reports. |
| Rating | Element | Evidence commonly presented |

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|---|---|---|
| MA | (a) Health records management systems are evaluated, and improvements are made as required.<br>The organisation regularly evaluates its system for the management of client files to assess compliance with all facets of the Client File Management Policy (for example, number of client files completed as per policy, number of incidents related to client files, accuracy of file indexing and cross-referencing). The Client File Management System is reviewed as part of the QI policy review plan and audits occur as part of evaluation of the system. The organisation has a mechanism to ensure that improvements suggested by the QI Audit are implemented in practice. | Client File Management Policy and related procedures.<br>Quality Improvement Action Plan and progress reports. |
| | (b) Checks for consumers / patients that have multiple identifiers are regularly made on the central index and improvements / links are made when required.<br>The organisation regularly checks its file management system to ensure that each client has only one identifier and that each identifier refers to only one client. This check also ensures that where multiple files exist for the one identifier, they refer to the one client and are linked according to organisational policy. The organisation carries out these checks as part of its overall audit of its client file management system and quality review, to ensure that the central client identifier database is accurate and reflects one identifier per person. Any identified errors are fixed in a timely fashion. | Client File Management Policy and related procedures.<br>Quality Improvement Action Plan and progress reports. |
| | (c) Tracking and monitoring of health records is evaluated and improvements are made when required.<br>As part of its QI process, the organisation has implemented policy and procedures for tracking client files. This tracking system is regularly evaluated to ensure that all parts of all files can be located, that they are where they are supposed to be, and that where a file has multiple parts, all parts are locatable and linked. There is a system to ensure that improvements are made when errors or process flaws are identified. | Client File Management Policy and related procedures.<br>Quality Improvement Action Plan and progress reports. |
| | (d) Coding and reporting processes are evaluated, and improvements are made when required.<br>*Not applicable.* | *Not applicable.* |

Performance measures

Suggested performance measures related to this criterion are on pages 331 to 332 of *The ACHS EQuIP5 Guide – Book 2*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Clinical file audit tool | Clinical file audit tool developed to guide standard audit practice. Schedule of clinical file audits made for three times per year. | Standard file audit tool identified specific areas of file management for clinical and managers to improve on. Specific discussion and training was implemented to support file management improvement. Over a 12 month period to March 2012, the number of file management errors has decreased from 14 (of 6 files) to 3 (of 6 files). |
| 2 | Training in clinical file management. | Senior administration officer received formal training in clinical file | Clinical file management adheres to current legislative requirements; new system for the creation, storage and use of client files; clinical staff provided with information on their file management responsibilities. |

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| | | management. | |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | System for tracking location clinical files developed, including hard and electronic copy. | Administration Officer | September 2013 |
| 2 | Staff in-service on clinical file management responsibilities. | Program Manager | September 2013 |

## Standard 2.3: Information management systems enable the organisation's goals to be met

### Criterion 2.3.2
### Corporate records management systems support the collection of information and meet the organisation's needs

The intention of this criterion is to focus on issues beyond those associated with clinical records and to ensure that the organisation's records management systems help to facilitate effective management of the organisation and associated research and education facilities.

Refer to the *ACHS EQuIP5 Guide – Book 2,* page 334 for further information, including the relationship 2.3.2 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) There is a corporate records management policy and system that ensures:<br>(i) the secure, safe and systematic storage of data and records<br>(ii) timely and accurate retrieval of records stored on or off site<br>(iii) appropriate retention and destruction of records<br>according to all relevant standards / legislation / policy / guidelines.<br>The organisation has a system for managing corporate records, including records relating to human resources, meeting minutes (staff, management, Board), governance decisions, organisational planning documents, financial records and archived policies. This system includes guidance and processes for how and where to store records, how they are accessed and how they are destroyed. | Corporate Records Management Policy and related procedures.<br>Human Resources Management Policy and related procedures.<br>Client Records Management Policy and related procedures.<br>Information and Records Management Policy and related procedures.<br>Quality Improvement Policy and related procedures. |
| | (b) Policy / guidelines exist that define the governance and accountability for corporate records management. | Corporate Records Management Policy and related procedures. |

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| | The organisation's implemented Corporate Records Management Policy defines the accountabilities associated with the governance of the records management system, and identifies those individual with responsibilities in this area, including maintaining oversight of, and reporting on, the system. | Information and Records Management Policy and related procedures. |
| | (c) The corporate records management system specifies the requirements for standardised record creation and tracking.<br>The organisation's implemented Corporate Records Management Policy and its associated procedures provide guidance for staff and management on how to create corporate records, including meeting minutes, records of decisions made, and financial records, in what formats they should/can be created, where and how to store them, and how to track these records from a central database so that they can be accessed when required. | Corporate Records Management Policy and related procedures.<br>Information and Records Management Policy and related procedures. |
| | (d) Staff are made aware of their responsibilities in relation to corporate records management.<br>The organisation ensures through its orientation processes, other educational opportunities such as annual policy refresher training, and by ready access to policy and procedure manuals that staff are aware of their roles and responsibilities with regards to corporate records management. | Corporate Records Management Policy and related procedures.<br>Information and Records Management Policy and related procedures.<br>Human Resources Management Policy and related procedures - staff orientation.<br>Completed staff orientation checklists. |
| Rating | Element | Evidence commonly presented |
| SA | (a) The corporate records management system is managed with reference to relevant standards, legislation, policy, codes of practice and industry guidelines.<br>The corporate records management system includes implemented policy and procedures, which reference and are directed by the relevant standards, legislation and industry guidelines. The system is reviewed regularly to ensure that it is in compliance with the most recent legislation, standards and guidelines. | Corporate Records Management Policy and related procedures.<br>Information and Records Management Policy and related procedures.<br>Legal and Regulatory Policy and related procedures. |
| | (b) Corporate records created by the organisation are supported by relevant records systems.<br>The organisation has an implemented system for the creation, modification, tracking and storage of corporate records. Policy and procedures describe processes for the maintenance of security, the use of electronic file paths, the various formatting and storage requirements for different record types, document dissemination and version control. | Corporate Records Management Policy and related procedures.<br>Information and Records Management Policy and related procedures. |
| | (c) Training on corporate record keeping and records management is available to staff.<br>The organisation ensures that all staff with responsibilities in corporate record keeping and management, according to their position descriptions, receive relevant training. The training addresses all aspects of organisational records management and includes 'refresher' sessions as required, to facilitate staff compliance with organisational policy and procedures. | Corporate Records Management Policy and related procedures.<br>Information and Records Management Policy and related procedures.<br>Human Resource Management Policy and related procedures.<br>Staff orientation checklist.<br>Staff training records. |
| Rating | Element | Evidence commonly presented |
| MA | (a) Corporate records management systems are evaluated and improvements are made as required.<br>In addition to regular audits to monitor compliance with related policy and procedures, the records management | Previous and current Corporate Records Management Policy and related procedures. |

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| | system itself is evaluated to ensure that it meets organisational need and fulfils the current requirements of relevant legislation, standards and guidelines. Required improvements identified through regular audits, incident investigation or because of changes to legislation are implemented. | Information and Record Management Policy and related procedures.<br>Quality Improvement Action Plan and progress reports.<br>Physical evidence of implemented improvements. |
| | (b) Training on corporate record keeping and records management is evaluated, and improved as required.<br>The organisation evaluates the training provided to staff in corporate records keeping and management both from the perspective of compliance with policy and procedures, and staff satisfaction. The evaluation forms part of the regular assessment of the corporate records management system. Improvements are made to the content and method of the training provided as required. | Quality Improvement Action Plan and progress reports.<br>Record of staff record management training, and review and feedback reports.<br>Staff satisfaction surveys. |
| | (c) Corporate records creation and tracking is evaluated and improved as required.<br>Policy and procedures for the creation and tracking of corporate records are regularly evaluated. The effectiveness of organisational processes for creating different types of record (for example, personnel records, Board minutes, Decision Journals), and for tracking records including those comprised of multiple parts or in different formats, is assessed and improvements made to any identified shortfalls. | Current and previous Corporate Records Management Policy and related procedures.<br>Current and previous Information and Record Management Policy and related procedures.<br>Quality Improvement Action Plan and progress reports. |

Performance measures

Suggested performance measures related to this criterion are on page 338 of *The ACHS EQuIP5 Guide – Book 2*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | File audit tool | A file audit tool / plan developed to ensure the regular review of corporate records and the Corporate Records Management Policy. | Outcomes of record audits were tabled at staff meetings and relevant staff received training on corporate records management.<br><br>The percentage of records in compliance with policy has increased from 86% to 92% over a 12 month period from January 2011. |
| 2 | Records management review system | System developed for review of organisation records against legislation and best practice. Schedule of review and update incorporated into Quality Improvement Action Plan. | Organisation records and management of them reviewed regularly against current legislation. |

Plans for Improvement

| No. | Intended Improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | File retrieval system to be developed to track the location of files once they are removed from file room. | Administration Officer | September 2013 |

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| 2 | Staff training in file management to increase the accuracy of file content. | Team Manager | August 2013 |

## Standard 2.3: Information management systems enable the organisation's goals to be met.

### Criterion 2.3.3
### Data and information are collected, stored and used for strategic, operational and service improvement purposes

The intent of this criterion is to ensure that the organisation has systems in place for the collection of data and information, that these data and information are available for use in a timely manner, stored safely and used effectively.

Refer to the *ACHS EQuIP5 Guide – Book 2,* page 340 for further information, including the relationship 2.3.3 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) The collection, storage and use of data comply with professional and statutory requirements.<br>The organisation's implemented information management policy and procedures ensure that processes for the collection, storage and use of data comply with all relevant jurisdictional requirements. | Information and Record Management Policy and related procedures.<br>Legal and Regulatory Policy and related procedures.<br>Privacy and Confidentiality Policy and related procedures. |
| | (b) Policy / guidelines exist for the validation and protection of data and information.<br>The organisation's information management system includes policy and procedures defining the methods used to validate the various forms of data collected (for example, client data, financial data, utilisation statistic), the acceptable levels of tolerance within each form of data, and how data are protected. | Information and Record Management Policy and related procedures.<br>Privacy and Confidentiality Policy and related procedures.<br>Data collection and use guides.<br>Electronic network user guides. |
| | (c) Data are available for:<br>(i) research<br>(ii) development<br>(iii) improvement activities<br>(iv) education<br>(v) corporate and clinical decision making.<br>The information management system and its related policies and procedures ensure that relevant data are collected and stored in appropriate formats and locations, so that they are accessible when required for purposes including organisational development, research (internal or external), education and decision making. | Information and Record Management Policy and related procedures.<br>Quality Improvement Policy and related procedures.<br>Program Evaluation Policy and related procedures.<br>Research Policy and related procedures.<br>Range of data collections – human resources, quality improvement, feedback, surveys, financial, etc. |
| | (d) Resources exist for the assessment, analysis and use of data. | Information and Record Management Policy and related procedures. |

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| | The organisation provides adequate resources, including computers and training, to ensure that the data collected are properly stored and analysed and put to the most effective use. | Quality Improvement Policy and related procedures.<br>Program Evaluation Policy and related procedures.<br>Human resources – dedicated positions and/or roles/responsibilities, data related training.<br>Information technology software and hardware. |
| | (e) Reference and resource materials are available for use by staff.<br>The organisation ensures that staff have access to reference and resource materials, whether through a hard copy library or access to online databases and reference materials. Staff have access to research materials produced 'in-house'. Policy and procedures specify how staff are educated in the information available to them, how and when to access it (particularly with respect to essential safe practices), and how this information is maintained. | Information and Record Management Policy and related procedures.<br>Quality Improvement Policy and related procedures.<br>Program Evaluation Policy and related procedures.<br>Data collection and use guides.<br>Electronic network user guides.<br>Resource and reference library access, internet access, newsletters and journals. |
| Rating | Element | Evidence commonly presented |
| SA | (a) An information management plan is implemented and identifies the needs of the organisation at all levels.<br>The organisation has an information management plan attached to the Information Management Policy that addresses all issues related to information management, the creation of information and data, the sourcing of outside information and data and the use of information and data. The plan is developed in consultation with relevant staff, and external specialists as required, to ensure that organisational needs are met. | Quality Improvement Action Plan and progress reports.<br>Records of specific data collection and management activities.<br>Schedule of data collections. |
| | (b) A system is implemented for validation and protection of data and information.<br>There are implemented policy and procedures to guide the validation of data via processes including data checking prior to entry, and cross-checking / spot-checking of data within the organisation's systems. There are also processes including restricted password access to ensure that data are protected (for example, against inappropriate alteration) and correctly accessed and used. | Information and Record Management Policy and related procedures.<br>Data collection systems and processes – cross checks, audits, validation requirements, electronic prompts, etc.<br>Records of specific data collection audit activities.<br>Data security systems – password protection, locked storage, restricted access, etc. |
| | (c) Data storage and retrieval are facilitated through effective classification and indexing.<br>The organisation has effective methods of classifying and indexing all data and information, including systems of cross-referencing and the use of file numbers. Staff are trained in these methods to ensure accurate data storage and timely retrieval. | Information and Record Management Policy and related procedures.<br>Data dictionaries.<br>Client file management procedures and guidelines.<br>Data and information management orientation and training for staff. |
| | (d) Responsibility and accountability for action on data and information are clearly delineated.<br>Organisational accountabilities and responsibilities for the governance and management of data and information are defined within the Information Management Policy and other relevant policies and related documents. | Information and Record Management Policy and related procedures.<br>Functions and Delegations Matrix.<br>Data and information management orientation and training for staff.<br>Position descriptions. |
| | (e) Databases are linked to provide access within and across units and departments.<br>As defined within the information management policy, procedures and plan, databases within the organisation are | Information and Record Management Policy and related procedures.<br>Data collection systems and processes. |

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| | linked and cross-referenced using codes, hyperlinks, and other methods, to facilitate staff access to data and information across all sections of the organisation. Information relating to database linkage is stored in a central directory. | Data dictionaries. |
| | (f) Staff have access to training on information and data management.<br>The organisation ensures that new staff are oriented to and trained in the information management policy and procedures, including how to create, validate and save data, and how to access data and information when required. Ongoing training in the form of 'refresher' courses is provided as required, or when there is an alteration to any aspect of the information management system. | Human Resources Policy and related procedures.<br>Data and information management orientation and training for staff.<br>Staff training calendar/schedule.<br>Staff participation in data/information management in-services and forums. |
| | (g) Liaison with external bodies improves the quality of information supplied and received.<br>The information management system includes policy and procedures describing how the organisation works with external bodies to share data and improve the quality of information. The organisation submits data to external bodies, including funding and regulatory bodies, shares its information with agencies with which it forms partnerships, and accesses information created by other bodies, for example research information or regulatory information. | Information and Record Management Policy and related procedures.<br>Information sharing agreements and procedures.<br>Schedule of data/information exchange with external bodies – MDS, performance reports, regulatory reporting, etc. |
| | (h) The organisation contributes to external databases and registers.<br>The organisation contributes to external databases and registers as prescribed, including Minimum Data Set information provision to its regulators, voluntarily to other bodies such as collaborative research groups. | Information and Record Management Policy and related procedures.<br>Information sharing agreements and procedures.<br>Schedule of data/information exchange with external bodies – MDS, performance reports, regulatory reporting, etc. |
| | (i) There are systems to provide information for authorised stakeholders that are consistent with jurisdictional privacy legislation.<br>The organisation has policy and procedures in place to ensure that it provides information as required to its authorised stakeholders. For example, the organisation has a process for providing Minimum Data Set information to the relevant health funding bodies, which defines who is responsible for providing the information, and how it is to be provided. | Information and Record Management Policy and related procedures.<br>Privacy and Confidentiality Policy and related procedures.<br>Information sharing agreements and procedures.<br>Funding Agreements.<br>Functions and Delegations Matrix. |
| | (j) The needs of staff for reference and resource materials are identified, analysed and prioritised.<br>The information management policy addresses staff needs for access to resources and reference materials. The organisation undertakes a needs analysis to assess the requirements of staff, and plans how to best meet those needs through prioritisation and the allocation of available resources. | Information and Record Management Policy and related procedures.<br>Human Resources Policy and related procedures.<br>Staff survey reports.<br>Quality Improvement Action Plan and progress reports.<br>Reference and resource material access. |
| Rating | Element | Evidence commonly presented |
| MA | (a) Systems used for validation and protection of data and information are evaluated and improved as required.<br>The organisation evaluates its processes for validating and protecting its data by examining the quality of its data through a system of pre-determined sample sizes and benchmarks. Where errors or irregularities are identified, the cause is determined (for example, data entry errors or misclassification of data) and steps taken to improve existing | Current and previous Information and Record Management Policy and related procedures.<br>Quality Improvement Action Plan and progress reports.<br>Development data validation systems over time. |

