(Competitive Paper)

Outstanding Achievement and Lessons Learned about Consumer/Patient-Centred Care in the Australian Healthcare System

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Abstract

The paper examines the Australian College of Health Standards' (ACHS) Evaluation and Quality Improvement Program (EQuIP) focusing on how the category of Outstanding Achievement (OA) performance is awarded and reported in Organisation Summaries in the area of consumer/patient-centred care, the term adopted by ACHS to address patient-focused care. Analysing outstanding achievements in healthcare is an important way to advance our understanding of healthcare innovation. EQuIP provides a unique resource for healthcare managers, but its very success can be daunting. The range of initiatives represented in the EQuIP database reflects the fact that healthcare delivery is multi-faceted, complex and evolving, involving multiple layers of government, and both public and private provision of care. Further, there are different models of healthcare delivery, for example, 'family-centred', 'hospital-centred' and multi-purpose programs. We outline the various standards, criteria and elements relating to consumer/patient-centred care in EQuIP. We develop a framework of patient-centred care to illustrate how the ACHS' outstanding achievement exemplars go beyond what is commonly understood as optimal practice in this area. We then analyse the organisational summaries in the 2007-2008 ACHS report using this framework. The summaries are produced at the end of an accreditation cycle and it is extremely difficult for a facility to attain an OA rating. The 2008-2009 summaries are the most comprehensive available at the time of writing this paper. We discuss the implications of our findings and

how the notion of outstanding achievement can be further developed as well as identifying areas for future research. **(248)**

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Introduction

In recent times Australia has endeavoured to move towards increased patient-focused or centred care. Despite these attempts there is the perception that more needs to be done. This perception is based partly on the lack of knowledge within the industry about the exemplary or standout examples currently operating in the health sector that are not sufficiently widely disseminated. This paper examines outstanding achievement (OA) in consumer/patient-centred care across healthcare facilities in Australia. The paper examines, for the first time, public domain empirical material produced by the Australian College of Health Standards (ACHS) accreditation surveys from 2007-2008 in which Organisation Summaries are produced as exemplars of outstanding achievement (ACHS 2009). While previous ACHS reports have produced similar summaries, the 2007-2008 one is the most comprehensive produced to date. The ability to compare this and other reports with future documents, such as the 2009-2010 report (due for release in late November, 2011), has the potential to inform a wide audience of healthcare policy makers and managers on current trends and patterns of successful innovations in the achievement of health care outcomes.

Given the patchiness of existing research, it is hard to get a handle on the breadth and scope of what patient-focused or centred healthcare covers in Australia, let alone elsewhere. In 2010 Braithwaite et al. published findings from their assessment of the ACHS' accreditation model or EQuIP and noted that of the 19 facilities in their study "…most participant organisations had low levels of consumer participation, suggesting, it is timely to review the way health services can involve consumers more effectively" (Braithwaite et al. 2010, p. 18).

The key findings of their study related to accreditations conducted to 2006. They argued that "…different approaches to consumer participation had to be trialled and evaluated" (2010, p. 19), noting that accreditation had helped some organisations to lift their game in this area but also argued that more had to be done in future accreditation.

Some evidence of what might constitute exemplars of patient-centred care is available and hence, why the EQuIP program affords a rare opportunity to explore outstanding achievement based on independent assessments by ACHS surveyors. The growing importance of accreditation has to be understood in the context of ever increasing pressure on governments to do more with their healthcare dollars. An effective, efficient and equitable healthcare system is vital. It is a critical part of the infrastructure that pays dividends in terms of increased productivity and economic growth. Governments are thus increasingly and appropriately focused on healthcare innovation leading to evidence based healthcare outcomes. To this end, ACHS set up EQuIP in 1996, which evaluates healthcare initiatives and encourages their dissemination (ACHS 2006). EQuIP underwent a significant program review and redevelopment in 2003, and provides for ACHS member organisations to be engaged in a four-year quality assurance and improvement cycle (Phase 1 – self-assessment; Phase 2 - organisation wide survey (OWS); Phase 3 -self-assessment; Phase 4 - periodic review (PR) (ACHS 2006, p. 7). The OWS and PR (Phases 2 and 4) involve both a healthcare organisation's self-assessment on achievements to ACHS' standards and criteria as well as independent assessment and ratings by healthcare professionals as trained ACHS surveyors.

The paper proceeds as follows. We outline the EQuIP program focusing on how the OA performance is awarded and reported in organisation summaries. A discussion follows on what patient-centred care means noting that it is a highly contested concept. The various

standards, criteria and elements relating to consumer/patient-centred care are discussed in terms of the ACHS guidelines. Organisation summaries are examined using a framework we develop se to illustrate how the ACHS' outstanding achievement exemplars add important new dimensions to our understanding of consumer/patient-centred care. We discuss the implications of our findings on a number of levels. We conclude with suggestions for future research on outstanding achievement performance.

The EQuIP Program and OA

The EQuIP program, strategy and evaluation, and quality improvement processes are centred on the ACHS standards which have been developed and published across three core functions (clinical, support and corporate). These standards or overall goals are enabled through the articulation of criteria used to describe key components of standards, which are further identified and explained through the use of elements that describe the attributes required to achieve criterion requirements. EQuIP4 has 13 standards supported by 45 criteria, with 14 criteria defined as mandatory and 31 as non-mandatory in respect to compliance impact for ACHS accreditation awards. In 2007, and following an extensive consultation process, 15 new criteria were added (ACHS 2007, pp. 22-26). Compliance and achievement of the EQuIP criterion is reported through achievement ratings allocated by healthcare facilities derived from self-assessment and assessment by ACHS surveyors at the time of OWS and PRs. The expectations incorporated in criteria and elements, demonstrated by achievement ratings, is part of the EQuIP methodology to encourage and recognise growth and improvement in systems and healthcare delivery in accredited facilities. The facilities include both private and public hospitals and other healthcare providers.

