Evaluation and Quality Improvement Program

EQuIP7

HOSPITAL STANDARDS

ACHS International

THE ACHS EQuIP7 HOSPITAL STANDARDS

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FOREWORD

On behalf of the Board of Directors, it is my pleasure to present the 7th edition of the Australian Council on Healthcare Standards' (ACHS) Evaluation and Quality Improvement Program (EQuIP) for Hospitals.

During the development of the EQuIP7 Hospital Standards, ACHS engaged widely across the health industry seeking strategic and technical input. The rigorous process included consultation with stakeholders, member organisations, assessors, health professionals and patients / service users, the convening of Working Groups, which included members from Australia and internationally, field review of the draft standards, then pilot testing in a number of organisations of various sizes and specialties.

The EQuIP7 Hospital Standards have been evaluated by member organisations and the ACHS Standards Committee to ensure that each standard, criterion, and element is relevant, understandable, measurable, beneficial and achievable.

The generous response of time and expertise both across Australia and internationally is indicative of the esteem held within the health industry for ACHS. For this we are very grateful.

On behalf of the Board and Council, I commend to you the Evaluation and Quality Improvement Program (EQuIP) 7th edition Standards for Hospitals.

Professor Leonard Notaras AO
President, ACHS and ACHS International
August 2021

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CARE DELIVERY

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STANDARD 1: PATIENT CARE

1.1: Information on Services

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

The information that organisations may be required to provide to their community includes:

- the services available within the organisation, such as specialty medical services, emergency services, outpatient services, pharmacy, counselling, rehabilitation and education classes, as well as any auxiliary services
- how the organisation will handle health information, irrespective of whether consent is given. This information should be provided at the earliest opportunity and in line with Privacy legislation of the relevant jurisdiction
- inclusion and/or exclusion criteria for admission to the health service
- collaborative links between the organisation and specific community / advocacy / support groups
- schedule of programs and/or education sessions
- transport and/or parking information.

Organisations should undertake regular evaluations of the information on its services that it provides to its patients, to assess whether the content of the information, the formats in which it is provided and the channels through which it is disseminated are appropriate to meet the needs of its community.

LA Policy / guidelines define what information is required for the community that the organisation serves and how that information is disseminated.

Elements

1. The organisation develops or sources information about the specific services it provides, how those services can be accessed and supplies this information to the community.
2. Information is available appropriate to the diverse needs and/or diverse backgrounds of patients.
3. Health professionals within the organisation have information on relevant external services.
4. Relevant external health service providers are supplied with information on the health service and are informed of referral and entry processes.

H 1. The organisation has defined what information regarding general and specialty services is to be provided to the identified patients, family and community.

H 2. Patients and the community have equal and easy access to information about services through various means.

EQuIP7 | FUNCTION 1 | CARE DELIVERY
STANDARD 1: PATIENT CARE • CRITERION 1.1

1.1: Information on Services

SA Information on services provided and how to access those services, is available for the community.

Elements

1. Patients are provided with information about the specific service(s) they are using.
2. Staff are trained to communicate effectively to provide information that addresses the diverse needs of patients.
3. Patients are informed about access to after-hours care.
4. An internal service directory listing operational and contact details of external health service providers is kept up to date and made available to relevant staff.
5. There is collaboration between the organisation, patients, family and external health service providers to develop information about referral and entry processes.

H 1. Information is available to patients on relevant procedures /services that are provided by the hospital.

H 2. Information is available on outpatient services and how the patient can access those services.

MA Evaluation demonstrates the effectiveness of information provided to the community, and improvements are made where issues are identified.

Elements

1. Information supplied to the community about the services it provides is comprehensive and addresses community needs.
2. Processes for distribution of information on the organisations services meets patient and stakeholder needs.
3. The external health service providers' directory is monitored to ensure it is up to date.
4. Collaboration with patients, family and external health service providers to develop information about referral and entry processes meets the organisations' needs.

H 1. There is evidence of equal and easy access to relevant information.

STANDARD 1: PATIENT CARE

1.2 Access and Admission

The intent of the Access and Admission criterion is to ensure that communities and patients have access to necessary health care and services.

Access cannot be assumed as it is subject to variables that may affect the type of access, for instance in the absence of referral documentation a specialist service can be suspended until the correct documentation is received. In the case of a patient suffering an acute illness, referral documentation may be unnecessary prior to receiving care.

LA Policy / guidelines address organisational access and admission processes.

Elements

1. There are clear inclusion and/or exclusion criteria for admission to the service.
2. There are processes to manage patients who do not meet the inclusion criteria.
3. The entry process is designed to minimise duplication.
4. There is a system to manage waiting times / wait lists.
5. The system for prioritising care meets the needs of the patient.

H 1. There is a process for admitting inpatients and for registering outpatients.
H 2. The organisation identifies its high-risk conditions and treatments.
H 3. Admission to high-risk departments is determined by established criteria.
H 4. At admission, the patient and family receive:
(i) education and orientation to the environment
(ii) information on the patient services
(iii) expected costs for care.

SA Admission / entry processes are designed to meet patient needs.