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| | processes, with further staff training provided as required. | Development of data security systems over time. |
| | (b) Monitoring and analysis of clinical and non-clinical data and information occurs to ensure:<br>(i) accuracy, integrity and completeness<br>(ii) timeliness of information and reports<br>(iii) the needs of the organisation are met<br>and improvements are made as required.<br>The organisation's system for entering, analysing and storing data is continually monitored to ensure that the data are being entered correctly and in a timely fashion, and that the implemented procedures for the collection and use of data meet the needs of the organisation. System monitoring occurs through audits and performance reporting, and the analysis of any incidents indicating deficiencies in the system. | Reports from data and information audit activities.<br>Review of feedback from external receivers of organisation/client data<br>Quality Improvement Action Plan and progress reports. |
| | (c) Training is evaluated to ensure it improves skills in information and data management.<br>The organisation evaluates the training it provides in information and data management to ensure that it is meeting organisational and staff needs by improving staff skills in information and data management, data entry and data classification. The evaluation is conducted both through quality analysis of data and information, including the accuracy and timeliness of data entry, and through consultation with staff and staff satisfaction surveys. | Reports from information and data management training evaluation.<br>Reports from staff feedback and consultation.<br>Review of data and information audit reports to ensure improvement over time in data quality. |
| | (d) Data use and reporting processes are evaluated and improved as required.<br>The organisation evaluates its data use and reporting processes internally by assessing accuracy and timeliness of data entry and whether organisational needs are met, and externally by consultation with the agencies to which data are submitted. Steps are taken to address any identified deficiencies. | Reports from data and information audit activities.<br>Review of feedback from external receivers of organisation/client data<br>Quality Improvement Action Plan and progress reports. |
| | (e) The organisation reviews results from external databases and registers and improves care and services as indicated.<br>The organisation ensures that its care and services reflect current best-practice through continual review of resources, references and the latest evidence, and by making improvements according to the best available evidence. | Program Evaluation Policy and related procedures.<br>Quality Improvement Action Plan and progress reports.<br>Reports, action plans and completed activities from client, staff and stakeholder feedback.<br>Program and care services developed over time. |
| | (f) Reference management and resource material systems are evaluated and improved as required.<br>The organisation's processes for managing references and resources are regularly evaluated through staff consultation to ensure that they are meeting organisational and staff needs, and improvements are made to the content of the resources and the arrangements for access according to identified need. | Reports, action plans and completed activities from staff feedback relating to resource management.<br>Quality Improvement Action Plan and progress reports.<br>Staff interview. |

Performance measures

Suggested performance measures for this criterion are on page 346 of *The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Develop specific procedures for standard data collection from external sources. | Procedures developed to guide staff in what and how information is to be collected from external sources, including client information from referring organisations and feedback from stakeholders. | All staff understand minimum data/information collection requirements and processes.<br>Staff report less time taken up with obtaining required data/information from external providers, as all parties now have clarity as to what is needed and the related processes. |
| 2 | Resource library | Electronic and hard copy resource library established for staff, including a system of registering and cataloguing items. | All staff have access to reference materials to support organisation governance, management and clinical practice. Staff report being better informed in their decision making. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Develop and implement standard training evaluation form for staff feedback on training undertaken. | Quality Improvement Coordinator and Team Manager | November 2013 |
| 2 | Develop Information Management Plan to identify current and future data/information needs, processes for collection and management, and how the data is to be used. | Quality Improvement Coordinator and Business Manager. | December 2013 |

## Standard 2.3: Information management systems enable the organisation's goals to be met

### Criterion 2.3.4
### The organisation has an integrated approach to the planning, use and management of information and communication technology (I&CT)

The intent of this criterion is to ensure that the organisation's information and communication technology needs are met through appropriate use and management of technology.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 348 for further information, including the relationship 2.3.4 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|

| | | |
|---|---|---|
| LA | (a) There is effective governance of I&CT that is supported by policy and procedure.<br>Management of information and communication technology is guided by policy and a development plan. The policy identifies governance and operational responsibilities, financial delegation, security, risk and emergency management. | Information Technology Policy and related procedures.<br>Information Technology Plan.<br>Organisation Strategic Plan. |
| | (b) Licences are purchased as required.<br>Licences for the use of software are purchased and currency maintained. | Information Technology Policy and related procedures.<br>Copies of software licenses. |
| | (c) A system of I&CT operational support exists.<br>The organisation's Information Technology Policy provides guidance on accessing and using I&CT support, both within the organisation and externally, and including 'out of hours'. | Information Technology Policy and related procedures.<br>I&CT emergency contact procedure/flyer/poster. |
| | (d) There is a documented plan for managing I&CT risks and crises.<br>I&CT risks, crises and management responses are identified, and address preventative strategies, emergency operating procedures, recovery plans, responsibilities and contacts. | Information Technology Policy and related procedures.<br>Risk Management Policy and related procedures. |
| Rating | Element | Evidence commonly presented |
| SA | (a) A strategy for current and future I&CT needs is implemented.<br>The organisation has developed a strategy to address both its current and future information and communication technology needs, which addresses hardware and software purchases, upgrade and repair of existing technology, organisational growth and change, scheduled and unplanned software upgrades, and staff training needs. | Information Technology Plan.<br>Organisation Strategic Plan. |
| | (b) Strategies for:<br>(i) backup<br>(ii) security<br>(iii) protection of privacy<br>(iv) virus detection<br>are implemented and used.<br>The organisation implements I&CT security measures, including manual and automatic network/system back-ups, firewalls and other anti-virus software, data encryption software, varying staff access levels, and password protection. | Information Technology Policy and related procedures.<br>Privacy and Confidentiality Policy and related procedures.<br>Schedule of manual and automatic network/system back-ups.<br>Anti-virus software.<br>Restricted access to networks/drives/software. |
| | (c) There is a planned system for preventative maintenance for I&CT.<br>I&CT maintenance is undertaken by both internal staff and external providers as required. Maintenance may include scheduled system upgrades and annual asset checks, | Information Technology Policy and related procedures.<br>Schedule of manual and automatic network/system back-ups.<br>Maintenance log / schedule.<br>Agreement with external I&CT provider.<br>I&CT asset register. |
| | (d) A strategy and plan for disaster recovery / business continuity is implemented. | Information Technology Policy and related procedures. |

| | | |
|---|---|---|
| | Data and information management during and after a disaster is addressed in the Information Technology Policy, including delegations, responsibilities, communication, and procedures. | Emergency Management Policy and related procedures.<br>Defined roles and responsibilities of staff and external I&CT providers.<br>Data recovery plan and checklist.<br>Schedule of manual and automatic network/system back-ups. |
| | (e) The I&CT system supports the collection, aggregation and analysis of data.<br>The physical system (hardware and software) and the organisational system (policy and procedures) support the use of data to meet organisational needs. Both systems guide data collection, validation, protection and application. | Information Technology Policy and related procedures.<br>Defined roles and responsibilities of staff.<br>Existing hardware and software.<br>Organisation Strategic Plan.<br>Information and data collection schedule. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The I&CT system, including compliance with I&CT policy and procedures, is evaluated and improved as required.<br>I&CT systems are reviewed on a schedule and changes made in response to organisational need. Staff I&CT is monitored to identify compliance with policy and information and/or training needs. | Current and previous Information Technology Policy and related procedures.<br>Quality Improvement Action Plan and progress reports.<br>Information Technology Plan – activities and achievements.<br>I&CT audits – equipment functionality, security, system failures, staff use, etc. and actions.<br>ports from<br>I&CT reviews by external expertise – reports and action undertaken.<br>Staff survey and feedback - reports and action undertaken. |
| | (b) The preventative maintenance system for I&CT is evaluated regularly and improved as required.<br>Preventative maintenance of the organisation's I&CT is managed by an internal, and where required, an external provider. services provided by the external service provider are evaluated as agreed in the contract, including staff survey to gauge satisfaction with the performance of computers and other technology. | Current and previous Information Technology Policy and related procedures.<br>Quality Improvement Action Plan and progress reports.<br>Information Technology Plan – activities and achievements.<br>I&CT audits – equipment functionality, security, system failures, staff use, etc.<br>Agreements with external I&CT maintenance providers over time. |
| | (c) The risk and crisis management system for I&CT is evaluated regularly and improved as required.<br>The organisation arranges for regularly tests its arrangements for I&CT crisis management to ensure that data are protected in the event of an emergency. Testing of the risk and crisis management system is conducted by an external service provider and improvements are made when recommended. | Current and previous Information Technology Policy and related procedures.<br>Quality Improvement Action Plan and progress reports.<br>Information Technology Plan – activities and achievements.<br>Emergency and I&CT incident review reports and action plans. |

Performance measures

Suggested performance measures for this criterion are on page 353 of *The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Computer password protections | Network coded to automatically require all users to change log-in passwords every 6 months. | Increased integrity in the network's security, with greater protection of organisation, staff and client information. |
| 2 | I&CT Emergency Management Guide | Developed and implemented an I&CT Emergency Management Guide for all sites to ensure business continuity. Staff instructed in responsibilities and practice relating to preventative measures, internal and external contacts, data recovery, reporting and incident review. | Staff report greater understanding and confidence in responding in an I&CT emergency. During last I&CT emergency (power outage on 12/03/2013) no data was lost and no equipment was damaged. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Create register of all software licence requirements, including expiry dates and process for renewing. | Operations Officer | September 2013 |
| 2 | Implement central I&CT fault register and reporting system to track I&CT incidents. | Operations Officer and Team Leaders | December 2013 |

## Standard 2.4: The organisation promotes the health of the population

### Criterion 2.4.1
### Better health and wellbeing is promoted by the organisation for consumers / patients, staff and the wider community

The intent of this criterion is to ensure that healthcare organisations take some responsibility for promoting the health and wellbeing of the Australian population.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 355 for further information, including the relationship 2.4.1 has with other criteria.

| Rating | Element | Evidence commonly presented |
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| LA | (a) Staff and other key stakeholders are informed of population health principles and participate in evidence based health promotion strategies.<br>The organisation's staff and stakeholders understand and apply evidence based health promotion strategies with clients and the community they serve. | Health Promotion Policy and related procedures.<br>Client Treatment Policy and related procedures.<br>Staff resource library.<br>Position descriptions – selection criteria outlining population health principles requirements.<br>Health promotion campaigns. |
| | (b) The organisation is aware of the current and emerging health priority areas.<br>Health priorities are identified through a number of mechanisms, including from external sources, staff, stakeholders and clients. | Client feedback, surveys, and health data.<br>Staff resource library and incoming information sources – newsletters, journals, subscriptions. Membership of health promotion and related organisations, alliances and professional bodies.<br>Attendance at conferences and forums.<br>Health priority related research. |
| | (c) The organisation is aware of its statutory requirements for reporting public health matters.<br>The organisation has documented and understood requirements for reporting on public health matters, including infectious diseases. | Work Health and Safety Policy and related procedures.<br>Infection Control Policy and related procedures.<br>Funding Agreements. |
| Rating | Element | Evidence commonly presented |
| SA | (a) Policy / guidelines are implemented that are consistent with health promotion programs and interventions and reflect jurisdictional priorities.<br>Policies relating to the health of clients and staff align with NSW and national priorities. | Health Promotion Policy and related procedures.<br>Reference and research that supports development of health promotion and client intervention programs.<br>Work Health and Safety Policy and related procedures.<br>Funding Agreements.<br>Staff health programs and initiatives. |
| | (b) The organisation works collaboratively and has partnerships in place to utilise resources effectively to support health promotion activities.<br>The organisation collaborates and partners with external bodies to increase health promotion opportunities and outcomes. Activities may include education and information provision for clients and the community, shared fund-raising activities, joint research, collaborative program development and partnered service delivery. | External Partnerships Policy and related procedures.<br>Collaborative Agreements, Memoranda of Understanding, Partnership Commitments, etc. |
| | (c) The organisation optimises the delivery of health promotion programs and interventions to consumers / patients and carers.<br>Health promotion activities with clients, carers and the community may be planned and structured, such as nutrition and cooking classes with residential clients or promoting drug awareness and support service availability; or may be opportunistic such as raising alcohol consumption in general discussion with clients. | Health Promotion Policy and related procedures.<br>Client Intervention Policy and related procedures.<br>Client treatment program.<br>Residential group and education program schedule.<br>Health promotion programs and activities. |
| | (d) Training and resources are available for staff to support the development of evidence based health | Staff Performance and Development Policy and related procedures. |

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|---|---|---|
| | promotion and interventions to consumers / patients, carers and the wider community.<br>Staff are supported to develop knowledge and practice of evidence-based health promotion through education, training, skill development, networking and research. | Staff orientation program.<br>Staff supervision.<br>Register of staff training events – in-services, external, etc.<br>Partnerships and membership with research bodies and health and promotion organisations.<br>Staff interview. |
| | (e) Opportunistic health promotion / education strategies are undertaken in partnership with consumers / patients, carers and the wider community.<br>Health promotion strategies are provided through less formal opportunities, including through general discussion with clients, carers and the community, as well as through brochures, posters, and electronic messages on emails and the organisation's website. | Events Policy and related procedures.<br>Health Promotion Policy and related procedures.<br>Client Intervention Policy and related procedures.<br>Client treatment program.<br>Health promotion brochures and posters throughout facility.<br>Organisation website.<br>Messages on electronic mail and organisation website. |
| | (f) Health surveillance data is appropriate to the organisation.<br>Information relating to the client and community that the organisation serves is collected and analysed to better understand needs, develop appropriate health responses and report data as required by funding bodies and government. | Health Promotion Policy and related procedures.<br>Client Intervention Policy and related procedures.<br>Schedule of data collection and reporting requirements. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The outcomes of health promotion programs and interventions are evaluated for their effectiveness in improving the health and wellbeing of consumers / patients, staff, carers and the wider community and improved as required.<br>Health promotion strategies are regularly reviewed and improved to ensure optimal effectiveness and resource allocation. | Current and previous Health Promotion Policy and related procedures.<br>Current and previous Client Intervention Policy and related procedures.<br>Quality Improvement Action Plan and progress reports.<br>Reports and actions from client, community and staff survey relating to effectiveness of health promotion strategies.<br>External review of health promotion strategies. |
| | (b) Performance measures are developed and quantitative data collected, to evaluate the effectiveness / outcomes of health promotion programs and interventions implemented by the organisation.<br>Client and community health related data is collected and used to support improvement of health promotion strategies. For example, the organisation may set a target that all clients completing the residential treatment program have developed basic nutrition understanding and able to prepare health meals. | Health Promotion Policy and related procedures.<br>Client Intervention Policy and related procedures.<br>Quality Improvement Action Plan and progress reports.<br>Client program developed over time.<br>Schedule of data collection and reporting requirements.<br>Health promotion program performance reports. |

Performance measures

Suggested performance measures for this criterion are on page 362 of *The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Develop client's knowledge and safer practice relating to hepatitis. | Partnered with local government Hepatitis Education Officer to review and improve hepatitis education for clients, including electronic and hard copy information, group session and nutrition plans. | Clients are provided with consistent and current hepatitis information and how they can reduce risk of transmission and maintain health. |
| 2 | Health promotion survey with clients. | Current and exiting clients were surveyed to identify areas of health promotion need. Survey identified need to provide clients with support on developing relaxation and mindfulness techniques. | Twice-weekly session of relaxation and mindfulness now included in the program. After 6 weeks, 70% clients report they are satisfied with the relaxation and mindfulness classes. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Develop staff knowledge and skills in providing opportunistic interventions relating to client's smoking cessation. | Program Manager and Team Leader | March 2014 |
| 2 | Organisation to become member of health promotion bodies, groups and information dissemination. | Operations Manager and Team Leader | November 2013 |

## 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 2.5.1
The organisation's research program develops the body of knowledge, protects staff and consumers / patients and has processes to appropriately manage the organisational risk associated with research.

The intent of this criterion is to encourage participation in research and to ensure there is appropriate oversight, and that participating consumers / patients and staff are protected.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 365 for further information, including the relationship 2.5.1 has with other criteria.