Healthcare initiatives assessed within EQuIP are rated according to their level of achievement. The highest achievement rating is at the OA level. Only a small number of cases in the data studied (approximately 1%) of the total OWS and PR ratings are at OA level (see **Table 1).** This rating recognises several key attributes related to the healthcare facility's developments and performance (awareness, implementation, evaluation and benchmarking); achievement of key leadership abilities internal to the organisation relating to other standards; and demonstrating development and learning transfer amongst peers nationally and internationally (ACHS 2006, p. 15). An OA rating on any criterion is a significant outcome for a healthcare facility. It demonstrates that the facility is the best or is outstanding amongst peer organisations in the respective criterion. The rating is a demonstration of the facility's leadership in the criterion as well as having achieved all elements required at all rating levels in the particular criteria.

[TABLE 1 HERE]

Under EQuIP 4 facilities could self-rate at OA level at the time of OWS and PR survey by preparing an appropriate short submission that is provided to visiting surveyors and ACHS. These submissions set out steps, activities and strategies undertaken by the facility to support the justification of the OA rating. The criterion is assessed by the survey team and appropriate recommendations are made to the ACHS Council in regard to the possible award. Surveyors may also make an OA rating recommendation to ACHS Council without a self-rating of OA by the facility. In the EQuIP 5th Edition, which came into use in 2011, there

will be no requirement of self-assessment and the latter recommendation approach will be the only method of OA rating.

Research on the ACHS accreditation process has gained momentum over the last five years with the creation of the *Australian Accreditation Research Network* (AARN) under whose auspices a number of papers and other publications have been produced as well as major research projects with the ACHS established. As already mentioned, a key finding from one of these studies was that accreditation performance was significantly correlated with leadership (how power and influence is organised, how issues are handled and negotiated, and respect of followers and leaders) and organisational culture (staff well-being, communication, teamwork, decision making, standard of care produced and quality and safety focus of staff (Braithwaite et al. 2010, p. 17). However, they concluded that organisational climate and consumer (patient) involvement were unrelated to accreditation (2010, p. 18). From our perspective, the number of cases of outstanding achievement under consumer/patient involvement was very small in the pre-2007 data set, but increased in the 2007-2008 (ACHS 2009). We would expect further increases in in 2009-2010 as the numbers have been trending upwards since 2003.

In 2007-2008, 193 organisations were surveyed across all criteria in the OWSs while 261 were conducted through the PR and in the latter case, only on the mandatory criteria. As mentioned above, these differences relate to the four year cycle of accreditation. In all, 53 OA ratings were awarded (0.4%) to 36 facilities (20 public and 16 private) with 19 being awarded on the mandatory criteria, and 34 in the non-mandatory category. The majority of mandatory OAs were awarded on criterion 1.1.4 Care evaluation (n=5) and criterion 2.1.1 Continuous

quality improvement (n=4). In the non-mandatory criterion OAs were mainly given on criteria 2.5.1 Encouraging and governing research (n=7), and criterion 2.4.1 Health promotion, health protection and surveillance (n=5). As the ACHS states:

> "[M]andatory criteria are those where a rating of Moderate Achievement (MA) or higher is required to gain or maintain ACHS EQuIP accreditation. A criterion is mandatory if it is considered that a moderate achievement level is essential to ensuring the quality of care and/or service or the safety of people within the organisation" (ACHS 2006, p. 33).

The ACHS accreditation program has relevance and application for many health facilities and organisations (hospitals, community health services; corporate systems; palliative care services andprison medical services). ACHS has developed tailored accreditation in programs for particular facilities (e.g. day surgical services and mental health services). The program also relates to other accreditation programs (medical laboratory services). Some services are accommodated in separate agency accreditation programs (e.g. residential aged care).

ACHS standards and criteria relate to consumer input and engagement. ACHS surveyors include consumer surveyors bringing consumer perspectives, experience and expectations to the accreditation process. Facilities are also able to give feedback through a satisfaction survey conducted by ACHS which shows a high level of overall customer satisfaction with the process (ACHS 2009, pp. 52-60).

Patient-Centred Care

Patient-focused care is often used synonymously with patient-centred care (Irwin, 2006) and can also incorporate patient choice, patient engagement but rarely, if ever, patient led initiatives mentioned in the OBHC conference themes. Furthermore, patient-centred care is usually described differently at the health system, health service (e.g. general practice, tertiary care) and organisational levels as well as in terms of the type of care involved, such as chronic disease patient-centred care (e.g. diabetes and pulmonary disease) (ACSQH 2010; p. 15; Bensberg 2007, p. 7; Irwin 2006, p. 738) or end of life care. ACHS uses the term 'consumer/patient' as being anyone who uses a health service directly or indirectly. This definition also includes family members or carers who look after the consumer or patient but are not part of the healthcare team (ACHS 2006, pp. 56-7). The term can also cover clients or client groups or users in community health settings, for example (ACSQH 2010, p. 15). In primary care settings the term 'person centred care' is often used especially in care of older patients with the emphasis being on the relationships involved (ACSQH 2010, p. 15). For some it must include consumer organisations (Monash Institute of Health Services Research 2008; Safety and Quality Council 2002, p. 21; WA Health 2007, p.7). Others suggest that the term 'consumer' should be replaced by the word 'prosumer', which links the consumer (patient and citizen) to the notion of a producer, emphasizing the power of the consumer to define the product of healthcare through negotiating and bargaining (Iedema et al. 2008b, p. 105). When we turn to patient-centred care and patient safety, the issues are just as fraught. For example, in an extensive literature review conducted by Monash Institute of Health Services Research (2008, p. 32) on patient engagement in patient safety initiatives, the researchers found that a large number of publications had to be excluded because they focused on patient involvement in improving the safety of their own care as distinct from organisational level interventions that are largely overlooked.