*Note: This criterion may have limited application for some drug and alcohol organisations. It is recommended that organisations discuss its relevance with their ACHS Customer Service Manager.*

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) The organisation fosters and encourages clinical and health services research.<br>The organisation undertakes and/or supports other organisations and individuals in research activity with the aim of improving client care. | Research Policy and related procedures.<br>Relationships with external research bodies such as NDARC, NCETA and other research institutes.<br>External Partnerships Policy and related procedures.<br>Staff support for research activity. |
| | (b) The research policy / guidelines is consistent with:<br>(i) key NHMRC statements<br>(ii) jurisdictional legislation<br>(iii) codes of conduct.<br>Research related policies and guidelines are informed by, and adhere to, the three NHMRC statements: *National Statement on Ethical Conduct in Human Research (2009)*, *The Australian Code for the Responsible Conduct of Research (2007)*, and *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research (2003)*. Research undertaken also complies with NSW and Commonwealth laws, guidelines and codes of conduct relating to privacy, confidentiality, consent and professional standards. | Research Policy and related procedures.<br>Checklist of research compliance requirements. |
| | (c) The governing body demonstrates its responsibility for the governance of research.<br>Where the organisation undertakes and/or supports other organisations and individuals in research activity, the Board understands its responsibility in relation to:<br>- protection of clients, carers and staff<br>- protection of researchers<br>- protection of the organisation.<br>This may be demonstrated through policies and procedures, Human Research Ethics Committee (HREC) or Board subcommittee for research activity, and Board members with research expertise. | Research Policy and related procedures.<br>Checklist of research compliance requirements.<br>Governance Policy and related procedures.<br>Board member position descriptions.<br>Risk Management Policy and related procedures.<br>Existing HREC.<br>Board research subcommittee.<br>Board member's skills and experience. |
| | (d) The research policy / guidelines define which research requires ethical approval and under what conditions ethical approval will apply.<br>The organisation's research policy defines research that not require ethical approval (i.e. that which does not involve human subjects, such as statistical or literature reviews) and research that does require ethical approval (i.e. any research that involves human subjects). | Research Policy and related procedures.<br>Checklist of research compliance requirements. |
| | (e) Staff are aware of the research policy / guidelines.<br>Staff involved in, or those that have the potential to be, are aware of the organisation's research policy through orientation procedures, in-services, or specific training. | Research Policy and related procedures.<br>Checklist of research compliance requirements.<br>Staff orientation procedures.<br>Staff interview. |

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| | (f) Formal agreements exist with collaborating agencies.<br>Formal agreements exist with research bodies and other organisations collaborating in research activity. | Research Policy and related procedures.<br>External Relationships Policy and related procedures.<br>Collaborative Agreements, Memoranda of Understanding, Partnership Commitments, Research Agreements, etc. |
| Rating | Element | Evidence commonly presented |
| SA | (a) The research policy / guideline is implemented.<br>The organisation's research policy and related procedures are practiced in all research related activity. | Research Policy and related procedures.<br>Research proposals, plans, ethics approval, consent, advisory group, reports and communications.<br>Research Collaborative Agreements, Memoranda of Understanding, Partnership Commitments. |
| | (b) Scientific review standards of research are applied and demonstrated within the body of work.<br>Research undertaken by the organisation adheres to appropriate scientific review standards, and is demonstrated in the organisation's research policy and specific research activities. | Research Policy and related procedures.<br>Research proposals, plans, ethics approval, consent, advisory group, reports and communications. |
| | (c) The respective responsibilities of all parties involved in research are identified and documented.<br>Responsibilities of all involved in research activity is outlined in research related documents, including lead and other research officers, other staff, other organisations, governance committees, and clients. | Research Policy and related procedures.<br>Research proposals and plans.<br>Research Collaborative Agreements, Memoranda of Understanding, Partnership Commitments.<br>Research officer position descriptions.<br>Research advisory/steering group terms of reference.<br>Human Research Ethics Committee terms of reference.<br>Information provided to clients involved in research. |
| | (d) The role and reporting line of the organisation's human research ethics committee (HREC) are clearly defined.<br>An internal or external HREC terms of reference identify its role, responsibility and reporting lines, and this is available to all parties involved in research activity. | Research Policy and related procedures.<br>Research proposals and plans.<br>Research advisory/steering group terms of reference.<br>Human Research Ethics Committee terms of reference. |
| | (e) The HREC is adequately resourced.<br>The organisation provides financial and human resources to the internal HREC to support it to undertake its roles and responsibilities. Where the HREC is external, the organisation meets all fees associated with use of the HREC. | Research Policy and related procedures.<br>Organisation research budgets and accounts. |
| | (f) Ethics approval processes are timely, transparent and effective.<br>Timely, transparent and effective ethics approval processes ensures implementation of research activities. Where the HREC is external to the organisation, this may refer only to processes related to the submission for ethics approval and the response to HREC queries. | Research Policy and related procedures.<br>Research proposals and plans. |
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| | (g) Consumers and researchers work in partnership to make decisions about research priorities, policies and practices.<br>Participation in research by clients, carers and the community is considered in all aspects of research activity. | Research Policy and related procedures.<br>Research advisory/steering group terms of reference.<br>Human Research Ethics Committee terms of reference.<br>Research officer position descriptions.<br>Information provided to clients involved in research.<br>Record of minutes from research advisory/steering group terms of reference. |
| Rating | Element | Evidence commonly presented |
| MA | (a) Performance measures are used to evaluate the effectiveness of the governance of research.<br>The organisation develops performance measures for its research related activity, collates data and analyses it to measure research effectiveness. | Research Policy and related procedures.<br>Quality Improvement Action Plan and progress reports.<br>Reports of research activity reviews. |
| | (b) The system for ensuring effective research governance is evaluated and is improved as required.<br>Research activity governance is reviewed on a regular schedule and following research related detrimental incidents.<br>Improvements are made to further develop research activity governance. | Current and previous Research Policy and related procedures.<br>Quality Improvement Action Plan and progress reports.<br>Reports of research activity reviews.<br>Current and previous research advisory/steering group terms of reference. |

Performance measures

Suggested performance measures for this criterion are on page 373 of *The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Research participation information kit for clients | Standard set of information developed for clients participating in research, including consent form, research processes, summary of specific research activity, and process for making a complaint. | Number of clients withdrawing from participation in research has reduced over 12 months since implementing standard research participation information kit for clients, from 33% in February 2012 to 9% in February 2013.<br>Clients report better understanding of what their consent to participate in research means regarding privacy. |
| 2 | Research Working Group established | Research Working Group established to identify research needs and opportunities, and support the development of research proposals. | Number of research activities and related funding has increased from 3 in 2011 to 7 in 2012, including the level of associated funding. |

Plans for improvement

| No | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Develop a Research Policy to guide the organisation in undertaking and participating in research activity. | Quality Improvement Coordinator and Clinical Manager | December 2014 |
| 2 | Investigate opportunities for an external person with research expertise to become a Board member and/or join Research Working Group. | Clinical Manager | December 2014 |

# Corporate Function

EQuIP5

## Standard 3.1: The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services

### Criterion 3.1.1
### The organisation provides quality, safe health care and services through strategic and operational planning and development

The intent of this criterion is to ensure that the organisation has a planning process that begins at the strategic level and guides everyday work through operational planning.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 375 for further information, including the relationship 3.1.1 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) An organisational strategic plan has been developed and includes values, vision and mission.<br>The organisation has a current strategic plan that may include the organisation's self identified values, vision, mission, outcomes and principles. | Strategic Plan.<br>Separate values, mission and/or vision statement documents.<br>Documentation of strategic planning sessions and progress to finalisation.<br>Board endorsement of Strategic Plan. |
| | (b) Service delivery needs of the communities are analysed and considered when developing strategic and operational plans.<br>The organisation's consultations with staff, clients, families and other stakeholders on service delivery needs are used to inform the development of both strategic and operational plans. | Documented consultation activities – surveys, feedback reports, forums, staff meetings, etc.<br>Consultation reports and responding actions.<br>Documented analysis of client data and how this informs planning. |
| | (c) There is recognition of the need to develop relationships with relevant organisations and communities to achieve organisational and strategic objectives.<br>The organisation identifies external stakeholders which can support the development of strategic planning and achievements. It is understood that relationships and collaboration with state and national organisations and local communities can assist the organisation in meeting its goals. | External Relationship Policy and related procedures.<br>Documentation of external partners / stakeholders.<br>Strategic and operational plans identify the purpose and role of each stakeholder / group in supporting the organisation. |
| | (d) There is a planned approach to the development of facilities and services.<br>The organisation considers both the short and long term needs of the organisation's facilities and services, including infrastructure and resources, and develops plans to ensure future needs can be met. Responsibilities for facility and service development are identified and include both the governing body and management. | Operational Plan(s).<br>Documented future funding needs and action plans.<br>IT, equipment, building, resource audits and reports.<br>Documented Board and management responsibilities. |
| | (e) Operational plans are developed to achieve the organisation's goals and objectives and guide day-to-day activities.<br>An Operational Plan details what the organisation will do to achieve the Strategic Plan's goals and objectives. | Current and previous Operational Plan(s).<br>Board Development Plan.<br>Staff Professional Development Plan. |

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| | Some organisations may develop a number of Operational Plans specific to service sites, types or different parts of the organisation, i.e. residential and out-client counselling, or client service delivery and research projects. | |
| | (f) The activities of the organisation are covered by appropriate by-laws, articles of association and/or policies and procedures.<br>The organisation identifies and complies with legislation and policy that is relevant to the organisation and its stated and actual activities. Relevant legislation may include:<br>- *Associations Incorporation Act 2009*<br>- *Corporations Law Act 2001*<br>- *Australian Corporations (Aboriginal and Torres Strait Islander) Act 2006*<br>- *Co-operatives Act 1992*<br>- *Industrial Relations Act 1996*.<br><br>A number of tax and superannuation obligations apply to Australian not-for-profit organisations. A detailed guide of such obligations is available from the Australian Taxation Office website www.ato.gov.au/nonprofit.<br><br>Policies and procedures developed by and appropriate to the organisation, guide the activities of staff, Board members and volunteers of the organisation. | Governance Policy and related procedures.<br>Activities of the organisation align with legislation and policy.<br>Organisation operational policies and procedures.<br>Compliance register.<br>Legal compliance checklist. |
| Rating | Element | Evidence commonly presented |
| SA | (a) Organisational and service planning aligns with strategic objectives.<br>Operational Plans detail what the organisation will do to achieve the strategic plan's goals and objectives. Service development and subsequent activities contribute to achieve the organisation's strategic objectives. | Strategic Plan.<br>Current and previous operational plan(s).<br>Operational plans and activities.<br>Program/project specific plans and activities. |
| | (b) Clinical and non-clinical service planning reflects projected service demands.<br>Consultations, client data analysis and external environment scanning inform organisational and service planning. External environmental factors may include the political (e.g. change in government), social (e.g. change in a particular street drug's price and availability), economic (e.g. reduction in government grant funding) and technical (e.g. mandatory electronic performance reporting). Internal organisation considerations include future human resources requirements, building and infrastructure needs, technology requirements, future compliance costs, etc. | Documented analysis of consultations, client data, external and internal factors.<br>Documented Board, management and staff planning activities.<br>Current and previous operational plan(s). |
| | (c) Planning identifies priority areas for care / service development and the most efficient use of resources.<br>The organisation utilises data to inform priority areas for delivering services. This data may be sourced through staff's day-to-day experiences, client information, and external trends. Available resources are clearly defined and allocated. | Documented analysis of consultations, client data, external and internal factors.<br>Documented Board, management and staff planning activities.<br>Current and previous operational plan(s).<br>Organisation budgets and financial plans. |
| | (d) Stakeholders and where appropriate, consumers / patients and carers are involved in the development and implementation of plans. | Documented planning activities with client and stakeholder involvement. |

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| | The organisation utilises the knowledge and experience of external stakeholders, clients and others to develop and implement strategic and operational plans. Contribution may be through involvement in strategic and operational planning sessions, written submissions, feedback surveys, group forums, and individual interviews. Involvement in implementation of plans may be through assigning roles and responsibilities for certain activities, including partnership meetings, shared service delivery, and volunteer work. | Client and stakeholder planning consultations, interviews, surveys.<br>Operational and other plans – delegation of responsibilities.<br>Memorandum of understanding / service agreements. |
| | (e) Relationships with relevant external organisations are formally recognised in the planning process.<br>Strategic, operational and program/project planning recognises external organisations and stakeholders, their role in the planning process and their role in supporting the organisation. | Documented planning activities with client and stakeholder involvement.<br>External Relationship Policy and related procedures.<br>Memorandum of understanding / service agreements.<br>Strategic, operational and program / project plans. |
| | (f) Change and risk management strategies are documented to achieve the objectives of the strategic and operational plans.<br>The organisation recognises that implementing strategic and operational plans requires organisational change and development. An effective change management process includes clear communication of the vision and rationale for change, as well as having a leader to guide and support the organisations and individuals through the change. Change management considers the risks and barriers for successfully implementing and achieving strategic and operational plans and identifies responsive actions. | Operational and program / project plans identify responsibilities and address risks and barriers to implementation. |
| | (g) Planned changes are clearly communicated to relevant stakeholders.<br>The organisation communicates with staff, clients and external stakeholders on the planned changes to the organisation, including its values, mission / vision, and services. Internal communication may occur through direct staff notices and meetings, newsletters and other publications. External communication may occur through publication distribution, website notice, and meeting/forum presentation with stakeholders. | Communications Policy and related procedures.<br>Communication plans.<br>Documented communication activities. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The governing body evaluates progress towards achieving the vision, goals and strategic objectives of the strategic plan, and takes remedial action as required.<br>Supported by management and staff, the organisation's Board reviews organisation achievement against stated objectives and performance measures. Reviews identify supporting factors, barriers, and internal and external influences, as well as achievements beyond those planned. Reviews by the Board may be done at the midpoint of the strategic plan, every 12 months or on another regular schedule. Responding actions to reviews are documented and actioned to support the organisation in ongoing achievements. | Operational plans – schedule of review activities.<br>Board meeting minutes – review activities.<br>Strategic plan review reports and responding actions undertaken. |
| | (b) Changes driven by the strategic plan are evaluated in consultation with relevant stakeholders.<br>The organisation reviews its services and activities, including those that have been implemented from new or reviewed strategic and operational plans. | Quality improvement review schedule.<br>Documented review and improvement activities.<br>Client, staff and external feedback – reports and action undertaken. |

Performance measures

Suggested performance measures for this criterion are on page 382 of *The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Implementation and review of strategic plan. | Bi-monthly meeting established to review progress of implementing key activities of the strategic and operational plans, with staff elected representative to provide feedback from an operational perspective. | Staff have an improved understanding of how the strategic plan relates to their day-to-day work, as well as having more information on performance measures and progress, leading to improved engagement.<br><br>Staff are provided with development opportunity through participating in managers and Board meetings. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Develop and distribute to staff, clients and stakeholders, an annual brief progress report against strategic plan objectives. | Chief Executive Officer | September 2013 |

## Standard 3.1: The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services

### 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 structures and processes are in place for effectively managing the organisation, individual roles and responsibilities are understood, and there are clear channels of communication and accountability.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 384 for further information, including the relationship 3.1.2 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) The governing body is aware of its role for strategy and monitoring.<br>Board members are informed of their responsibilities, including those relating to developing, guiding and reviewing corporate practice and service delivery. | Governance Policy and related procedures.<br>Board orientation manual.<br>Board position descriptions / duty statements.<br>Functions and delegations matrix – Board responsibilities identified. |

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| | | Organisation's Constitution.<br>Board meeting agendas and minutes.<br>Signed Board member agreements – Code of Conduct, position descriptions / duty statements.<br>Board member interviews. |
| | (b) The governing body's duties and responsibilities are defined, documented and comply with relevant legislation.<br>Board members' responsibilities are identified, documented and available to Board members and other internal and external stakeholders. The responsibilities comply with relevant legislation such as the *Associations Incorporation Act 2009*, *Corporations Law Act 2001* or the *Australian Corporations (Aboriginal and Torres Strait Islander) Act 2006*. Responsibilities of the President, Vice President, Treasurer, Secretary and Ordinary Board members are defined. | Governance Policy and related procedures.<br>Board orientation manual.<br>Board position descriptions / duty statements.<br>Functions and delegations matrix – Board responsibilities identified.<br>Organisation's Constitution.<br>Signed Board member agreements – Code of Conduct, position descriptions / duty statements. |
| | (c) Leaders and managers understand their role as promoters of organisational culture.<br>The organisation's identified leaders and managers are aware of and understand how they contribute to the organisations' patterns of beliefs, attitudes, values and behaviours. Their role is communicated before and throughout their employment. | Employee position descriptions.<br>Functions and delegations matrix – leaders' responsibilities identified.<br>Performance and Development Reviews – reference to strategic and operational leadership, schedule of reviews.<br>Interviews with Board members and staff. |
| | (d) Terms of reference, membership and procedures are in place for meetings of the governing body.<br>The organisation has documented and known policies and procedures to guide the operations of Board meetings, including the structure, roles, responsibilities and administration. | Governance Policy and related procedures.<br>Governance Policy and related procedures.<br>Board and subcommittee meeting agenda template.<br>Board and subcommittee meeting minutes template.<br>Board and subcommittee meeting terms of reference.<br>Board meeting minutes. |
| | (e) A formal delegation system exists.<br>A documented delegation matrix exists to communicate role, responsibility and accountability expectations of all staff, particularly senior staff and managers, and Board members. The delegation matrix incorporates situations for temporary delegations and includes the limits of delegation for each position. | Functions and delegations matrix.<br>Employee position descriptions.<br>Board position descriptions / duty statements. |
| | (f) A formal system to appoint senior managers exists that identifies the accountability of managers for the safe provision of services.<br>The organisation has policies and procedures for the recruitment of all employees. All employee position descriptions identify role and responsibility expectations. | Human Resources Management Policy and related procedures.<br>Employee position descriptions. |
| | (g) A system exists to govern decision making with ethical implications.<br>The organisation provides mechanisms and opportunities that support staff in addressing and responding to ethical situations that may arise. Ethical situations may include priority access to services, adapting services/programs in recognition of client and community cultural or religious beliefs, service exclusions, or conflicts of interest for | Clinical supervision processes.<br>Specific advisory committees.<br>Program and service development committees.<br>Staff meeting agendas and minutes. |

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| | employees. Beyond policies and procedures, the organisation may implement forums for discussion and guidance on ethical situations that carry significant risk as well as smaller, everyday challenges. The Board and/or subcommittees may act as the final point of decision making for ethical situations that carry significant risk. External advice may be utilised to inform ethical decision making. | Board meeting agendas and minutes.<br>Employee position descriptions.<br>External consultations. |
| | (h) There are records of ethical decisions that have been referred by a clinician to the nominated consultative body for ethical decision making.<br>The organisation maintains documentation of all ethical matters that have been referred by managers and direct client workers to the Board, subcommittees or other structured forum. Documentation includes the nature of the ethical decision, decisions made and action to be undertaken. Note that confidentiality and privacy boundaries apply. | Board and subcommittee meeting minutes.<br>Specific advisory committee meeting minutes. |
| | (i) Financial processes are consistent with legislative and government requirements.<br>The organisation has clearly documented guidelines on how finances are to be managed within the organisation and that they are informed and consistent with legislation and funding body requirements. Relevant legislation includes:<br>- *Associations Incorporations Act 2009* (NSW)<br>- *Cooperatives Act 1982* (NSW)<br>- *Corporations Act 2001* (Commonwealth)<br>- *Lotteries and Art Unions Act 1901* (NSW)<br><br>The organisation's financial guidelines are also informed by policies, standards and/or requirements from:<br>- Australian Accounting Standards www.aasb.gov.au<br>- Australian Tax Office www.ato.gov.au<br>- NSW Office of Fair Trading www.fairtrading.nsw.gov.au<br>- NSW Office of Industrial Relations www.industrialrelations.nsw.gov.au | Governance Policy and related procedures.<br>Financial Management Policy and related procedures.<br>Risk Management Policy and related procedures.<br>Functions and delegations matrix.<br>Board meeting agendas and minutes.<br>Financial reports to Board and funding bodies.<br>Budget planning and review activities.<br>Organisation Constitution.<br>External financial audit reports.<br>Funding and Performance Agreements. |
| | (j) The organisation has a budget development and review process.<br>In addition to overarching short and longer term financial planning, the organisation undertakes budget forecasting and review that addresses expected expenditure and actuals. Responsibilities for these activities are defined and followed. | Financial Management Policy and related procedures.<br>Organisation / program / project / service budgets.<br>Program / project / service development and review meetings.<br>Board meeting agendas and minutes.<br>Functions and delegations matrix.<br>Records from financial planning and budget review activities.<br>Annual reports. |
| | (k) Allocation of resources is based on the service requirements identified in the strategic and operational planning processes.<br>Development and review of budgets directly relates to the financial requirements of the organisation in order for it to work towards and achieve identified strategic and operational outcomes. To do this, the organisation needs to understand the costs of resources, equipment, facilities and maintenance, including such items as staff salary and on-costs, rent, utilities, client supports, etc. | Program / project / service costings / models.<br>Organisation / program / project / service budgets.<br>Board meeting agendas and minutes.<br>Financial planning and budget review activities. |
| Rating | Element | Evidence commonly presented |

| | | |
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| SA | (a) Members of the governing body receive formal orientation and ongoing education regarding their role.<br>The organisation ensures all Board members understand their role in guiding and monitoring the organisation and understanding the business and operations of the organisation. Orientation also includes expectations on how Board members relate to each other, employees, and external bodies and individuals. Role understanding may be supported by providing an orientation to the drug and alcohol sector, its history and development, current influences, challenges, and future outlooks. | Governance Policy and related procedures.<br>Board orientation pack.<br>Board member interview.<br>Board meeting agendas and minutes. |
| | (b) The vision, mission and values are demonstrated through the culture of the organisation.<br>Documentation, attitudes and behaviour of the Board and employees reflects that of the organisation, as demonstrated through their interactions with each other and with external bodies and individuals, as well as the services provided to clients and stakeholders, and the consistency of messages throughout the organisations written/electronic materials. | Governance Policy and related procedures.<br>Board orientation pack.<br>Human Resources Policy and related procedures.<br>Strategic and operational plans.<br>Staff Performance and Development Policy and related procedures.<br>Employee position descriptions.<br>Organisation brochures, website and publications. |
| | (c) Leaders and managers are educated in their role as promoters of organisational culture.<br>The organisation's identified leaders and managers are informed of and understand how they contribute to the organisation's patterns of beliefs, attitudes, values and behaviours. This role is communicated before and throughout their employment through position descriptions, staff supervision, and performance and development reviews. | Employee position descriptions.<br>Functions and delegations matrix – leaders' responsibilities identified.<br>Staff Performance and Development Policy and related procedures.<br>Staff professional development activities relating to leadership and management.<br>Interviews with staff. |
| | (d) The governing body ensures that committees have access to terms of reference, membership and procedures.<br>Board, subcommittee and other formal groups of the governing body document and distribute their terms of reference and address items such as membership, purpose, meeting schedule, relationship with other Board meetings, and administration. | Board and subcommittee meeting terms of reference.<br>Governance Policy and related procedures. |
| | (e) Minutes, decisions and actions of committee and governing body meetings are recorded and confirmed.<br>The organisation documents the discussions, decisions and actions of the Board and any subcommittees. This information is usually captured in Board meeting minutes; however decisions and actions undertaken outside of Board meetings may be recorded through email and saved electronically in a central repository. Documented discussions, decisions and actions are confirmed as accurate (or otherwise) by attendees. | Board and subcommittee meeting agendas and minutes.<br>Records of Board and subcommittee decisions. |
| | (f) Decisions of the governing body are implemented.<br>The organisation actions decisions and documents progress and completion. | Board and subcommittee meeting agendas and minutes – actions reported on.<br>Records of Board and subcommittee decisions and actions.<br>Operational plan progress reports. |
| | (g) The governing body receives, monitors and accesses issues referred for ethical consideration. | Governance Policy and related procedures. |

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| | The organisation's mechanisms support the Board to accept, review and determine actions in response to ethical issues referred by managers and staff. | Board and subcommittee meeting agendas and minutes.<br>Specific advisory committee meeting minutes. |
| | (h) The organisation has sound financial management practices that ensure its ongoing financial viability.<br>Financial management practices are guided by policies and procedures that align and are compliant with relevant legislation and standards. Both short and longer term financial planning considers current contractual requirements and future service development, expenses and external influences. | Financial Management Policy and related procedures.<br>Governance Policy and related procedures.<br>Annual reports.<br>External financial audit reports.<br>Organisation / program / project / service budgets.<br>Board meeting agendas and minutes.<br>Financial planning and budget review activities. |
| | (i) Useful, timely and accurate financial reports are provided to the governing body and managers with delegated financial authority.<br>The organisation develops and distributes financial reports on a regular schedule – monthly, bi-monthly, quarterly – for those identified with delegation. | Financial Management Policy and related procedures.<br>Governance Policy and related procedures.<br>Records of financial reports and their distribution.<br>Board meeting agendas and minutes.<br>Interviews with Board members and managers. |
| | (j) The governing body regularly shares information about its activities and decisions with relevant stakeholders.<br>The organisations' Board, and where relevant subcommittees, communicate relevant activity and decisions to stakeholders. This may be done through sharing of minutes from Board and subcommittee meetings, providing quarterly activity / progress reports, annual reports, newsletters and presentations. Distribution may be targeted to certain groups depending on relevance, privacy, legal boundaries and communication format. | Board and subcommittee meeting agendas and minutes distribution.<br>Organisation reports and formal communications.<br>Presentations regarding organisation activity / programs / services. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The vision, mission and values of the organisation are evaluated and changes are made as required.<br>The organisation reviews the currency and relevance of its stated vision, mission and values and makes changes where necessary. This may be undertaken as part of a strategic planning process and/or where external factors create significant impacts on the organisation. | Current and previous vision, mission and values statements.<br>Current and previous Strategic Plan.<br>Documentation of strategic planning sessions and progress to finalisation. |
| | (b) The governing body assesses its performance, and the performance of its members and improvements are made as required.<br>An effective Board regularly assesses its performance and reviews governance arrangements to ensure the organisation has the best structures, systems and policies in place to help it achieve its mission.<br><br>Missing membership skills or Board activities may be identified and be used to inform a Board development plan. Such a plan may list specific training for Board members, Board meeting presentations / in-services, meetings with specific groups / governments / politicians, restructuring governance arrangements, improving Board communication processes, etc. Progress and update against the Board development plan may be carried out as a short agenda item at each meeting, or every 3 months, and again after a year. | Board self-assessment / review template.<br>Board self-assessment / review reports.<br>Board Development Plans.<br>Board meeting minutes.<br>Board review and development activities – planning sessions, review of legal requirements, external and independent assessment. |

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| | (c) The governing body receives, evaluates and takes action to respond to reports on the quality of care and services.<br>A clear process exists for the Board to be informed of and respond to reports on the services the organisation has/is providing. Such a process may include managers providing performance reports to Board meetings covering client and stakeholder feedback, incident management, work health and safety (WHS) management and/or quality improvement. | Board and subcommittee meeting agendas and minutes distribution.<br>Quality Improvement Action Plan and progress reports.<br>Incident management and action reports.<br>WHS audit and action reports.<br>Client and stakeholder consultation reports.<br>Funding body feedback reports and other communication. |
| | (d) The outcomes of clinical ethical issues are reviewed and improvements are made as required.<br>Supported by management and staff, the organisation's Board reviews broader outcomes of ethical issues and decisions made, ensuring alignment with policies, strategic direction and relevant legislation. Continual improvement processes support ongoing development. | Board and subcommittee meeting agendas and minutes.<br>Quality Improvement Action Plan and progress reports.<br>Performance and activity reports. |
| | (e) Organisational structures and processes are reviewed to ensure quality services are delivered. | Board and subcommittee meeting agendas and minutes.<br>Organisation policies and procedures.<br>Quality Improvement Action Plan and progress reports.<br>Finance and human resource reports – budgets, actual, staff activity, staff satisfaction.<br>Current and previous organisation structure. |
| | (f) Compliance with delegations is monitored and evaluated and improved as required.<br>The organisation ensures that delegation responsibilities and boundaries are adhered to by implementing and reviewing policies, reviewing activity and delegation reports, regular employee performance and development reviews against performance requirements and external review of operations. Continual improvement processes support ongoing development. | Board and subcommittee meeting agendas and minutes.<br>Employee Performance and Development Reviews.<br>Reviews of functions and delegations matrix.<br>Compliance checklists and reports.<br>Finance reports.<br>Current and previous position descriptions.<br>External organisation reviews.<br>Quality Improvement Action Plan and progress reports. |
| | (g) The effectiveness of formally constituted committees is monitored, regularly evaluated and improved as required.<br>The organisation's Board and management reviews committee structures, processes, usefulness, and resource requirements to ensure quality, performance and governance are aligned and working together and support the organisation in its mission. | Board and subcommittee meeting agendas and minutes.<br>Subcommittee planning sessions, action plans, progress reports. |
| | (h) By-laws, operating requirements and management requirements are regularly reviewed to reflect current requirements.<br>The organisation's Board and management puts systems in place to ensure that the organisation stays informed of legislation and policy requirements, and practices are updated accordingly. | Organisation policies and procedures – current and previous.<br>Quality Improvement Action Plan and progress reports.<br>Compliance checklists and reports.<br>Connection to legislative and government bodies – email updates, memberships, etc.<br>Human resources, WHS, financial management, and clinical practices. |

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| | (i) Financial performance is evaluated and improved as required.<br>The organisation's Board and management reviews processes and outcomes of its financial management practice. Areas covered include:<br>- delegations<br>- planning and budgeting<br>- insurance program<br>- budget and expenditure comparison<br>- reporting<br>- internal control and security<br>- statutory compliance<br>- plans, actions and achievements. | Board and subcommittee meeting agendas and minutes.<br>Financial Management Policy and related procedures – current and previous.<br>Quality Improvement Action Plan and progress reports.<br>External audit reports.<br>Compliance checklists and reports.<br>Finance reports – budget and actual.<br>External review report of financial practices. |

Performance measures

Suggested performance measures for this criterion are on page 392 of *The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Board self assessment. | A Board self assessment tool was developed to measure current knowledge and skills, and identify areas for improvement. | Board members complete a self assessment on an annual basis and reflect on both their individual performance and the performance of the Board. Areas for improvement inform a Board development plan for the coming 12 months. |

Plans for Improvement

| No | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Develop Financial Management Policy. | CEO and Administration Officer | February 2014 |

## Standard 3.1: The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services

### Criterion 3.1.3

*Processes for credentialling and defining the scope of clinical practice support safe, quality health care*

The intent of this criterion is to ensure that the skills and competence of *all* drug and alcohol professionals are correctly aligned with the competence of an organisation, so that the right professionals are providing the right care and services in the right organisation.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 394 for further information, including the relationship 3.1.3 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) The governing body is aware of its responsibilities for ensuring services are provided by competent clinicians.<br>The Board is informed of what it must do to ensure that safe and quality care is provided by staff with the sufficient skills, experience and competencies, and that this is matched with the organisation's level of service provision, resources and support systems. | Board orientation manual.<br>Board position descriptions/duty statements.<br>Functions and delegations matrix – Board responsibilities identified.<br>Human Resource Management Policy and related procedures.<br>Employee position descriptions. |
| | (b) There is an organisational policy for credentialling clinicians within the organisation.<br>The organisation has a policy which defines the process of verifying the qualifications, experience, and other professional attributes of drug and alcohol, administration, and management staff. This process informs the assessment of an employee's knowledge, skills, attitudes and overall ability related to the relevant position. | Human Resources Management Policy and related procedures.<br>Staff Recruitment Procedure.<br>Employee Performance and Development Policy and related procedures. |
| | (c) There is an organisational policy for defining the scope of clinical practice of all clinicians within the organisation.<br>The organisation has a policy which defines the scope of practice by individual drug and alcohol professionals and other staff. Drug and alcohol professionals may include counsellors, social workers, psychologists, nurses, doctors, caseworkers, and client support workers. The policy identifies:<br>- relevant legislation<br>- responsibility for defining and monitoring the limits of practice<br>- professionals and positions required to be registered (i.e. nurses, psychologists)<br>- process and circumstances for reviewing and rescinding the scope of practice<br>- process for employees to appeal decisions regarding the scope of practice<br>- circumstances, if any, where drug and alcohol professionals may provide interventions outside their identified scope of practice. | Human Resources Management Policy and related procedures.<br>Employee Performance and Development Policy and related procedures.<br>Functions and delegations matrix.<br>Position descriptions.<br>Client Intervention Policy and related procedures. |
| | (d) Policy exists for the safe introduction of new interventions and treatments.<br>The organisation has policy and guideline for the delivery of all interventions and treatments, and clearly identifies the process and procedure for delivering new interventions and treatments. | Client Intervention Policy and related procedures.<br>Specific intervention guidelines / procedures. |
| Rating | Element | Evidence commonly presented |
| SA | (a) There is a credentialling system to confirm the formal qualifications, training, experience and clinical competence of clinicians.<br>The organisation's policy which details the process of verifying the qualifications, experience, and other professional | Human Resources Management Policy and related procedures.<br>Staff Recruitment Procedure.<br>Employee Performance and Development Policy and related |