Patient experience has also been found to be a lever for promoting patient-centred care at the organisational level as recent research suggests that addressing management issues such as wait times and patient flow are not necessarily sufficient to improve the patient experience. Patients' perception of staff courtesy and communication is the single most influencing factor in patient reports of overall quality of care (Piper et al. 2010). Hence, there is clearly a need to optimise the patient experience and bring it into patient-centred care. Moreover, there have been attempts to improve patient experience by involving patients to assist with the redesign of acute hospital departments. For example, driven by the NSW State Health Plan 'Towards 2010' (NSW Department of Health 2007), NSW Health initiated the Co-design Program in 2007. The objective was to engage patients in the co-design of the Emergency Department by identifying their best and worst experiences, to co-produce solutions, and give them a voice in matters that go beyond the personal care trajectory and clinical decision-making (Iedema et al. 2008a).

The *Institute for Healthcare Improvement* (IHI) adopts the term 'patient–family centred care' (PFCC) (ACSQH 2010, p. 15; Bensberg 2007, p. 31) because of the need to include children and their families in healthcare settings and is more demanding about the types and levels of engagement. A number of approaches suggest that patient-centred care cannot privilege the consumer/patient/family or carer over healthcare professionals or staff (ACHSQ 2010; Picker Institute 2008, p. 5). These approaches recognise that staff are stakeholders in healthcare and are most responsible for outcomes. Given the doctor's legal/fiduciary/trust responsibility to the patient and similar duties on the part of other healthcare professionals, it is self-evident that these stakeholders will have more power, more duties and different relationships within the organisational network. In this paper we use the term 'consumer/patient-centred care' to

be consistent with ACHS but with the caveat that it is a contested concept and not necessarily inclusive of all relevant stakeholders. It is however widely recognised as integral to reforming and improving healthcare outcomes (Epstein et al 2010) and hence why it is a critical part of any understanding of outstanding performance of any health facility.

Drawing on a number of different perspectives (ACHSQ 2010; Bensberg 2007, p. 27; Institute of Medicine 2001; International Alliance of Patients' Organizations 2006; Picker Institute 2008; WA Health 2007), 12 broad principles of patient-centred care can be identified. **Exhibit** 1 encapsulates these showing both the individual and organisational level aspects. Differing levels of participation are generally identified (e.g. Department of Public Health and Flinders University et al. (2000; WA Health Consumer Carer and Community Engagement Framework 2007).

[EXHIBIT 1 HERE]

EQuIP 4 and Consumer/Patient-Centred Care

'Involvement', 'partnership' and 'participation' are terms used in EQuIP 4 to describe consumer/patient-centred care and are found mainly under the clinical function where there are 6 standards and 21 criteria. As **Table 2** shows, standard 1.1 requires that "consumers/patients are provided with high quality care throughout the delivery process" (ACHS 2006, p. 34). While mention is made of the needs of consumers and patients across several criteria, it is the new mandatory criterion 1.1.2 that stipulates the requirements relating to consumer-patient partnership (see **Table 2)**. Other requirements for the direct involvement of patients and consumers can be found under criterion 1.1, e.g., criterion 1.1.4

states that "care is evaluated by healthcare providers and when appropriate with the consumer/patient and carer (ACHS 2006, p. 34) while criterion 1.1.5 requires that discharge and transfer process address the needs of the consumer/patient for ongoing care. Mandatory criterion 1.1.2 comprises of 17 elements based on the level of achievement involved (see **Table 3**).

[TABLES 2 and 3 HERE]

As mentioned above, the OA category requires that "the organisation demonstrates it is a leader in care planning and delivery practices" so that the overall standard has to be achieved. In 2007-2008, two OAs were awarded for mandatory criteria 1.1.2. (ACHS, 2009: 23).

However, none of the criteria, elements or specific guidelines stands alone and each is further reinforced by a number of non-mandatory standards including one specifically relating to consumer/patient partnership. In fact in 2007-2008 an additional non-mandatory criterion was introduced under the clinical function to encourage consumer participation. Standard 1.6 requires that "the governing body is committed to consumer participation" and as **Table 2** shows there are three criteria of which 1.6.3 is the newest. Criterion 1.6.1 relates to involvement of consumers, criterion 1.6.2 on consumer/patient rights and responsibilities, and criterion 1.6.3 recognition of cultural and special needs. Under each of these is found a further number of elements that have to be met in order to attain and OA rating. In 2007-2008, 5 OAs were awarded under standard 6 with three for criterion 1.6.3. (ACHS 2009, p. 24). When the ACHS framed the standard it referred to consumer participation in terms of

informing, listening to, responding to and involving the consumer /community group (ACHS 200, p. 130).

As mentioned above, there are two other functional groups in EQuIP 4 (and EQuIP5) and they are the support and corporate functions. Although these appear to be separate from the clinical standard, the ACHS supports and builds an integrated approach. So although not labelled as such, several of the other criteria also contain elements that lend themselves to patient/consumer participation**.**

Methodology and Organisation Summaries

Prior to an OWS and PR survey a healthcare facility prepares pre-survey documentation against standards and criterion in EQuIP and self-rate the organisation's achievement at criterion level. For those seeking an OA rating, self-assessed performance survey teams discuss achievements against criterion, verify compliance evidence and if agreed jointly prepare with the facility a statement of OA leadership status. This signals that a survey team has agreed on survey ratings at criterion level. A survey accreditation report is prepared and includes the pre-survey report by a facility and survey team function summaries, criterion comments, recommendations and recommendations to ACHS Council. The survey report and recommendations are reviewed by ACHS Council and decisions made on accreditation status and criterion compliance achievements. Biennial national accreditation program reports are prepared by ACHS and as stated above, include short summaries on organisation level outstanding achievements (ACHS 2007; ACHS 2009). Not all OA ratings may be included in the biennial reports as facilities may elect not to proceed with publication. **Exhibit 2** contains an example of a typical organisation summary.

[EXHIBIT 2 HERE]

Empirical data for this paper comprises a series of organisation summaries that are in the public domain. The researchers, mindful of the different approaches to the study of documents (Prior 2004), sought to use a deductive approach and identify how the summaries align with key themes in the consumer/patient-centered care literature. We read the text summaries and identified which parts of matched with our main themes recognizing that the ACHS had already produced a similar though less extensive summary of key themes around consumer participation (see below). Content analysis that treats documents as a resource tends to consider descriptions, images, representations and accounts that are present as text in the document (Prior, 2004, Prior 2006). Such an inductive approach was used when we initially analysed the summaries by using a descriptive technique (Graneheim and Lundman,2004; Krippendorff 2004; Neuman 2010). This paper extends on that work.

ACHS gives the following broad reasons for achieving OAs in the standard of consumer participation, i.e. on criteria 1.6.1, 1.6.2 and 1.6.3 (ACHS 2009, p. 47):

- Committed leadership through overseeing a culture that supports consumer engagement at all levels of the organisation as evidenced by having documented policies, processes for recruiting consumers or community advisory committees, and holding focus groups with consumers.

- Working with consumer support groups and providing education through orientation programs as well as targeted ongoing education for consumers involved in strategic planning and care evaluation committees.

- Ongoing education for staff about consumer rights and responsibilities including having printed materials about consumer rights and responsibilities as well as internet based modes of engaging consumers.

- Organisations with diverse communities providing information in a variety of formats, providing interpreter services and linking consumers to relevant community groups. Some provide specialist volunteer programs for consumers with cultural and linguistically diverse backgrounds.

- Methods in place to obtain consumer feedback such as satisfaction surveys and focus groups though response to feedback varied across organisations with some incorporating feedback into reviewing services and strategic planning.

- Those that demonstrated effective consumer participation programs were able to demonstrate improvements developed through effective consumer participation strategies with a number benchmarking their participation strategies with others to identifying new opportunities.

ACHS also notes that consumer involvement or partnership is covered by standard 1.1 as already indicated but is not included it in the summary points. However, when we further analysed the organisation summaries, a much more complex picture emerges of what an OA rating means. **Table 4** describes the OA criteria examined in terms of the broad principles identified in **Exhibit 1. Table 4** shows that being externally focused in the areas of collaboration, benchmarking, education and support and gaining recognition are important defining features of outstanding achievement that are missing from **Exhibit 1**. The organisation summaries help broaden our knowledge and understanding of exemplary performance in the field of consumer/patient-centred care and suggest a level of achievement that has not been captured in the literature.

[TABLE 4 HERE]

Table 4 does not contain all the OAs in the 2007-2008 report but provides a sample across the relevant criteria under the clinical function thus, excluding others that also have a consumer/patient focus. The organisation summaries have been analysed using the framework outlined in **Exhibit 1**, thus allowing for comparisons of OA ratings in descriptive terms. It also provides an approach that can identify gaps across the summaries in consumer/patient-centred care approaches. It noteworthy that no facility achieved what is termed 'patient empowerment' and there was no mention made of patient voice, stories or narrative evidence (Charon and Wyer 2008; Meisel and Karlawish 2011). This absence could be attributed to the brevity of the summaries and the method used for reporting them. Only one of the facilities mentioned in **Table 4** had previously been awarded an AO while another was rated as an OA on a related mandatory criterion.

Table 4 captures the reasons why an OA would be awarded in a way that lends itself to learning and knowledge transfer as well as comparisons with other such accreditation systems using principles not derived from ACHS alone. Reflecting the clinical focus of the standard, the most common area in which an outstanding achievement was reported was for what we term safe and responsive services. Collaboration was also a common factor in achieving the OA rating but the external areas also featured prominently as would be expected. The ACHS standards contain guidelines that provide ample scope for individual facilities to exercise discretion and creativity in how they go about achieving an OA rating. **Table 4** contains many examples and learning moments for other institutions keen to pursue an OA rating and pursue innovative approaches to consumer/patient centred-care.

Discussion

Accreditation is an important way of reforming practice as research shows that accreditation can change the way healthcare professionals respond to consumer/patient-centred care (Bensberg 2007, p. 28). Achieving and sustaining an outstanding achievement is not easy and of the facilities that have been surveyed from 2003-2008, only a small number have gained an OA rating on more than one occasion. Nor should it be assumed that accreditation is a magic bullet for developing consumer/patient-centred care because there is always going to be gamesmanship especially at the MA level that is the minimum standard for being re-accredited. For example, Greenfield, Naylor and Braithwaite (2009) investigated the reliability of the ACHS accreditation process and identified key aspects that determined acceptance of the methodology amongst its stakeholders. They noted six factors that affected reliability of the ACHS accreditation program in terms of expectations and conduct.

However, the most interesting finding from our point of view was the observation that the first four factors comprised the 'technologies' of the accreditation process because these were the ones that most directly contributed to standardization and created the "explicit structure and interactive processes that shape organisational actors, accreditation personnel and survey teams" (Greenfield et al. 2009, p. 113). They go on to describe how in each accreditation instance, the participants come together and 'knot work' to achieve discrete tasks around expectations and the conduct required that comprises a survey and then each 'knotting unties' as each participant moves on.