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| | attributes of drug and alcohol professionals provides clear instruction on what individuals in the organisation must do to confirm a drug and alcohol professional's credentials at recruitment and throughout employment.<br><br>A drug and alcohol professional's credentials may be confirmed by demonstration of:<br>- university degrees<br>- fellowships / membership of professional colleges or associations<br>- registration by professional bodies<br>- certificates of service with previous employees<br>- certificate of completion of courses<br>- verifiable formal instruction or training<br>- validated competence<br>- professional referee reports.<br><br>Confirmation of registration for nurses, psychologists, doctors and several other health practitioners can be undertaken on the Australian Health Practitioner Regulation Agency website www.ahpra.gov.au.<br><br>A register or list of employees and the maintenance of their credentials may assist in monitoring currency. | procedures.<br>Employee position descriptions.<br>List of employees with credentialling requirements. |
| | (b) The process for assessing the credentials of applicants is consistent with national standards and guidelines, and with organisational policy.<br>Staff responsible for the recruitment and supervision of employees adhere to the organisation's policy on assessing applicants' credentials which is consistent with national standards and guidelines. | Human Resources Management Policy and related procedures.<br>Staff Recruitment Procedure.<br>Previous recruitment documentation.<br>Previous reviews of employees' credentials.<br>List of employees with credentialling requirements. |
| | (c) Ongoing monitoring and review of clinicians' performance is linked to the credentialling system.<br>The organisation's performance and development review processes incorporate ongoing review of employee credentials, such as evidence of current registration. | Human Resources Management Policy and related procedures.<br>Employee Performance and Development Policy and related procedures.<br>Performance and Development Review template. |
| | (d) A process for recommending the scope of clinical practice is consistent with national standards and guidelines and organisational policy.<br>The organisation provides staff with guidance on the process for defining the scope of clinical practice, including the development of position descriptions, review of staff performance, and developing and implementing new client related interventions and treatments. | Human Resources Management Policy and related procedures.<br>Employee Performance and Development Policy and related procedures.<br>Performance and Development Review template.<br>Quality Improvement Policy and related procedures. |
| | (e) The process of defining the scope of clinical practice is organisation or facility specific and relates to the role and capabilities of the organisation.<br>Consideration is given to the mission and goals of the organisation, contracted and other services to be provided, available resources and supports, other environmental factors, and the drug and alcohol professionals. | Organisation plans – strategic, operational, human resources, financial.<br>Funding / performance agreements.<br>Site specific orientation manuals.<br>Employee position descriptions. |
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| | (f) A process for reviewing the scope of clinical practice is in place and is defined as part of the appointment process.<br>The organisation regularly reviews the scope of practice for all positions, including individual employee practice, through performance and development reviews. | Organisation plans – strategic, operational, human resources, financial.<br>Human Resources Management Policy and related procedures.<br>Employee Performance and Development Policy and related procedures.<br>Performance and Development Review template.<br>Employee position descriptions. |
| | (g) Ongoing monitoring and review of clinicians' performance is linked to the system of defining the scope of clinical practice.<br>Employee performance and development reviews include a review of scope of clinical practice of individuals. Performance indicators and related measures are linked to clinical practice where appropriate. | Human Resources Management Policy and related procedures.<br>Employee Performance and Development Policy and related procedures.<br>Performance and Development Review template.<br>Employee position descriptions. |
| | (h) A system exists for the safe introduction of new interventions and treatments.<br>The organisation has policy and guidelines for the delivery of all interventions and treatments, and clearly identifies the process and procedure for delivering new interventions and treatments. Responsibilities and limitations are identified, as are timeframes for review, risk management and incident management. | Client Intervention Policy and related procedures.<br>Specific intervention guidelines / procedures. |
| | (i) The clinician's credentials are reviewed prior to the introduction of new services, procedures or other interventions.<br>The organisation undertakes an assessment of the organisation's capacity to deliver new services and interventions, including the resources, skills, knowledge, experience and expertise required by the employees. | Employee skill, knowledge and competency assessments.<br>Performance and development reviews.<br>Staff training sessions.<br>Records from staff meetings or clinical meeting where new services are developed. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The system for credentialling clinicians is reviewed, evaluated and improved as required.<br>The organisation ensures that the system / process for credentialling drug and alcohol professionals is regularly reviewed and improved as part of the organisation's quality improvement program. | Current and previous Human Resources Management Policy and related procedures.<br>Current and previous Employee Performance and Development Policy and related procedures.<br>Quality Improvement Action Plan and progress reports. |
| | (b) The system for defining the scope of clinical practice for clinicians is reviewed, evaluated and improved as required.<br>The organisation reviews how decisions are made regarding scope of practice to ensure safe and quality care is provided by appropriate personnel with appropriate resources and support. There is continual review and improvements made to ensure compliance with legislation and guidelines. | Current and previous Human Resources Management Policy and related procedures.<br>Current and previous Employee Performance and Development Policy and related procedures.<br>Quality Improvement Action Plan and progress reports.<br>Reports of staff feedback relating to scope of practice reviews. |
| | (c) The system for the safe introduction of new interventions and treatments is evaluated and improved as | Current and previous Client Intervention Policy and related |

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| | required.<br>The organisation reviews how new interventions are implemented and how to improve processes. | procedures.<br>Quality Improvement Action Plan and progress reports.<br>Reports of client, staff and stakeholder feedback relating to new interventions. |

Performance measures

Suggested performance measures for this criterion are on page 401 *of The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Update Human Resources Management Policy. | Policy updated to include processes for confirming applicants' credentials, as part of recruitment and performance and development review. The Staff Recruitment Procedure includes a checklist for identifying a number of credentialling requirements such as qualifications and registration with a professional body. | 100% of successful applicants' credentials are confirmed. |

Plans for improvement

| No | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Conduct an audit of personnel files to ensure all staff have up to date credentials. A report and action plan will address any non-compliance with Human Resources Management Policy. | Operations Manager | August 2013 |
| 2 | Develop a register of staff with credentialling requirements, and schedule annual credential checks. | Operations Manager | August 2013 and then annually |

## Standard 3.1: The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services

### Criterion 3.1.4
### External service providers are managed to maximise quality, safe health care and service delivery

The intent of this criterion is to ensure that external service providers are managed effectively to provide safe, quality care and services.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 404 for further information, including the relationship 3.1.4 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) Policy exists for the management of external service providers.<br>The organisation provides guidelines for staff in engaging with external service providers, both clinical and non-clinical. Guidelines address:<br>- delegations and responsibilities<br>- services to be provided externally<br>- financial boundaries<br>- identification and recruitment process<br>- risk management<br>- dispute management<br>- standards and regulation compliance requirements<br>- administrative requirements – documents, signatures, etc. | External Relationships Policy and related procedures.<br>Financial Management Policy and related procedures.<br>Consultant agreements / contracts.<br>Memorandum of Understanding / Partnership Agreements.<br>Functions and delegations matrix. |
| Rating | Element | Evidence commonly presented |
| SA | (a) External service providers can demonstrate compliance with relevant regulatory requirements.<br>Engaged external service providers demonstrate compliance with relevant standards and regulation. The organisation is responsible for confirming compliance on initial engagement and monitoring if in a long-term arrangement. Compliance requirements may relate to:<br>- food services<br>- pathology services<br>- trade services - electricians, plumbers, builders, etc<br>- linen services<br>- clinical services – psychologists, nurses, etc. | External Relationships Policy and related procedures.<br>Consultant agreements / contracts.<br>Memorandum of Understanding / Partnership Agreements.<br>Compliance register. |
| | (b) Services provided externally are consistent with specific standards.<br>The organisation ensures that services from external providers are consistent with standards set by the organisation. These standards may reflect, or be greater than, those set by other bodies. For example, a minimum number of years experience or qualifications for certain service provision; and/or organisational accreditation. | External Relationships Policy and related procedures.<br>Consultant agreements / contracts.<br>Memorandum of Understanding / Partnership Agreements.<br>Minimum standard requirements for specific services. |
| | (c) There are documented agreements with all external service providers that include performance measures.<br>The organisation has documented agreements with external service providers that identify service expectations of service delivery (numbers, quality, range, reports, products, etc), cost, performance measures, and timelines. A range of documentation may be used, depending on the type of service being provided. Examples include:<br>- consultant agreement / contract | External Relationships Policy and related procedures.<br>External service provider agreement templates.<br>Current external service provider agreements. |

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| | - memorandum of understanding / partnership agreement<br>- trade contract<br>- funding agreement<br>- service agreement. | |
| | (d) External service providers supply evidence of internal evaluation for the services that they are providing to the organisation.<br>Agreements with external service providers include a requirement to undertake and report on evaluation of the service they are providing. For example, an external organisation may trial staff training within the organisation, evaluate the training, and provide the organisation with a report outlining the process and impact of the training; or a food supplier may provide documentation on internal audits undertaken. | External Relationships Policy and related procedures.<br>Current and previous external service provider agreements.<br>External service provider reports and products. |
| | (e) Dispute resolution mechanisms are identified and communicated to the external provider.<br>The organisation clearly communicates the process for resolving disputes between the organisation and external parties, including in the external service provider agreement and in the organisation's policy and procedures. | External Relationships Policy and related procedures.<br>Current and previous external service provider agreements.<br>Feedback and Complaints Policy and related procedures. |
| Rating | Element | Evidence commonly presented |
| MA | (a) Agreements with external service providers are reviewed and improved as required.<br>Individual agreements with external service providers are reviewed throughout and at cessation of the agreement time schedule. Feedback from relevant internal and external provider staff informs ongoing improvement to the process and purpose of external provider engagement, and may inform whether ongoing engagement is to occur. | Current and previous External Relationships Policy and related procedures.<br>Quality Improvement Action Plan and progress reports.<br>Specific external service provider review reports.<br>Record of feedback and meetings from internal and external provider staff. |
| | (b) The organisation evaluates the performance of external service providers through agreed performance measures including clinical outcomes and financial performance where appropriate, and improvements are made as required.<br>Performance measures are identified in agreements with external providers, and the organisation reviews performance against these throughout and at cessation of the agreement time schedule. Performance measures may include:<br>- specific service delivery, e.g. five group counselling sessions, weekly cleaning of kitchens<br>- timeframes, e.g. fortnightly staff supervision for 12 months<br>- products to be provided, e.g. WHS assessment and action report<br>- quality and standard requirements, e.g. provide daily client meals following Food Standards Australia New Zealand (FSANZ) standards for food safety. | Current and previous external service provider agreements.<br>Specific external service provider review reports.<br>Quality Improvement Action Plan and progress reports.<br>Feedback and Complaints Policy and related procedures.<br>Feedback and complaint reports. |

Performance measures

Suggested performance measures for this criterion are on page 408 *of The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | External Relationships Policy and related procedures. | An External Relationships Policy was implemented. A Consultant Agreement template was also developed to be used when formally engaging an external service provider. | 100% of external service providers have a Consultant Agreement with clear performance measures. |

Plans for improvement

| No | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Develop list of previous and current external service providers, detailing contacts, services, time schedules, etc. | Operations Manager | December 2013 |

## Standard 3.1: The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services

### Criterion 3.1.5
### Documented corporate and clinical policies and procedures assist the organisation to provide quality, safe health care


The intent of this criterion is to ensure the organisation is guided by effective policy, and that employees, external contractors, volunteers, clients and other stakeholders are informed of policy, guidelines and processes relevant to their role within the organisation.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 410 for further information, including the relationship 3.1.5 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) The organisation is aware of relevant:<br>(i) legislation<br>(ii) professional guidelines<br>(iii) codes of practice<br>(iv) Australian standards<br>(v) codes of ethics.<br>The organisation identifies relevant corporate and clinical operating requirements which inform and are referred to throughout organisational policies and procedures. | Organisational policies and related procedures – reference to legislation, etc.<br>Policy Development Policy and related procedures. |

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| | (b) Documented corporate and clinical policies and procedures refer to by-laws, operating and management requirements.<br>The organisation's policies, procedures and supporting documents incorporate local, state and national operating requirements, and make reference to specific legislation, professional guidelines, codes of practice, Australian standards, and codes of ethics. | Organisational policies and related procedures – reference to legislation, etc. |
| Rating | Element | Evidence commonly presented |
| | (a) A framework for corporate and clinical policy and procedure development and review is in place.<br>Policy development is guided by the Policy Development Policy which details the essential elements to be included; such as the policy aim, expected outcomes, evidence and references used to inform the policy, delegation and authority, monitoring, review and updating.<br>A documented schedule for reviewing and updating policies also details those responsible for leading and participating in the review process. | Policy Development Policy and related procedures.<br>Quality Improvement Action Plan and progress reports.<br>Functions and Delegations Matrix. |
| | (b) Policies and procedures reference:<br>(i) current issues<br>(ii) Australian standards<br>(iii) legislation<br>(iv) professional guidelines<br>(v) codes of practice<br>(vi) codes of ethics<br>(vii) evidence.<br>The organisation's policies and procedures are informed by and reference specific corporate and clinical operating requirements, and components of those operating requirements, for example, the *Long Service Leave Act 1955*, or Section 8 of the *Long Service Leave Act 1955*. | Organisational policies and related procedures – reference to legislation, drug and alcohol intervention guidelines, etc. |
| | (c) A system exists that:<br>(i) audits compliance with relevant legislation<br>(ii) informs relevant staff of new or amended legislation<br>(iii) educates staff on relevant legislation applicable to their area of responsibility.<br>The organisation supports compliance with legislation by informing staff of specific legislation and providing guidance on its application and implementation. This may be achieved by providing orientation for new staff, regular in-services/training, written communication of legislative updates, staff being responsible for reviewing and updating policies, and/or registering for notice of legislative updates.<br>Compliance with legislation, policies and procedures is monitored through review of reportable incidents, spot-checks, knowledge and practice audits, general observation and external review. | Legal and Regulatory Policy and related procedures.<br>Compliance Register.<br>Legal Compliance Checklist.<br>Employee induction and orientation processes.<br>Staff in-services and training events related to legislation application and implementation.<br>Organisational policies and related procedures – detailing relevant legislation<br>Quality Improvement Action Plan and progress reports.<br>Employee position descriptions.<br>Performance and development reviews – compliance with organisational policy.<br>Communication mechanisms with staff – email notices, staff meetings, |

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| | letters, etc.<br>Spot check and audits reports.<br>Incident reviews and action plans. |
| (d) Stakeholders including staff are involved in the development of local policy and procedures.<br>Staff are actively involved in identifying, developing and reviewing policies relevant to their position, knowledge and/or skills. External stakeholders are consulted and engaged in the development and review of policies, where there is a relationship between the stakeholder and the organisation's practice. | Policy Development Policy and related procedures.<br>Quality Improvement Action Plan and progress reports.<br>Functions and Delegations Matrix.<br>Employee position descriptions.<br>Policy review reports. |
| (e) Changes to practice and service in clinical and non-clinical areas are reflected in updated policies and procedures.<br>The organisation has a policy review schedule to ensure governance, management and service delivery practice corresponds with that which is described in policies and procedures. The review schedule ensures all policies and procedures are reviewed within a minimum time-frame (such as every 2 years), when a new program or service commences and/or when new legislation or standards are established. | Current and previous policies and procedures.<br>Policy Development Policy and related procedures.<br>Quality Improvement Action Plan and progress reports.<br>Policy review reports. |
| (f) A system for document control is implemented.<br>The organisation provides guidance on how policy and procedure documents are to be prepared, referenced, disseminated, retracted, and stored. Systems for policy and procedure document control may include:<br>- spreadsheet list of current and previous documents with their title, status (draft, final), date of issue, lead author, date for review, and record of policy change and development<br>- final endorsement and quality check of all policies and procedures before dissemination<br>- standard numbering/referencing for all policies and procedures<br>- standard formatting for all policies and procedures<br>- separate network drive for all policies and procedures<br>- nominated staff member / position for the administration of policy and procedure documents<br>- limited editing access to electronic versions of policies and procedures<br>- policies and procedures for the storage and retention of organisational documents<br>- commercial software program for managing all organisational documents. | Policy Development Policy and related procedures.<br>Information Management Policy and related procedures.<br>Policy and procedure templates.<br>Quality Improvement Action Plan and progress reports – policy review schedule.<br>Electronic and hard filing system – structure, program, access.<br>List of previous and current policies and procedures and details of review. |
| (g) A process for the distribution and implementation of new and reviewed policies is in place.<br>The organisation has clear guidelines to ensure that all new and updated policies and procedures are communicated with staff for awareness, understanding and consistent application. Guidelines include how and when policy and procedure communication is to occur, and how policy and procedure is applied, such as:<br>- staff orientation and induction<br>- staff / team meetings<br>- staff policy and procedure working groups<br>- email, newsletters, hard and electronic copies for all staff, etc<br>- training sessions / in-services<br>- policies detail who they apply to and how they are applied step-by-step | Policy Development Policy and related procedures.<br>Information Management Policy and related procedures.<br>Staff meeting agendas and minutes.<br>Location of, and staff access to, hard and electronic policies and procedures.<br>Communication mechanisms with staff – email notices, staff meetings, letters, etc.<br>Previous notices of policy and procedure updates to staff.<br>Employee induction and orientation processes.<br>Policy and procedure template. |

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| | - staff work-plan meetings<br>- hard and electronic copies amended for each update. | Record of staff training / in-services relating to policy implementation. |
| | (h) There is adherence to by-laws, operating requirements and management requirements.<br>All relevant staff and volunteers act within the organisation's policies, procedures and external requirements (i.e. legislation, codes of practice). | Organisational policies and related procedures.<br>Staff and volunteer behaviour. |
| | (i) A system for monitoring compliance with policies and procedures is implemented.<br>The organisation ensures that staff and volunteers act according to the organisation's policies, procedures through monitoring systems, such as:<br>- reviews of incidents<br>- discussions with staff and volunteers – individual, team meetings, work-plan meetings<br>- staff and volunteer feedback<br>- supervisor observation<br>- external review and reporting<br>- WHS audits. | Policy Development Policy and related procedures.<br>Legal and Regulatory Policy and related procedures.<br>Compliance Register.<br>Legal Compliance Checklist.<br>WHS Policy and related procedures.<br>Team meeting minutes.<br>Performance and Development Review template.<br>Incident review reports and action plans. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The framework for policy development and review is evaluated and improved as required.<br>The organisation improves how policy needs are identified and subsequently how policies are developed, reviewed and improved. | Quality Improvement Action Plan.<br>Current and previous Policy Development Policy and related procedures. |
| | (b) Policies and procedures are regularly reviewed, updated and improved as required.<br>The organisation has a schedule for the review and improvement of all policies and procedures, as well as updating policies and procedures within the planned timeframe as required. | Quality Improvement Action Plan.<br>Current and previous policies and related procedures – demonstrating improvement over time. |
| | (c) The system for ensuring implementation of, and compliance with, key or amended legislative requirements is evaluated and improved, as required.<br>The implementation and compliance processes relating to key or amended legislative requirements is continually improved. | Quality Improvement Action Plan.<br>Current and previous Policy Development Policy and related procedures.<br>Current and previous Legal and Regulatory Policy and related procedures.<br>Reviews and reports of policy and legislative compliance – internal and independent. |

Performance measures

Suggested performance measures for this criterion are on page 415 *of The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Policy review schedule. | An electronic policy review schedule was developed, detailing:<br>- policy name<br>- date for review<br>- related procedures and other supporting documents<br>- lead staff responsible<br>- notes section (for summary of areas to be addressed, new legislation to look up, etc.).<br><br>The review schedule is discussed at staff meetings to identify upcoming policy reviews. | 100% of policies are reviewed within two months of their scheduled review period.<br><br>All staff are aware of the policy review schedule and their responsibilities relating to policy reviews. |