These observations lend weight to the importance of studying in depth those facilities that achieve OA ratings and can also sustain them. The surveyor reports offer some additional useful information as would the 2009-2010 cases in developing an appreciation of how these standards are being maintained over time. The framework we have used is one way of developing a project around such an endeavour. The OA ratings in consumer/patient-centred care provide evidence based judgements, albeit limited at this stage to the organisation summaries in 2007-2008. The summaries themselves are confirmation of very high levels of achievement but cannot be treated as the end point of what might be considered outstanding achievement.

When we examine other approaches to assessing patient-centred care it becomes evident that an outstanding achievement is a stretch goal with no end point. The prestigious IHI in the US produces an organisation self-assessment tool (IHI 2011) that has eleven domains that are both managerial and clinical and contain many elements (see **Table 5)**. This is a much more simplified version of the Picker Institute's (2008) *Self-Assessment Tool* and both support an

organisation-wide approach inasmuch as PFCC is incorporated into all key domains with the clinical given less significance than by ACHS. Both approaches move consumer/patient-centred care beyond what is commonly practiced in health facilities in Australia. The use of such self-assessment tools, somewhat finessed, could form part of the reporting on outstanding achievement and can be operationalized further by reference to the Picker Institute's tool. These tools provide different approaches to developing and promoting consumer/patient-centred care through ensuring that it is embedded across all key areas such as HR, recruitment and so on. These approaches are more conducive to making consumer/patient centred-care an integral part of the leadership and culture of the facility and thus, to accreditation (see earlier comment by Braithwaite et al. 2010). These tools would enhance ACHS' mission which is to promote customer focus, strong leadership and a culture of improvement, both being part of its core principles (ACHS 2006, p. 3). The IHI's approach places PFCC at the core of its mission, vision and values of the organisation thus capturing quite clearly what leadership is all about. The ACSQH (2010 Appendix 1) also produces two tools for assisting facilities to improve patient-centred care (Patient-Centred Care Organisational Status and the Where We stand Checklists) that incorporate much of what the other two approaches cover but also includes, for example, research that actively encourages consumer/patient participation not just as subjects but as co-researchers.

The various toolkits are aimed at being progressive and at the leading edge of best practice yet when we look more closely at them, they appear to be remarkably inward looking when compared to what the outstanding achievement facilities are doing through ACHS' accreditation process. These facilities are disseminating findings nationally and internationally as well as spreading their ideas and methods across the sector as evidenced by

prizes and awards and proof of peer esteem. They collaborate with other services and suppliers of healthcare including in the case of one, with competitors. Such external collaboration is vital to developing integrated care across communities and boundaries. Previous studies show that the effective transition of care of patients across the healthcare networks improves the quality of care, positively impacts on health and lowers financial burden (Naylor et al. 1999; Shim et al. 2000). This shift in focus is needed given the challenges facing an ageing population in countries such as Australia who can no longer afford to treat healthcare as though it is still about acute care. The ACHS could take the lead in encouraging this as part of outstanding achievement.

We acknowledge that a trade-off exists between improving the process of care and between competing goals of efficiency and effectiveness to achieve better health outcomes. Indeed, resources diverted towards the improvement of process of care may reduce the amount of resources available to improve health outcomes (Morris et al. 2007). The question then becomes: by how much should a facility improve their process of care? The answer will vary substantially among facilities depending on their source of funding, specialisation, levels of expertise, location, size and so on. Thus any examination of achievement in consumer/patient-centred care should take into consideration the opportunity costs of pursuing these goals, which is not a consideration in ACHS because of its necessary focus on compliance.

Conclusion

Accreditation is an important process for shifting healthcare systems away from a principally acute care focus to one that can be designed to cater for the growth in chronic diseases and the need to manage these health challenges in a patient-centred paradigm. The organisation

summaries provide valuable insights into how patient/consumer participation is occurring in healthcare facilities that have been surveyed, though only the OA results are published. They provide an important and valuable resource for studying patient-centred care across a range of healthcare facilities.

The current paper and the analysis undertaken provides the starting point for describing what facilities have done to achieve their outstanding performance based on reliable evidence. This is only the beginning and we see the need for case studies as well as longitudinal studies that can capture processes and practices in much greater depth to enhance the learning and transfer of knowledge that will not only help the accreditation system to be adaptive and robust but can provide the empirical evidence for promoting innovation and reform in this hugely important area of healthcare. The opportunity to compare across 2007-2008 and 2009-2010 organisational summaries will also enable us to strengthen the framework we are developing and to provide another perspective on outstanding achievement that can aid the transfer of knowledge and ensure the integrity and comparability of ACHS' OA ratings. Understanding how an EA becomes an OA rating is also important to study as this is where key lessons are to be learnt. Our work also opens up the opportunity for comparative studies with other accreditation systems nationally and internationally and this is particularly important given that Australia is moving to de-regulate the accreditation industry as well as introducing a new federal system of compliance for healthcare facilities.

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Table 1: ACHS Criterion Achievement Ratings in EQUIP

Levels of Achievement
Level 1 Little Achievement (LA) Organisations that achieve an LA rating will have an awareness or knowledge of responsibilities and systems that need to be implemented but may have only basic systems in place. At this level there will be compliance with legislation and policy that relates to the criterion. **Level 2 Some Achievement (SA)** An organisation that achieves an SA rating will have achieved all the elements of LA and will have implemented systems for the organisation's activities in relation to the criterion. At this level there is very little or no monitoring of outcomes or efforts towards continuous improvement. **Level 3 Moderate Achievement (MA)** An MA rating requires that all the elements of LA and SA have been achieved and there are efficient systems for collecting relevant outcome data, monitoring performance, evaluating procedures and responding to improve outcomes. **Level 4 Extensive Achievement (EA)** To achieve a rating of EA in the EQuIP 3rd edition, organisations were required to benchmark their performance against other organisations or internally in order to demonstrate extensive achievement. In the EQuIP 4 program, **all the elements in LA, SA and MA must be achieved** but in addition, EQuIP 4 recognises that extensive achievement can be demonstrated in other ways. **Level 5 Outstanding Achievement (OA)** The elements of LA, SA, MA and EA must be achieved as well as a demonstration of leadership in this criterion. Leadership in a criterion does not necessarily mean that the organisation is the best in Australia. It may mean that the organisation can demonstrate that it is one of the best performing organisations or is outstanding amongst its peers.
Source: Australian Council on Healthcare Standards (ACHS). (2006) *The ACHS EQuIP Guide: Part 1 - Accreditation, Standards, Guidelines (*4th ed.). Sydney, NSW: ACHS, pp.15-16.

Exhibit 1: Broad Framework for Analysing Patient Centred Care

- *Communication* – healthcare professional listens and interacts with the patient and treats the patient as a person (i.e. deal with emotions, feelings etc.) and upholds patient/family/carer perspectives and choices as the basis of making decisions about patient care and quality of life issues.
- *Respect and acknowledgement* – patient/family/carer values, beliefs and culture are treated as integral to the planning and delivery of care.
- *Safe and responsive care* – patients/family/carers receive evidence based, cost effective care that maximises health, alleviates discomfort and is safe and free from avoidable errors while being able to respond quickly and efficiently to patient needs.
- *Information sharing and gathering* – patients/family/carers have the ability to obtain timely, complete and accurate information they can understand so that they can make appropriate and informed health decisions/choices relating to their care and safety and that data is collected (e.g. surveys) to assist this process.
- *Active involvement* – clearly articulated practices about patient/family/carers having the right and responsibility to participate in health care decisions that affect their lives and at the level of their own choosing with due consideration given to their differing levels of ability to be involved.
- *Consultation* – feedback and opinion gathering through formalised methods such as focus groups and forums.
- *Collaboration* – patients, family and carers can manage their care in properly coordinated healthcare teams and within integrated systems of care.
- *Partnership* – patient, family/carers/ are encouraged and supported to participate on an institution-wide basis in policy and program development, strategy, design, implementation and evaluation as well as the delivery of care and ensuring that informed choices can be made by patients, families and carers.
- *Empowerment* - consumer/patient groups/organisations play leadership roles in the organisation and are able to initiate consumer/patient led change.
- *Education and support* - provide resources and programs to help patients/family/ carers and consumers to engage in meaningful ways in healthcare organisations.
- *Staff focus* – develop strategies to build capacity of staff to support patient centred care, work force reviews and staff recruitment and retention to focus on patient centred care, staff satisfaction, environment and culture are treated as integral to patient centred care.
- *Leadership* – patient centred mission, vision and senior leadership as champions of patient centred care.

Table 2: EQuIP 4 Mandatory and Non Mandatory Criteria

1. Clinical

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

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

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

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

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

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

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

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

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

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

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

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

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

1.3.1 Healthcare and services are appropriate and delivered in the most appropriate setting.

1.4 The organisation provides care and services that achieve expected 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 practice.

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

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

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

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

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

1.6 The governing body is committed to consumer participation.

1.6.1 Input is sought from consumers, carers and the community in planning, delivery and

evaluation of the health service.

1.6.2 Consumers/patients are informed of their rights and responsibilities.

1.6.3 The organisation makes provision for consumers/patients from culturally and linguistically diverse backgrounds and consumers/patients with special needs.

Source: Australian Council on Healthcare Standards (ACHS) (2009) *The ACHS National Report on Health Services Accreditation Performance 2007–2008.* Sydney, NSW: ACHS, p. 10..

Table 3: EQuIP 4 Criterion 1.1.2 as an example of the structure of ACHS standards

<u>Function 1 – Clinical Standard 1.1.2</u> Consumers/patients are provided with high quality care throughout the care delivery process	
<u>Criterion</u>	1.1**.2 Care is planned and delivered in partnership with the consumer/patient and when relevant, the carer, to achieve the best possible outcomes**.
Little Achievement (LA) ***Awareness***	(a) Evidence based guidelines on care planning and delivery are available. (b) Care is provided in response to consumer/patient needs in a timely manner and in accordance with established policies and procedures. (c) A comfortable and caring environment is provided for consumers/patients.
Some Achievement (SA) ***Implementation***	(a) Care planning and delivery are based on the assessment of the consumer/patient needs and with the consumer/patient and, when relevant, their carer. (b) All care planning, decisions, actions and changes are documented in the consumer/patient health record. (c) Care is delivered by skilled and trained individuals within a competent multidisciplinary team with an identified team leader. (d) A system exists for the effective identification and management of a deteriorating consumer/patient. (e) Consumers/patients and carers, when appropriate, are given information that allows them to understand their care. (f) There is evidence that the consumer/patient has been provided with information on care delivery options.
Moderate Achievement (MA) ***Evaluation***	(a) The care planning and delivery processes are evaluated and improved as required. (b) Policies and procedures for care delivery are evaluated against evidence, professional guidelines, codes of practice and medico-legal requirements. (c) Multidisciplinary team processes for care delivery are evaluated and improved as required. (d) The environment in which care is provided is evaluated and improved as required. (e) A system for the effective identification and management of a deteriorating patient is evaluated and improved as required.
Extensive Achievement (EA) ***Excellence***	(a) Care planning and delivery practices, together with data on variances are compared with internal and external systems and improvements are made, to ensure better practice. and/or (b) Multidisciplinary team work is compared with other health services and/or industries and improvements are made to ensure better practice. and/or (c) The organisation undertakes research relevant to care planning and the delivery of care and acts on results.