Plans for improvement

| No | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Audit of staff knowledge and practice relating to policy development and review. As required, workshops scheduled for staff. | Operations Manager and QI Officer | February 2014 |

## Standard 3.2: The organisation maintains a safe environment for employees, consumers / patients and visitors

### Criterion 3.2.1
*Safety management systems ensure safety and wellbeing for consumers / patients, staff, visitors and contractors*


The intent of this criterion is to ensure that organisations take responsibility for the health and safety of employees, contractors, management, clients and visitors via a comprehensive and integrated safety management system.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 418 for further information, including the relationship 3.2.1 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) Documented policies for safety management systems are in accordance with relevant jurisdictional legislation and include:<br>(i) workplace health and safety<br>(ii) workers compensation<br>(iii) manual handling<br>(iv) radiation safety<br>(v) management of dangerous goods and hazardous substances.<br>The organisation's Work Health and Safety Policy (and related procedures and supporting documents) and Human Resources Management Policy (and related procedures and supporting documents) are informed by, and adhere to, relevant legislation, including:<br>- *Work Health and Safety Act 2011* (NSW)<br>- *Work Health and Safety Regulation 2011* (NSW)<br>- *Industrial Relations Act 1996* (NSW)<br>- *Workers Compensation Act 1987* (NSW)<br>- *Workplace Injury Management and Workers Compensation Act 1998.* | WHS Policy and related procedures.<br>Human Resources Management Policy and related procedures. |
| | (b) Health and safety risks that may cause harm are identified.<br>Risk is the possibility that harm (death, injury or illness) might occur when exposed to a hazard (a situation or thing that has the potential to harm a person, such as moving heavy objects, using chemicals or electricity, a repetitive job, bullying and violence at the workplace). WHS risks specific to the organisation, services provided and location are identified by the organisation. Refer to WorkCover Authority of NSW 'How to manage work health and safety risks: Code of practice'. | WHS Policy and related procedures.<br>Human Resources Management Policy and related procedures.<br>Risk Management Policy and related procedures.<br>Risk register – health and safety.<br>WHS audit template.<br>WHS audit reports. |
| | (c) Staff are educated about and provided with information on workplace health and safety and their responsibilities.<br>The organisation provides orientation and training to staff on work health and safety, including risk identification, incident management, and their responsibilities. | WHS Policy and related procedures.<br>Human Resources Management Policy and related procedures.<br>Risk Management Policy and related procedures.<br>Employee induction and orientation processes.<br>Functions and Delegations Matrix.<br>Staff position descriptions. |
| | (d) External service providers are supplied with relevant information and comply with the organisation's health and safety requirements.<br>The organisation provides consultants, contractors and other external service providers with health and safety information relevant to the location and type of service being provided. Information provided may include:<br>- location of building emergency exits<br>- fire safety procedures<br>- incident response procedures<br>- health and safety expectations and responsibilities of external service providers<br>- staff contacts. | WHS Policy and related procedures.<br>External Relationship Policy and related procedures.<br>External service provider agreements.<br>General and organisation/site specific health and safety information – brochures, posters, orientation.<br>Visitor register. |

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| | (e) Occupational Health and Safety (OH&S) requirements are communicated to carers and visitors as required.<br>The organisation provides carers and visitors with health and safety information relevant to their service/site visits. Information provided may include:<br>- location of building emergency exits<br>- fire safety procedures<br>- incident response procedures<br>- health and safety expectations and responsibilities of carers and visitors<br>- staff contacts. | WHS Policy and related procedures.<br>Volunteer Policy and related procedures.<br>General and organisation / site-specific health and safety information – brochures, posters, orientation.<br>Visitor register. |
| | (f) There are documented policies and procedures on the procurement, management and disposal of dangerous goods and hazardous substances, and a register of hazardous substances is maintained.<br>The organisation's WHS Policy and related procedures provide clear guidance on how staff are to safely manage dangerous goods and hazardous substances, including purchasing, labelling, storage, handling and disposal of:<br>- needles / syringes and related injecting equipment<br>- blood and other bodily fluids<br>- printer ink cartridges and other chemicals<br>- cleaning products<br>- pest management chemicals and products.<br><br>A register of hazardous substances is maintained which details:<br>- product details – name, manufacturer<br>- storage location<br>- date of last audit.<br><br>Safety Data Sheets are installed for all dangerous goods and hazardous substances. A Safety Data Sheet is a document that provides information on the properties of hazardous chemicals and how they affect health and safety in the workplace. They include information on the identity, health and physio-chemical hazards, safe handling and storage, emergency procedures and disposal considerations. | WHS Policy and related procedures - managing dangerous goods and hazardous substances.<br>Safety Data Sheets posted at storage and use locations of hazardous substances.<br>Hazardous substances register. |
| | (g) A register is kept for all radiation substances, safe disposal of all radioactive waste and radiation equipment.<br>*This element has limited, if any, application in non government drug and alcohol organisations. Contact your ACHS Customer Services Manager for further advice.* | |
| | (h) A personal radiation monitoring system is in place, together with any relevant area monitoring.<br>*This element has limited, if any, application in non government drug and alcohol organisations. Contact your ACHS Customer Services Manager for further advice.* | |
| Rating | Element | Evidence commonly presented |
| SA | (a) Safety management systems are managed with reference to any relevant: | WHS Policy and related procedures – reference to operating |

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| | (i) Australian standards<br>(ii) legislation<br>(iii) codes of practice<br>(iv) industry guidelines.<br>WHS related policies, procedures and practices are informed by and reference operating requirements, such as the *Work Health and Safety Act 2011* (NSW), and profession relevant guidelines. | requirements and professional guidelines.<br>Staff interviews – knowledge and behaviour. |
| | (b) There is an organisation-wide system to assess health and safety risks, determine priorities and eliminate the risks or implement controls.<br>WHS policies and procedures link with other policies and procedures to ensure a holistic system of workplace health and safety. The WHS system incorporates: leadership from the Board and management; staff training and consultation; delegation of roles and responsibilities; resources to assess, respond and review to risks; and planning and budget development.<br>Refer to WorkCover Authority of NSW 'How to manage work health and safety risks: Code of practice'. | WHS Policy and related procedures.<br>Risk Management Policy and related procedures.<br>Functions and Delegations Matrix.<br>WHS resources and tools – audit guides, checklists.<br>WHS audit reports and action plans.<br>Record of staff WHS training.<br>WHS budget and expenditure.<br>Strategic and operational plans.<br>Risk management strategies – information, education, training, personal protective equipment (PPE), physical structures. |
| | (c) Service planning includes health and safety together with injury prevention strategies.<br>The organisation considers health and safety needs when developing or reviewing programs and service delivery, physical structures, site locations, resource requirements, budgets, and human resources. Consideration is given to: workplace entry and exits; work area layouts; flooring; lighting; temperature; welfare facilities (toilets, water, etc); outdoor work; and accommodation. Refer to WorkCover Authority of NSW 'Managing the work environment and facilities: Code of practice'. | Strategic and operational plans – WHS content.<br>Review and response to WHS audits and incidents.<br>Current and previous strategic and operational plans. |
| | (d) Staff are involved in decisions that affect workplace health and safety and wellbeing.<br>The organisation facilitates staff involvement in developing, implementing and reviewing workplace health and safety decision making. Refer to WorkCover Authority of NSW 'Work health and safety consultation, co-operation and co-ordination: Code of Practice. | WHS Policy and related procedures.<br>Risk Management Policy and related procedures.<br>Functions and Delegations Matrix.<br>WHS meetings – staff leadership and membership.<br>Staff meeting minutes – record of WHS decisions.<br>Board meeting minutes – record of staff WHS recommendations and subsequent decisions.<br>Staff interview. |
| | (e) There are documented safe work practices / safety rules for all relevant procedures and tasks.<br>The organisation provides staff with written guidelines for activities and tasks that have known or potential health and safety risks. | WHS Policy and related procedures.<br>Safety Data Sheets.<br>WHS signage and instruction throughout facility. |
| | (f) A hazards identification system identifies risks and implements controls, and takes corrective action.<br>The organisation's system of workplace health and safety includes processes for identifying and responding to risks. Processes include WHS audits, reporting, decision making, resource provision, information and education provision, | WHS Policy and related procedures.<br>WHS resources and tools – audit guides, checklists.<br>WHS audit reports and action plans. |

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| | action planning and implementation. | Safety Data Sheets.<br>Safety infrastructure – secure doors, personal alarms, PPE. |
| | (g) Manual handling risks in both clinical and non-clinical areas are assessed and appropriate controls are implemented.<br>The organisation identifies, assesses and implements controls in the management of manual handling risks. Identifying risks includes collecting information about previous manual handling incidents, consultation with staff, and observing practice. All identified risks are assessed with consideration of frequency and duration of task (i.e. data entry), postural factors (i.e. sitting at computer), load weight and other characteristics (i.e. moving furniture), environmental factors (i.e. outdoor group activities with clients), and staff experience (i.e. staff new to operating dishwasher).<br><br>A hierarchy of control is applied in response to identified risks. Commencing with level 1, the risk is to be eliminated with control measures. Where this is not practical or as a short term measure, level 2 includes substitution, isolation and engineering controls. Level 3 includes administrative controls, and level 4 refers to personal protective equipment controls. Refer to WorkCover Authority of NSW 'Hazardous manual tasks: Code of practice'. | WHS Policy and related procedures.<br>Specific manual handling procedures.<br>Safety Data Sheets.<br>WHS signage and instruction throughout facility.<br>WHS audit reports and action plans.<br>WHS incident reports and action plans.<br>Record of staff training in manual handling.<br>Staff delegations, responsibilities and restrictions. |
| | (h) There is an injury management program that reflects legislation.<br>The organisation's system of workplace health and safety is informed by the *Work Health and Safety Act 2011* (NSW) and the *Workers Compensation Regulation 2011* (NSW). Processes for managing workplace injuries, including the workers' prompt, safe and durable return-to-work include:<br>- treatment of the injury<br>- rehabilitation back to work<br>- retraining into a new skill or new job<br>- management of the workers compensation claim<br>- the employment practices of the employer.<br><br>Staff are made aware of workplace injury management processes through orientation, workplace notices and information provision, and these are reiterated following a workplace injury. | WHS Policy and related procedures.<br>Specific return to work procedures / guidelines for the organisation and staff.<br>Staff orientation procedures.<br>Injury management signage throughout facility.<br>Records of incidents requiring staff injury and return-to-work management.<br>Staff return-to-work plans.<br>Staff interviews. |
| | (i) Staff with formal OH&S responsibilities are appropriately trained.<br>Staff members identified as having formal WHS responsibilities are provided with time, resources and other support to attend accredited WHS training. Training may include first aid, fire safety, workers compensation, and WHS officer representative training. | WHS Policy and related procedures.<br>Records of staff WHS training – completed and scheduled.<br>Training attendance / completion certificates in personnel files.<br>Staff interviews. |
| | (j) There is a radiation safety management plan which is coordinated with external authorities.<br>*This element has limited, if any, application in non government drug and alcohol organisations. Contact your ACHS Customer Services Manager for further advice.* | |
| | (k) Consumer / patient radiation is kept to a minimum whilst maintaining good diagnostic quality.<br>*This element has limited, if any, application in non government drug and alcohol organisations. Contact your ACHS* | |

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| | *Customer Services Manager for further advice.* | |
| | (l) Staff exposed to radiation is kept low and reasonable achievable (ALARA).<br>*This element has limited, if any, application in non government drug and alcohol organisations. Contact your ACHS Customer Services Manager for further advice.* | |
| | (m) A radiation safety report is provided to the ethics committee on any research proposal involving irradiation of human subjects.<br>*This element has limited, if any, application in non government drug and alcohol organisations. Contact your ACHS Customer Services Manager for further advice.* | |
| Rating | Element | Evidence commonly presented |
| MA | (a) The safety management and injury management systems are evaluated and improvements are made to support safe practice and a safe environment.<br>The organisation's workplace health and safety system includes review of: policies; procedures; staff knowledge and application; risk management; incidents; physical environment; resources; budgets; and potential future needs. Data gathered informs ongoing development of the workplace health and safety system. | Current and previous WHS policies and related procedures.<br>WHS audit reports and action plans.<br>WHS incident reports and action plans.<br>Staff consultation and feedback reports.<br>Quality Improvement Action Plan. |
| | (b) The design and layout of the organisation's current or planned physical environment are evaluated.<br>The organisation reviews the current and planned physical environment with consideration of safe and effective use of space – equipment availability and placement, workstation design and placement, workflow efficiency and infection control, reduction or elimination of falls risks. Buildings where clients and other occupants sleep must comply with the Building Code of Australia (BCA) requirements, and organisations must undertake and pass a BCA Building Fire Safety inspection within each four year EQuIP cycle. | WHS Policy and related procedures.<br>WHS audit reports and action plans.<br>BCA Building Fire Safety inspection report.<br>External review reports.<br>Physical layout of buildings, offices and service sites. |

Performance measures

Suggested performance measures for this criterion are on page 426 *of The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | WHS Policy and related procedures reviewed to ensure compliance with current legislation and known best practice regarding safe management of injecting equipment. | WHS Policy and procedures were amended to include training for all staff, additional sharps bins installed, and emergency contact numbers provided to all staff and displayed in appropriate places. | 100% of staff understand their responsibilities and the procedure for managing discarded injecting equipment.<br><br>10% fewer incidents of discarded injecting equipment found on and surrounding premises. |
| 2 | Audit of all manual handling tasks. | Identification of all manual handling | 100% of staff understand their responsibilities and the procedure for all manual handling tasks. |

| No | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| | | tasks. Procedures and Safety Data Sheets developed, installed, communicated with staff, and training provided. | All manual handling tasks are guided by procedures and/or Safety Data Sheets. |

Plans for improvement

| No | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | External review of staff return-to-work program, with a focus on the process for managing worker psychological distress. | CEO and WHS Officer | December 2013 |

## Standard 3.2: The organisation maintains a safe environment for employees, consumers / patients and visitors

### Criterion 3.2.2
### Buildings, signage, plant, medical devices, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively

The intent of this criterion is to ensure that all buildings, signage, plant, medical devices, equipment, supplies, utilities and consumables owned or used by the organisation are managed to support a safe environment.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 428 for further information and the relationship 3.2.2 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) Documented policy / procedures for:<br>(i) buildings / workplaces<br>(ii) plant<br>(iii) medical devices and equipment<br>(iv) other equipment<br>(v) supplies<br>(vi) utilities<br>(vii) consumables<br>(viii) workplace design | WHS Policy and related procedures.<br>Specific manual handling procedures.<br>Safety Data Sheets.<br>WHS signage and instruction throughout facility.<br>WHS audit reports and action plans. |

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| | address health, safety and service requirements.<br>The organisation's Work Health and Safety Policy (and related procedures and supporting documents) are informed by, and adhere to, relevant legislation, including the *Work Health and Safety Act 2011* (NSW) and the *Work Health and Safety Regulation 2011* (NSW), and align with codes of practice. | |
| | (b) Medical devices are:<br>(i) selected<br>(ii) installed<br>(iii) operated<br>(iv) maintained<br>(v) repaired<br>(vi) calibrated where necessary<br>by competent, qualified people.<br>*This element has limited, if any, application in non government drug and alcohol organisations. Contact your ACHS Customer Services Manager for further advice.* | |
| | (c) Plant and equipment are installed and operated in accordance with manufacturer specification.<br>The organisation ensures the installation and operation of plant and equipment is in accordance with manufacturer specification, including testing, commissioning and obtaining of required licenses. Manufacturer's product information is available and used as guidance in operating and maintaining plant and equipment. Plant and equipment may range from the building's fire sprinkler system, motor vehicles, gas bottles, ovens and computers, to water kettles and toasters. | WHS Policy and related procedures.<br>Specific manual handling procedures.<br>Safety Data Sheets. |
| | (d) Plant logs exist and are in accordance with manufacturer requirements.<br>The organisation maintains a plant log / asset register to ensure plant and equipment is serviced or renewed/replaced as required. For example, schedule of fire extinguisher checks and replacement. | Asset Management Policy and related procedures.<br>Asset register.<br>Plant / equipment register – purchase, maintenance and replacement records. |
| | (e) There is a cleaning schedule for all areas of the building and for equipment.<br>The organisation establishes routine and emergency cleaning processes, identifying areas and specific surfaces/objects that are to be cleaned, those that are not to be cleaned, and those that are to be cleaned by specifically skilled/qualified personnel. | Contracts with external cleaners.<br>Cleaning schedule and tick-off of cleaning.<br>Standard of hygiene throughout the facility.<br>Infection Control Policy and related procedures. |
| | (f) Purchase and supply procedures ensure that products are available or that appropriate alternatives are supplied.<br>The organisation has a system of identifying and obtaining services and products that meet the needs of the organisation. The organisation may identify approved providers, services and products through purchasing guidelines, and detail provider name (e.g. Como Supermarket), specific product or product type (e.g. general groceries), purchase limitations (cost, number of items, specific items), method of payment (petty cash, business credit card) and delegations (e.g. Service Manager up to $200). Clear guidance is provided on the process of making payments and staff reimbursements. | Financial Management Policy and related procedures.<br>Approved provider list. |