Outstanding Achievement (OA*)** ***Leadership	(a) The organisation demonstrates it is a leader in care planning and delivery practices.

Source: Australian Council on Healthcare Standards (ACHS) (2009) *The ACHS National Report on Health Services Accreditation Performance 2007–2008.* Sydney, NSW: ACHS, p. 9.

Exhibit 2: Sample Organisation Summary

The Queen Elizabeth Hospital and Health Service, Woodville, SA
Mandatory Criterion 1.1.2 **Care is planned and delivered in partnership with the consumer/patient and when relevant, the carer to achieve the best possible outcomes**
↘ Care delivery is achieved through well documented clinical pathways and care plans. ↘ A multidisciplinary approach is adopted in all clinical departments. ↘ Patient treatment goals and objectives are discussed with the patient and relative care givers. ↘ The consumer Advisory Council takes an active role in identifying consumer's satisfaction with the delivery of their care and treatment. ↘ Patients receive a comprehensive range of education material to inform them of their treatment options and anticipated clinical outcomes. ↘ The program *Advances Directives, Respecting Patient Choices* clearly advocates the involvement of patients, carers, clinicians and community services. ↘ Staff competencies are assessed across all clinical areas, with many links to annual mandatory training such as basic life support and medication management. Further planned education programs have been identified in relation to medical staff cardio-pulmonary resuscitation, and emergency response allocations and responsibilities. ↘ Nurse practitioner models have been introduced to support and complement the delivery of clinical services. ↘ Senior clinicians have also embraced this very collaborative approach to patient care delivery, particularly in ear, nose and throat, and the emergency department. ↘ Variance analysis and length of stay outliers are used to monitor patient care outcomes and review patient care deliverables. ↘ Considerable work has been conducted by the pharmacy department in relation to medication management. Medication chart reviews and the implementation of clinical pharmacists in emergency department, preadmission clinic and the wards are commended. This clinical resource has provided timely evaluation of prescribing errors and drug related interactions to the medical staff, to reduce the incidence of medication adverse events occurring.

Source: Australian Council on Healthcare Standards (ACHS). (2009) *The ACHS National Report on Health Services Accreditation Performance 2007–2008.* Sydney; NSW: ACHS, pp. 34-35.

Table4: Examples of OA Using Broad Areas of Consumer/Patient Centred Care

Criterion	Facility and Type	Main Area and Organisational Summary Details
Mandatory Criterion 1.1.2	***The Queen Elizabeth Hospital and Health Service, WA (public)*****	*Safe and responsive care*: well documented clinical pathways and care plans as well as sophisticated monitoring and evaluating patient outcomes and reviewing patient deliverables; nurse practitioner models used to augment delivery of clinical services. *Information sharing and gathering*: patients receive comprehensive range of educational materials to inform them of their treatment options and anticipated clinical outcomes. *Active involvement*: the program, *Advance Directives, Respecting Patient Choices,* advocates involvement of patients, carers, clinicians and the community; patient treatment discussed with patient and carers. *Collaboration:* multidisciplinary teams across clinical departments; senior clinicians have embraced this collaborative approach. *Partnership:* the Consumer Advisory Council takes active role in identifying consumer satisfaction. *Leadership*: through the active involvement and partnership.
Mandatory Criterion 1.1.4	***Perth Clinic. West Perth WA (independent – private-psychiatric hospital)*****	*Safe and responsive care:* care plans developed with extensive ongoing monitoring and evaluation. *Information sharing and gathering*: Wellbeing index used to give feedback to patients and visually graphed so patients can see them. Uses Consumer Perception of Care outcome measures to monitor consumer satisfaction. *Collaboration*: care plans reviewed twice daily in collaboration with treating team. **External Collaboration*: benchmarks widely with other organisations and engages in National Centralised Data Management Service.
Mandatory Criterion 1.1.5	***St Vincent's Private Hospital, Darlinghurst, NSW*****	*Safe and responsive care*: a number of innovative programs that offer rehabilitation in the home for orthopaedic patients; an extended care program is being established; at risk patients identified at admission and in house *deLacey* program used to enable discharge planning; major education program for orthopaedic surgeons linked to pre-admission interview and reducing discharge to rehabilitation facilities for these patients.; uses **External benchmarking*: Balanced Scorecard for KPIs relating to discharge; length of stay has been compared to other external systems **External recognition*: have received an award for clinical excellence in discharge planning.
Non Mandatory Criterion 1.1.7	***Silver Chain Hospice Care Service, Osborne Park, WA***	*Respect and acknowledgement*: focus of the service is to facilitate the care of the patient to meet the patient/family wishes; staff and volunteers uphold values. *Safe and responsive care*: resources have been identified for patient/carer need in the home; ongoing evaluation; used pilot