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| | (g) There is clear external signage at appropriate locations.<br>The organisation provides external signage that clearly indicates:<br>- organisation / service / program name<br>- appropriate access routes<br>- hours of access<br>- after-hours access if applicable<br>- telephone numbers<br>- other health facilities in the area, such as accident/emergency facilities<br>- safe parking sites<br>- smoking rules. | External signage to and around the external facility. |
| | (h) The organisation has identified disability and cultural signage needs.<br>Location, access, and safe and welcoming visiting needs of staff, clients, carers, and other stakeholders are identified in reference to external and internal facility signage. | External signage to and around the external facility. |
| | (i) Disability access and facilities meet legislative requirements where they exist and/or are based on recognised guidelines.<br>The organisation's access and available facilities are informed by and comply with disability related legislation and/or are based on recognised guidelines. | External signage to and around the external facility.<br>Disability accessible buildings and facilities. |
| | (j) The organisation has procedures that ensure the efficient and sustainable use of energy and water.<br>The organisation recognises energy and water cost and resource savings by implementing practices that create efficiencies and are more sustainable, including purchasing electrical products with a high energy saving rating, using tap filters, turning off electrical equipment (computers, TVs), installing water tanks, and using energy-efficient light globes. | Physical existence of energy efficient electrical products, water tanks, etc. |
| Rating | Element | Evidence commonly presented |
| SA | (a) There is a system to plan, manage and operate:<br>(i) buildings / workplaces<br>(ii) plant<br>(iii) medical equipment / devices<br>(iv) supplies<br>(v) utilities<br>(vi) consumables<br>The organisation has processes that identify, obtain, maintain and utilise physical facilities, devices, products, utilities, and consumables that consider sustainability, accessibility and ergonomics. | WHS Policy and related procedures.<br>Asset Management Policy and related procedures.<br>Asset register.<br>Plant / equipment register – purchase, maintenance and replacement records.<br>Function and Delegation Matrix. |
| | (b) Buildings, plant, medical devices and equipment, utilities, consumables and supplies are managed with reference to any relevant: | WHS Policy and related procedures – reference to legislation, etc.<br>Specific manual handling procedures. |

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| | (i) Australian standards<br>(ii) legislation<br>(iii) codes of practice<br>(iv) industry guidelines.<br>The organisation's Work Health and Safety Policy (and related procedures and supporting documents) are informed by, and adhere to, relevant legislation, including the *Work Health and Safety Act 2011* (NSW) and the *Work Health and Safety Regulation 2011* (NSW), and align with codes of practice. | Safety Data Sheets. |
| | (c) Relevant staff are trained in the safe and appropriate use of medical devices and equipment.<br>The organisation ensures that staff using medical equipment are trained in its safe and appropriate use. | Staff training register.<br>Record of in-services / education sessions. |
| | (d) There is a documented, planned and coordinated preventative maintenance system.<br>The organisation has processes that maintain the safety, cleanliness and good working order of physical facilities, devices, and utilities in order to prevent breakage, malfunctioning and injury. | WHS Policy and related procedures.<br>Asset Management Policy and related procedures.<br>Asset register.<br>Plant / equipment register – purchase, maintenance and replacement records.<br>Function and Delegation Matrix. |
| | (e) The organisation provides resources that support cleaning requirements.<br>Staff, products and equipment are available for the type and schedule of cleaning required to maintain a safe and healthy facility. | Dedicated cleaner positions and staff.<br>Position descriptions include cleaning activity requirements as relevant.<br>Staff training – cleaning of facilities, equipment.<br>Cleaning products and equipment.<br>Staff interview. |
| | (f) Services / departments are sign posted appropriate to the needs of the community and the organisation.<br>Organisations display external and internal signage to assist staff, clients and visitors in identifying, locating and accessing the facility; with consideration given to language, visibility, and literacy. | Accessible signage to, around and within the facility. |
| | (g) Sign posting reflects the use of multilingual / international symbols appropriate to the community's needs.<br>Organisations display external and internal signage to assist staff, clients and visitors in identifying, locating and accessing the facility; with consideration given to language, visibility, and literacy. Community languages and symbols are used as relevant. | Accessible signage to, around and within the facility. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The safety and accessibility of the buildings / workplace, and the safe and consistent operation of plant and equipment, is evaluated, and improvements are made to reduce risk.<br>The organisation improves safety and accessibility through a schedule of review and update to policies, procedures, equipment, signage, staff knowledge and application. Areas for improvement are identified and applied. | Current and previous WHS policies and related procedures.<br>WHS audit reports and action plans.<br>WHS incident reports and action plans.<br>Staff consultation and feedback reports.<br>External review reports. |

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| | | Quality Improvement Action Plan. |
| | (b) The acquisition, use, maintenance and storage of medical devices / medical equipment is monitored and evaluated.<br>The organisation improves processes for medical equipment management through a schedule of review and update to policies, procedures, equipment, signage, staff knowledge and application. Areas for improvement are identified and applied. | Current and previous WHS policies and related procedures.<br>Current and previous asset management policies and related procedures.<br>WHS audit reports and action plans.<br>WHS incident reports and action plans.<br>Staff consultation and feedback reports.<br>External review reports.<br>Quality Improvement Action Plan. |
| | (c) Maintenance and replacement of buildings, plant, medical and other equipment is planned, prioritised and budgeted for.<br>The organisation considers the current and future building, plant, medical and other equipment needs to ensure safe and effective delivery of services. Specific budgets / line items are given to the maintenance and replacement of building, plant, medical and other equipment. | Organisational budgets.<br>Current and previous asset management policies and related procedures.<br>Plant / equipment register – purchase, maintenance and replacement records.<br>Purchase and maintenance receipts. |
| | (d) Incidents and hazards associated with building, plant, medical devices, equipment, utilities, consumables and supplies are documented, evaluated, and action is taken to reduce risk.<br>The organisation improves processes for incident and hazard management through a schedule of review and update, as well as following up any incidents related to building, plant, medical devices, equipment, utilities, consumables or supplies. | Current and previous WHS policies and related procedures.<br>Current and previous asset management policies and related procedures.<br>WHS audit reports and action plans.<br>WHS incident reports and action plans.<br>Quality Improvement Action Plan.<br>Current and previous risk register. |
| | | |
| | (e) The quality of cleaning practices is evaluated and improved as required.<br>The organisation reviews the cleaning practices of all sites with consideration of: safe and effective use of equipment and products, standard of hygiene and infection control, skill and training needs of responsible staff (and clients if relevant), incidents of infection, cost and resourcing, and new requirements. | WHS audit reports and action plans.<br>WHS incident reports and action plans.<br>Quality Improvement Action Plan.<br>Current and previous cleaning guidelines.<br>Staff and client consultation reports.<br>External review report. |
| | (f) The organisation regularly evaluates whether the signage meets community needs and makes necessary improvements.<br>The organisation ensures facility signage is accessible, safe and welcoming for communities through scheduled review and update. Feedback is sought from clients, carers and other stakeholders and improvements are made. | External stakeholder consultation reports.<br>External review report.<br>Quality Improvement Action Plan.<br>Reviews against known best practice/standards. |
| | (g) Energy and water use is evaluated annually and improvements are made to enhance efficiency.<br>The organisation reviews electricity, gas and water use, and identifies strategies to enhance efficiency with the view of reducing overall costs and acting more sustainably. Practices implemented may include installing water tanks, | Current and previous physical infrastructure – water tanks, window coverings, shade areas, efficient lighting.<br>External review report. |

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| | using grey water, and installing window shades. | Quality Improvement Action Plan. |

Performance measures

Suggested performance measures for this criterion are on page 435 *of The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Cleaning schedule developed. | Cleaning schedule developed for all buildings and equipment, detailing responsibilities, timing, areas/items to be cleaned (or otherwise) and linked to relevant cleaning procedures. | Cleaning and other staff better understand their duties and responsibilities.<br>Allocation of human resources for cleaning is more accurate resulting in less staff stress and improved facility hygiene.<br>Purchasing of cleaning products and equipment is more accurate, ensuring resources are available as required and that it is easier to monitor use. |

Plans for improvement

| No | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Review internal and external signage, to ensure accessibility needs are met, and that clear direction and instruction are provided for emergency situations and when using equipment/products. | WHS Officer and Quality Improvement Coordinator | April 2014 |

## Standard 3.2: The organisation maintains a safe environment for employees, consumers / patients and visitors

### Criterion 3.2.3
### Waste and environmental management supports safe practice and a safe sustainable environment

The intent of this criterion is to ensure that the organisation demonstrates safe practice and a responsible environmental approach to waste management.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 438 for further information and the relationship 3.2.3 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|

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|---|---|---|
| LA | (a) There is an organisation wide waste and environmental management policy.<br>The organisation has a waste management policy that guides the safe collection and disposal of waste, including paper, plastic, food, medical/clinical, electronic devices (computers, fridges, etc), clothing and linen. The policy aims to protect health and safety, provide a safe work environment, reduce waste handling, volume and costs, and minimise environmental impact. | Waste Management Policy and related procedures. |
| | (b) Waste management streams are identified and signage is displayed.<br>The organisation provides guidance on the types of waste it produces and displays signage for collection, storage and disposal. For example, distinction is made between paper, plastic and general waste bins with specific symbol and text signs. Hazardous waste collection bins are clearly identifiable with recognised symbol and text signs. | Waste signage displayed throughout the facility and around waste bins. |
| | (c) Staff are instructed in, and provided with, information on their responsibilities in waste and environmental management.<br>All staff are provided with information and where relevant training, on their responsibilities of the safe and environmental management of organisational waste. Initial instruction is provided at orientation, with additional information and training provided when there is a change in how the organisation manages waster, legislative amendments, new/updated codes of practice, etc. | Waste Management Policy and related procedures.<br>Staff orientation procedures.<br>Staff orientation checklist.<br>Records of staff waste management training / in-services – completed and scheduled. |
| | (d) External service providers comply with any requirements for the handling, transport and disposal of waste.<br>External contractors employed to collect, transport and dispose of the organisation's waste are correctly licensed and operate in accordance with legislation and codes of practice. | Waste Management Policy and related procedures.<br>External waste management provider contracts. Copies of external waste management provider licenses, accreditation and audits. |
| | (e) There is a policy to reduce carbon emissions and improve environmental sustainability.<br>The organisation's waste management policy and procedures include guidance on reducing carbon emissions, including water and electricity efficient practices, and recycling where possible. | Waste Management Policy and related procedures. |
| Rating | Element | Evidence commonly presented |
| SA | (a) Waste is managed with reference to any relevant:<br>(i) Australian standards<br>(ii) legislation<br>(iii) codes of practice<br>(iv) industry guidelines.<br>The organisation's waste management policy and procedures are informed by and reference legislation, standards, codes of practice and industry guidelines. The Australian Government Living Greener website www.livinggreener.gov.au provides information on environmental sustainable practices. | Waste Management Policy and related procedures – reference to legislation, etc. |
| | (b) Controls are implemented covering identification, handling, separation and segregation of clinical, radioactive and hazardous waste and non-clinical waste.<br>The organisation provides guidance in identifying and managing all waste types. Guidance includes policies, | Waste Management Policy and related procedures.<br>Staff orientation procedures.<br>Staff orientation checklist. |

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| | procedures, orientation, training, signage, resources (bins, tools, etc.), spot checks, audits, review of incidents, external review, and scheduled review and updates of these. | Waste management audit reports and action plans.<br>Waste management related incident reports and action plans.<br>External review reports.<br>Resources and signage throughout the facility.<br>Quality Improvement Action Plan. |
| | (c) There is a system to assess, separate, handle, transport and dispose of all waste streams.<br>The organisation's system of waste management includes processes for identifying, separating and storing waste types, as well as transporting and disposal of all waste types. Information is provided on what is considered paper, plastic, food (compostable or otherwise), medical / clinical, electronic devices (computers, fridges, etc), clothing, linen and building equipment, and who is responsible within and external to the organisation, and emergency procedures. | Waste Management Policy and related procedures.<br>Resources and signage throughout the facility.<br>Emergency response guidelines and signage throughout the facility. |
| | (d) Waste management systems are coordinated with external authorities.<br>The organisation's system of waste management aligns with relevant authorities, such as local council waste collection days, and this is communicated with staff to ensure safe and efficient collection and disposal of waste. | Waste Management Policy and related procedures.<br>Waste collection schedule – type of waste, collection days, internal responsibility, external contact details. |
| | (e) Recycling, reducing and reusing processes support resource conservation and waste and environmental management.<br>The organisation identifies safe recycling, reducing and reusing practices that contribute to environmental sustainability. This may include installing paper, plastic and metal recycling bins throughout the facility, double sided photocopying / printing, using environmentally-friendly products where possible (i.e. cleaning products), installing food compost bins / sites, buying items in bulk to reduce packaging, and donating old computers and mobile phones to recycling programs. | Waste Management Policy and related procedures.<br>Waste separation bins throughout the facility.<br>Composting and other recycling practices. |
| | (f) The system to reduce carbon emissions and improve environmental sustainability is implemented.<br>The organisation identifies and implements practices that support reducing carbon emissions, particularly related to water and electricity consumption. Practices may include installing energy efficient lighting, reducing the number of lights (while maintaining visibility safety), installing tap filters to reduce water flow / pressure, using captured water for laundry, toilets and external outlets, and replacing the lawn space with gardens. | Waste Management Policy and related procedures.<br>Action plans to reduce water and electricity consumption.<br>Completed actions to reduce water and electricity consumption. |
| Rating | Element | Evidence commonly presented |
| MA | (a) The waste and environmental management system is evaluated, and improved as required.<br>The organisation reviews waste management processes to ensure constancy with legislation and best practice, and identify areas for improvement in safe recycling, reducing and reusing, and waste disposal. | Current and previous Waste Management Policy and related procedures.<br>Waste management audit reports and action plans.<br>Quality Improvement Action Plan.<br>Staff and client consultation reports.<br>External review report. |
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| | (b) The system to reduce carbon emissions and improve environmental sustainability is monitored over time and improvements are implemented as required.<br>The organisation reviews its consumption of water, electricity and gas over time, and practices are implemented with the aim of reducing carbon emissions where possible. | Current and previous Waste Management Policy and related procedures.<br>Tracking of water, electricity and gas use.<br>Quality Improvement Action Plan.<br>External review report.<br>Activities to reduce water, electricity and gas use. |

Performance measures

Suggested performance measures for this criterion are on page 443 *of The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Reduce office and kitchen paper consumption. | Photocopier and printer set to double-sided printing. Single-sided printed waste paper used for printing of draft documents. Paper towels replaced with reusable/washable kitchen cloths. | Reduction in office paper purchasing and consumption by 15% over 6 month period.<br>Kitchen budget reduced by $25 per month over 6 month period. |

Plans for improvement

| No | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Investigate, and install if suitable, electricity saving devices that automatically turn off lights and products - timer switches, sensor lighting. | Operations Manager and Administration Officer | August 2014 |

## Standard 3.2: The organisation maintains a safe environment for employees, consumers / patients and visitors

### Criterion 3.2.4
*Emergency and disaster management supports safe practice and a safe environment*


The intent of this criterion is to ensure organisations have systems, policies, procedures and training programs that identify and manage potential emergency situations

that may arise internally or externally.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 446 for further information and the relationship 3.2.4 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) There is an organisation-wide policy for emergency and disaster management and business continuity.<br>The organisation has an emergency and disaster management policy that guides the identification, planning and response to internal and external emergency and disaster situations, with consideration of continuity of business and service delivery. | WHS Policy and related procedures.<br>ICT Policy and related procedures. |
| | (b) Likely emergencies are identified and response and evacuation plans are prominently displayed.<br>Potential and likely emergencies are identified and the organisation displays response and evacuation plans, including diagrams and exit paths. | WHS Policy and related procedures.<br>Emergency response posters throughout the facility. |
| | (c) Staff are educated and trained at orientation and annually in response to emergencies and in evacuation.<br>The organisation ensures all staff receive orientation and ongoing training in emergency response procedures. | WHS Policy and related procedures.<br>Staff orientation procedures.<br>Staff orientation checklist.<br>Annual schedule and record of staff training in emergency management. |
| | (d) Emergency practice / drill exercises including fire and evacuation are regularly conducted.<br>The organisation ensures emergency practice drills are planned and conducted to ensure all staff are familiar with the correct course of action. | WHS Policy and related procedures.<br>Schedule and record of emergency practice drills. |
| | (e) External service providers comply with the organisation's requirements for the prevention of emergencies.<br>The organisation ensures that external service providers, such as contractors and agency staff, receive orientation in emergency response procedures. External contractors and agency staff responsible for client care must also be briefed in emergency communication and evacuation procedures. | WHS Policy and related procedures.<br>Staff orientation procedures.<br>Staff orientation checklist.<br>Visitor security briefing/orientation. |
| | (f) There is documented evidence that an authorised external provider undertakes a full fire report on the premises at least once within each EQuIP cycle and in accordance with jurisdictional legislation.<br>Building fire safety inspections are undertaken at least once within the EQuIP 4 year cycle by an authorised provider for those buildings where occupants sleep. An authorised provider may be a registered building engineer, registered builder or a registered business authorised to undertake building fire safety inspections. A fire safety inspection will review structural fire safety against the Building Code of Australia (2010) with a fire safety report provided; generally identifying the premises' risk rating within a three tiered level.<br><br>Where the organisation does not own the premises in which it operates, the responsibility for undertaking building fire safety inspection reports falls to the premises owner. However, the organisation must demonstrate: | Fire safety reports.<br>Requests to premises owner to undertake building fire safety inspections.<br>Actions undertaken in response to building fire safety inspection reports.<br>Date checked fire safety equipment. |