	(public)**	project to obtain recurrent funding to keep people at home to die; consistently achieve above target for the service and Australia-wide. *Information sharing and gathering*: established a system to record and establish where a patient wishes to die; a comprehensive healthcare record (information system in the home of the patient) has been developed called *Comcare*; 90% plus carer satisfaction. *Collaboration*: collaborative clinical research to improve its care models and patient outcomes. **External Collaboration*: provides significant clinical and policy leadership **External benchmarking*: sets high benchmarks for the service.
Non-Mandatory Criterion 1.6.1	***Blue Care Southern Region, Biggera Waters, Not for Profit (Uniting Care) community healthCare*****	*Information sharing and gathering*: conducts community surveys. *Consultation*: Runs Positive Ageing Expo, and stakeholder forums. *Active involvement*: developed Respite Activity Performance Indicator Database to capture consumer input and involvement for planning and design of services. *Partnership*: evidence of consumers and volunteer being satisfied with their involvement in organisation's business and strategic planning. *Education and support*: strong evidence of consumer training and volunteer support. **External Collaboration (*: strong linkages forged at all levels of their communities from first contact with client. Partnerships forged with external service providers that may or may not be in direct competition with the service. Innovation in this area.
Non Mandatory 1.6.2	***Eye Tech Day Surgeries and Eye Tech Solutions, Upper Mount Gravatt, Qld (private)******	*Information sharing and gathering*: informs patients of rights and responsibilities and complaint process through visible wall displays, through the website and a patient booklet which is extremely user friendly. Forms for consent, financial consent and privacy are widely available and used. *Staff focus*: staff given legal training, educated and updated on patient rights and responsibilities, privacy and complaint procedures **External Collaboration*: the resource booklet is shared with numerous organisations.
Non Mandatory 1.6.3	***Karitane, Villawood, NSW, community health*****	*Respect and acknowledgement*: the volunteer program has international recognition for its multicultural service, volunteer training program and for translation into many languages that reflect their diverse community-base. *Safe and responsive care*: outstanding volunteer program for clients from culturally and linguistically diverse backgrounds. Karitane Volunteer Program prominent in satisfaction surveys. Excellent provision of home visits to clients when they are unable to visit facilities due to cultural and religious reasons. Very diverse services for toddlers, families in stress, teens, children, women, dads and indigenous groups. *Education and support*: Karitane Volunteer Training Program

		and handbook translated into many languages and supported by a dedicated coordinator position. *<u>*External Education and support*</u>: Karitane Volunteer Program represented on many boards at state and national levels, their certificate course in Community Parenting is being adopted nationally and internationally; they are represented on many boards associated with education and training.

<u>Key:</u>

* Denotes and external focus.
** Denotes multiple OAs.
*** Denotes has had OA in this area in previous accreditation cycle (not applicable to new criteria) and published in previous organisation summaries.

Source: Australian Council on Healthcare Standards (ACHS). (2009) *The ACHS National Report on Health Services Accreditation Performance 2007–2008.* Sydney; NSW: ACHS, pp. 26-43.

Table 5: IHI Assessment Tool Patient Centred Care

Domain	Element	Low to high →					Do not know
Leadership/ Operations	Clear Statement of commitment to PFCC and PF partnerships	1	2	3	4	5	
	Explicit expectation, accountability, measurement of PFCC	1	2	3	4	5	
	PF inclusion in policy, procedure, program, guideline development, governing Board activities	1	2	3	4	5	
Mission, vision, values	PFCC included in Mission, Vision, and /or core value	1	2	3	4	5	
	PF "Friendly" Patient Bill of Rights and Responsibilities	1	2	3	4	5	
Advisors	PF serve on hospital committees	1	2	3	4	5	
	PF participate in quality and safety rounds	1	2	3	4	5	
	Patient and family advisory councils	1	2	3	4	5	
Quality Improvement	PF voice informs Strategic / operational aims/ goals	1	2	3	4	5	
	PF active participants on task forces, QI teams	1	2	3	4	5	
	PF interviewed as part of walk-rounds	1	2	3	4	5	
	PF participate in quality, safety, and risk meetings	1	2	3	4	5	
	PF part of team attending IHI, NPSF, and other meetings	1	2	3	4	5	
Personnel	Expectation for collaboration with PF in job descriptions & PAS	1	2	3	4	5	
	PF participate on interview teams, search committees	1	2	3	4	5	
	PF welcome new staff at new employee orientation	1	2	3	4	5	
	Staff/physicians prepared for & supported in PFCC practiceE	1	2	3	4	5	
Environment and Design	PF participate fully in all clinical design projects	1	2	3	4	5	
	Environment supports patient and family presence and participation as well as interdisciplinary collaboration	1	2	3	4	5	
Information/ Education	Web portals provide specific resources for PF	1	2	3	4	5	
	Clinician email access from PF is encouraged and safe	1	2	3	4	5	
	PF serve as educators/ faculty for clinicians and other staff	1	2	3	4	5	
	PF access to/ encouraged to use resources rooms	1	2	3	4	5	

Codes:PFCC=Patient-and Family-Centered Care;PF=Patient and Family;PAS=Performance Appraisal System

Domain	Element	Low to High →					Do not know
Diversity & Disparities	Careful collection and measurement; race/ethnicity/ language	1	2	3	4	5	
	PF provided timely access to interpreter services	1	2	3	4	5	
	Navigator programs for minority and underserved patients	1	2	3	4	5	
	Educational materials at appropriate literacy levels	1	2	3	4	5	
Charting and Documentation	PF have full and easy access to paper/ electronic record	1	2	3	4	5	
	Patient and family are able to chart	1	2	3	4	5	
Care Support	Families members of care team, not visitors, with 24/7 access	1	2	3	4	5	
	Families can stay, join in rounds & change of shift report	1	2	3	4	5	
	PF find support, disclosure, apology with error and harm	1	2	3	4	5	
	Family presence allowed/ supported during rescue events	1	2	3	4	5	
	PF are able to activate rapid response systems	1	2	3	4	5	
	Patients receive updated medication history at each visit	1	2	3	4	5	
Care	PF engage with clinicians in collaborative goal setting	1	2	3	4	5	
	PF listened to, respected, treated as partners in care	1	2	3	4	5	
	Actively involve families in care planning and transitions	1	2	3	4	5	
	Pain is respectively managed in partnership with patient and family	1	2	3	4	5	

Codes:PFCC=Patient- and Family-Centered Care;PF= Paient and Family; PAS= Performance Appraisal System

Source: Institute of Healthcare Improvement at www.ihi.org (accessed Nov 2011).