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| | - it has formally requested the premises' owner to undertake fire safety inspections<br>- it has acted on any fire safety inspection reports where relevant and appropriate<br>- that other fire safety measures have been addressed (such as fire extinguishers, hose reels, alarms, etc).<br><br>Annual essential service checks include the inspection of fire safety equipment, including extinguishers, hose reels, and fire blankets.<br>*Contact your ACHS Customer Services Manager for further advice on fire safety requirements.* | |
| Rating | Element | Evidence commonly presented |
| SA | (a) There is evidence that the systems to manage emergencies operate with reference to any relevant:<br>(i) Australian standards<br>(ii) legislation<br>(iii) codes of practice<br>(iv) industry guidelines.<br>The organisation's emergency management policy and procedures are informed by and reference legislation, standards, codes of practice and industry guidelines. | WHS Policy and related procedures – reference to legislation, etc. |
| | (b) Business continuity plans have been developed to cover disasters / emergencies.<br>The organisation's disaster and emergency management system includes plans for the safe continuation of service delivery where possible. Planned actions may include reducing the type and volume of services provided, relocation of clients to an alternative facility, renting of temporary premises, and ceasing client intakes. | WHS Policy and related procedures.<br>ICT Policy and related procedures.<br>Business / service delivery continuity plans for specific situations – lengthy power failure, bushfire, flood. |
| | (c) There are systems for prevention, preparedness, response and recovery in emergencies, including triage and deployment of medical teams where appropriate.<br>*This element has limited, if any, application in non government drug and alcohol organisations. Contact your ACHS Customer Services Manager for further advice.* | |
| | (d) Internal and external emergency and disaster management plans are developed and reviewed in consultation with relevant authorities.<br>Emergency and disaster management plans are developed and reviewed with relevant authorities and community groups including police, ambulance, fire services, local council and the state emergency services (SES). Planning and review addresses key responsibilities and accountabilities within and external to the organisation, as well as communication procedures, emergency service access, equipment requirements, evacuation procedures and drills and debriefing processes. | WHS Policy and related procedures.<br>Schedule and record of emergency practice drills.<br>Record of meetings with emergency services. |
| | (e) Communication systems are in place to manage any emergencies or disasters.<br>The organisation's disaster and emergency management system addresses communication processes, including fire indicator panel and fire alarms (where relevant), land-line and mobile telephone, key responsibilities and accountabilities within and external to the organisation, and displayed instructions. | WHS Policy and related procedures.<br>ICT Policy and related procedures.<br>Emergency response posters throughout the facility.<br>Functions and Delegations Matrix.<br>Fire emergency devices - fire indicator panel, fire alarms. |

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| | (f) Relevant staff have access to first aid equipment and supplies and are trained in their use.<br>The organisation appoints a minimum number of staff as first aid officers in both clinical and non-clinical areas, and provides adequate training to enable them to respond to incidents requiring first aid. First aid kits appropriate to the workplace type and level of risk are accessible and positioned where there is a risk of physical injury – kitchen, laundry, garden sheds, and vehicles. The appointed first aid officers and their contact details are identified in posters throughout the facility. | WHS Policy and related procedures.<br>First aid officers.<br>First aid kits throughout the facility.<br>Schedule and record of first aid officer training.<br>Personnel files indicating first aid officer certificates. |
| | (g) There is an appropriately trained fire officer.<br>The organisation appoints fire safety officers relevant to the size and number of sites of the organisation, and provides adequate training to enable them to lead the response to fire emergencies. The appointed fire safety officers and their contact details are identified in posters throughout the facility. | WHS Policy and related procedures.<br>Fire safety officers.<br>Schedule and record of fire safety officer training.<br>Personnel files indicating fire safety officer certificates. |
| | (h) There is a documented plan to implement the recommendations from the fire action plan.<br>The organisation develops an action plan in response to building fire safety inspection recommendations. This may be a separate action plan, incorporated into a WHS action plan or be part of a broader quality improvement action plan. | Specific fire safety action plan responding to recommendations.<br>Quality Improvement Action Plan. |
| Rating | Element | Evidence commonly presented |
| MA | (a) Emergency and disaster management systems are evaluated, and improved as required.<br>The organisation undertakes scheduled reviews of emergency and disaster management systems to ensure consistency with legislation and best practice, and identify areas for improvement in planning, evacuation, staff training, communication and other aspects of emergency and disaster management. Additionally, the system is reviewed and improved following an emergency or disaster event. | Current and previous WHS Policy and related procedures.<br>Current and previous ICT Policy and related procedures.<br>Emergency / disaster event review reports and action plans.<br>Quality Improvement Action Plan.<br>Staff and client consultation reports.<br>External review report. |
| | (b) Staff training and competence in managing emergency procedures, including evacuation, is evaluated and improvements are made as required.<br>The organisation's processes in staff training and competency in emergency procedures are reviewed and improvements made. Scheduled reviews are undertaken as part of the broader emergency and disaster management system review, following an emergency or disaster event, and following emergency response drills. | Current and previous WHS Policy and related procedures.<br>Emergency / disaster event review reports and action plans.<br>Quality Improvement Action Plan.<br>Staff and client consultation reports.<br>External review report<br>Emergency response drill reports and action plans. |

Performance measures

Suggested performance measures for this criterion are on page 454 *of The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | | | |

| No. | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| | Schedule of emergency evacuation drills. | WHS Officer and Fire Safety Officer establish a schedule and conduct emergency evacuation drills. In addition to one drill per year with a known scheduled date and time, at least one drill per year is conducted on a date and time unknown to staff and Board, other than by the WHS Officer and Fire Safety Officer. | In 2012, three emergency evacuation drills were conducted, with time taken to evacuate facility and meet at the correct point improved from 15 minutes to 12 minutes. |

Plans for improvement

| No. | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Update monthly WHS audit to incorporate stock-take of first aid kits. | WHS Officer | July 2014 |

## Standard 3.2: The organisation maintains a safe environment for employees, consumers / patients and visitors

### Criterion 3.2.5
### Security management supports safe practice and a safe environment

The intent of this criterion is to ensure that the organisation manages security to maintain a safe environment for staff, clients and visitors.

Refer to *The ACHS EQuIP5 Guide – Book 2,* page 456 for further information and the relationship 3.2.5 has with other criteria.

| Rating | Element | Evidence commonly presented |
|---|---|---|
| LA | (a) There is an organisation-wide security policy.<br>The organisation addresses security management through a stand-alone policy or as part of the Work Health Safety (WHS) Policy. The policy considers the following: | WHS Policy and related procedures.<br>Information Management Policy and related procedures. |

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| | - procedures for a secure environment for staff, clients and visitors<br>- physical security to prevent and minimise verbal and physical acts of violence / aggression<br>- personal security for clients and visitors to be confident in the credentials and background of individuals from the organisation<br>- logical security that utilises communications, information technology and information management. | |
| | (b) Major security risks are identified.<br>With a focus on the environment, work practices, work arrangements and equipment used, the organisation identifies their major security risks and considers:<br>- What could happen (or what could go wrong)?<br>- How would it happen?<br>- What harm would it cause?<br>- Who or what would be harmed? | WHS Policy and related procedures.<br>Risk Management Policy and related procedures.<br>Risk register. |
| | (c) Staff are educated and provided with information in relation to security risks and responsibilities.<br>The organisation ensures all staff receive orientation and ongoing training in security risks, responsibilities and the organisation's security management. Security management information may be communicated through staff meetings, newsletters, email updates, in-services, etc. | WHS Policy and related procedures.<br>Staff orientation procedures.<br>Staff orientation checklist.<br>Annual schedule and record of staff training in security management.<br>Emails, newsletters, letters, etc. |
| | (d) External service providers are supplied with relevant information and comply with the organisation's security controls.<br>The organisation ensures that external service providers, such as contractors and agency staff, receive orientation in security management procedures. External contractors and agency staff responsible for client care must also be briefed in security management procedures. | WHS Policy and related procedures.<br>Staff orientation procedures.<br>Staff orientation checklist.<br>Visitor security briefing/orientation. |
| Rating | Element | Evidence commonly presented |
| SA | (a) There is an organisation-wide system to assess security risks, determine priorities and eliminate risks or implement controls.<br>The organisation's system of security management includes processes for identifying, assessing, prioritising and responding to security risks. Security risks are prioritised according to their risk level, with initial responses to be elimination where possible, or implementation of risk controls. | WHS Policy and related procedures.<br>Risk Management Policy and related procedures.<br>Risk register.<br>Security risk controls throughout facility – physical, staff training, etc. |
| | (b) The system to manage security risks and violence and aggression prevention operates with reference to any relevant:<br>(i) Australian standards<br>(ii) legislation<br>(iii) codes of practice<br>(iv) industry guidelines.<br>The organisation's security management system is informed by and reference legislation, standards, codes of | WHS Policy and related procedures – reference to legislation, etc. |

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| | practice and industry guidelines, including:<br>- *Work Health and Safety Act 2011* (NSW)<br>- *Work Health and Safety Regulation 2011* (NSW)<br>- Protecting People & Property: NSW Health Policy & Guidelines for Security Risk Management in Health Facilities 2003 (NSW Ministry of Health)<br>- Zero Tolerance Response to Violence in the NSW Health Workplace 2003 (NSW Ministry of Health)<br>- Drug and Alcohol Withdrawal Clinical Practice Guidelines 2007 (NSW Ministry of Health)<br>- Clinical guidelines for nursing and midwifery practice in NSW: Identifying and responding to drug and alcohol issues 2007 (NSW Ministry of Health) | |
| | (c) Service planning includes strategies for security management.<br>The organisation considers the current and future security needs in any program, service, equipment or infrastructure planning. Specific budgets / line items are given to the installation, maintenance and replacement of equipment such as duress alarms and adequate lighting, as well as staff training and education. The architectural design of buildings and facilities contributes to the security of staff, clients and visitors, e.g. front of house / reception counter height, physical accessibility to staff areas and personnel information. | Program, service, equipment and infrastructure plans.<br>Specific security plans.<br>Quality Improvement Action Plan. |
| | (d) Staff are consulted in decision making that affects organisational and personal risks.<br>The organisation facilitates staff involvement in developing, implementing and reviewing the security management system. | Quality Improvement Action Plan.<br>WHS audit reports and action plans.<br>WHS incident reports and action plans.<br>WHS Committee reports and meeting minutes.<br>Staff consultation reports.<br>Staff interviews. |
| | (e) There is an organisation-wide violence and aggression prevention program.<br>Security management incorporates violence and aggression prevention measures including:<br>- policies addressing zero tolerance, internal violence, aggression and bullying<br>- elimination of risk or risk reduction<br>- control strategies<br>- protocols for reporting violent incidents<br>- management commitment<br>- staff education about responding to violent incidents. | Quality Improvement Action Plan.<br>WHS Policy and related procedures.<br>Staff Performance and Development Policy and<br>Poor Staff Performance and Misconduct<br>Staff orientation procedures.<br>Board engagement in security management.<br>Incident reports and action plans.<br>Schedule and record of staff training on managing violent incidents. |
| | (f) Security management plans are coordinated with relevant external authorities.<br>Security management plans are developed and reviewed with relevant authorities and contractors including:<br>- police<br>- ambulance<br>- security company<br>- building / facility owners<br>- information technology and information management companies<br>- lock and key provider | WHS Policy and related procedures.<br>Record of meetings with relevant authorities.<br>External expertise audit reports of security systems. |

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| | - confidential waste management company<br>- employment screening authority<br><br>Plans and reviews address key responsibilities and accountabilities within and external to the organisation, as well as communication procedures, incident identification and response procedures, and incident debriefing processes. | |
| Rating | Element | Evidence commonly presented |
| MA | (a) Performance indicators are used to evaluate the security management system, and improvements are made as required.<br>The organisation establishes indicators to measure performance of organisational and personal security over time and as part of an ongoing quality improvement program. Schedule reviews of security management are undertaken as well as following a security incident. Performance against the indicators is tracked and improvements made to the security management system as required. | Current and previous WHS Policy and related procedures.<br>Current and previous Security Management Policy and related procedures.<br>Security incident reports and action plans.<br>Quality Improvement Action Plan.<br>Staff and client consultation reports.<br>External review reports. |
| | (b) The violence and aggression prevention program is evaluated, and improved as required.<br>The organisation's violence and aggression prevention strategies are reviewed and improvements made. Scheduled reviews are undertaken as part of the broader security management review, as well as following a violent or aggressive incident. | Current and previous WHS Policy and related procedures.<br>Current and previous Security Management Policy and related procedures.<br>Current and previous violence and aggression prevention strategies.<br>Quality Improvement Action Plan.<br>Staff and client consultation reports.<br>External review reports. |

Performance measures

Suggested performance measures for this criterion are on page 461 *of The ACHS EQuIP5 Guide – Book 2.*

Key improvements

| No | Title of key improvements | What did you change | Result / Outcome |
|---|---|---|---|
| 1 | Staff safety on home and community client visits. | A new procedure was implemented for staff conducting home or community based client visits, aimed at improving staff safety. All home or community based client visits are to be registered, with the staff member required to call-in on arrival and departure, and an identified site based staff member to respond if no call-in is made or if a security incident is identified. | Staff report increased safety and confidence in undertaking home and community based client visits, and demonstrate a clear understanding of the new procedure.<br><br>An audit of the home and community based client visit register from January to March 2013 (n=22) showed 91% adherence to the policy by relevant staff. |

Plans for improvement

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| No | Intended improvement | Responsibility | Timeframe |
|---|---|---|---|
| 1 | Identify funding and a registered trainer to provide aggression and violence management training for all staff. | Clinical Team Leader and CEO | September 2013 |
| 2 | Review and update WHS Policy and related procedures regarding security management in consultation with relevant external authorities. | WHS Officer and identified staff member | October 2013 |

[i] *Drug and Alcohol Treatment Guidelines for Residential Settings*, NSW Health, 2007

[ii] *Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines Professional Practice Guidelines,* NSW Health, 2008

[iii] Marsh, A., Dale, A. and Willis, L. 2007. A Counsellor's Guide to Working with Alcohol and Drug Users (2nd edition). WA Drug and Alcohol Office.

[iv] Australian Pharmaceutical Advisory Council (APAC). *Guiding principles for medication management in the community*. Canberra ACT; Commonwealth of Australia; 2006.

[v] Australian Pharmaceutical Advisory Council (APAC). *Guiding principles to achieve continuity in medication management.* Canberra ACT; Commonwealth of Australia; 2005.

[vi] Commonwealth of Australia. *National strategy for quality use of medicines.* Canberra, ACT; Commonwealth of Australia; 2002.

[vii] National Health and Medical Research Council (NHMRC). *Australian guidelines for the prevention and control of infection in healthcare*. Canberra ACT; Australian Government; 2010.

[viii] NSW Health. *A-Z of infectious diseases*. Sydney; NSW Health. Accessed from http://www.nsw.gov.au/publichealth/infectious/a-z.asp on 22 July 2011.

[ix] World Alliance for Patient Safety. *WHO guidelines on hand hygiene in health care*. Geneva, CH; World Health Organization; 2009.

[x] NSW Health. *Infection control policy*. Sydney; NSW Health; 2007.

[xi] Australian Injecting and Illicit Drug Users League (AIVL). *Treatment Service Users Project: Final Report.* Canberra, Australia; 2007.

[xii] Hinton, T. *Voices on choices: Working towards consumer-led alcohol and drug treatment.* Tasmania, Australia; Social Action and Research Centre, Anglicare Tasmania.

[xiii] Australian Commission on Safety and Quality in Health Care (ACSQHC). *Australian Charter of Healthcare Rights (for consumers).* Sydney NSW; ACSQHC; 2008.

[xiv] Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing, 2009, *Well proud: A guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services.* Victoria, Australia; Department of Health. 2009.

[xv] Multicultural Mental Health Australia. National Cultural Competency Tool (NCCT) for Mental Health Services. Parramatta NSW; 2010.

[xvi] NSW Health Care Interpreter Services. *Guidelines for working with interpreters for counselling & health care staff working with refugees*. NSW; NSW Health Care Interpreter Services. 2011. Available at: www.sswahs.nsw.gov.au/sswahs/refugee/pdf/Resource/FactSheet/FactSheet_14.pdf

[xvii] Mills K, Deady M, Proudfoot H, Sannibale C, Teesson M, Mattick R, Burns L, 2009, *Guidelines on the management of co-occurring mental health conditions in alcohol and other drug (AOD) treatment settings*, National Drug and Alcohol Research Centre, University of New South Wales, Sydney.

[xviii] Australian Council for Safety and Quality in Health Care. *Open disclosure standard: a national standard for open communication in public and private hospitals, following an adverse event in health care.* Canberra ACT; Australian Council for Safety and Quality in Health Care; 2003