Elements

1. Physical access is assisted by wayfinding / signage and considers diverse needs.
2. Information in referral documents received on admission of the patient is utilised.
3. There are processes that ensure continuity of care between referrers and health service providers.
4. The organisation ensures the diverse needs of patients and their family are met during entry to the service.

H 1. There is a process to manage the flow of patients throughout the hospital.
H 2. The multidisciplinary team facilitates access to services with patient and family participation.

EQuIP7 | FUNCTION 1 | CARE DELIVERY
STANDARD 1: PATIENT CARE • CRITERION 1.2

1.2 Access and Admission

MA Evaluation demonstrates the effectiveness of access and admission processes/systems and improvements are made where issues are identified.

Elements

1. Regular reviews of the system of prioritisation of care occur.
2. There is patient satisfaction with admission / entry processes.
3. The inclusion / exclusion criteria, and the management of those not meeting the inclusion criteria are regularly reviewed to ensure the needs of patients and the organisation are met.
4. Data on utilisation of health services by people with diverse needs and/or from diverse backgrounds are collected and maintained to monitor access.

H 1. Referrers report satisfaction with the admission process.

STANDARD 1: PATIENT CARE

1.3: Screening and Assessment

Assessment is the first step in ensuring that care is planned and delivered in a holistic, coordinated and efficient manner. It recognises that the initial assessment, and regular reassessments, should promote a consultative, collaborative, person-centred approach that actively involves the patient and family so that it meets their needs and they understand what is occurring.

Assessment is the process by which the current and ongoing needs of the patient are identified and documented. It should provide a comprehensive overview of a patient's health and wellbeing and allow for the identification of risks and diagnoses.

An episode of care begins with assessment and requires contact between clinical staff and the patient. An assessment can initiate additional services and assistance.

LA Policy / guidelines define the requirements for patient assessment.

Elements

1. Holistic assessment includes the diverse physical, spiritual, cultural, medical, psychological and social needs of patients.
2. There are processes to identify, assess and manage vulnerable patients and diverse population groups.
3. Guidelines for patient assessment are based on current professional standards and evidence-based practice and are readily available to staff.
4. Assessments are conducted and documented as soon as practicable.
5. Reassessments are conducted to ensure changes to health status are documented and managed.
6. Patients and family where appropriate, are involved in the assessment and reassessment process.
7. Appropriate interpreters are available, and patients, family and staff are informed of the availability.

H 1. Health professionals discuss anticipated and expected outcomes of care with the patient and family prior to receiving care.

H 2. There are processes for the assessment of a patient's need for health education.

H 3. Referral systems to other relevant health service providers are in place.

H 4. Patient assessment includes:

(i) patient needs for preventive, palliative, curative, and rehabilitative services
(ii) emergency patients
(iii) preoperative assessment
(iv) screening and referral for further assessment and treatment when necessary
(v) screening for pain
(vi) identifying all surgical implants
(vii) identifying surgical /medical devices
(viii) monitoring and documentation of post-anaesthesia status
(ix) patient discharge from the recovery area.

EQuIP7 | FUNCTION 1 | CARE DELIVERY
STANDARD 1: PATIENT CARE • CRITERION 1.3

1.3: Screening and Assessment

SA Patient assessment ensures current and ongoing needs of the patient are identified.

Elements

1. There are processes to identify, assess and manage patients with chronic conditions who develop an unrelated health issue.
2. The assessment process is comprehensive, timely, multidisciplinary and provides all necessary information to inform the care plan.
3. Assessment includes the appropriateness of the setting in which care is to be delivered.

H 1. Planning for transfer of care / discharge commences at assessment, is multidisciplinary when necessary, and coordinated.

H 2. Feedback is sought from patients, family and the wider community regarding the organisation's provision of care and services to those with diverse needs and/or from diverse backgrounds.

MA Evaluation demonstrates the effectiveness of the screening and assessment of patients, and improvements are made where issues are identified.

Elements

1. Documented assessments meet the needs of the organisations and patients.
2. There is a process to ensure reassessments are conducted as needed.
3. Patient and family involvement in assessment and reassessment is effective.
4. Vulnerable patients and diverse population groups, and those with chronic conditions who develop an unrelated health issue are identified, assessed and managed.

H 1. There is evidence that interdisciplinary / departmental collaboration occurs to ensure the appropriate care is always provided.

H 2. Planning for transfer of care / discharge is evaluated to ensure that it:

(i) routinely occurs
(ii) is multidisciplinary when required
(iii) includes referral to specialty services when required
(iv) meets patient and family needs
(v) involves patients and family.

STANDARD 1: PATIENT CARE

1.4: Care Planning

The intent of this criterion is to ensure that care planning and delivery are responsive to patient needs and that there is a consultative, collaborative approach to the provision of health care that will actively involve the patient and their family.

Planning, delivery and coordination of care are the core business of all healthcare organisations. The key considerations in care planning are:

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

Healthcare organisations have an obligation to create an environment where recognition of diversity is embedded within the culture of the organisation and where all patients, whatever their individual circumstances, receive equality of care.

Diversity is a broad concept that refers to the various qualities that define the individual and exist across society as a whole. It includes characteristics or factors such as age, race, ethnicity, language, gender, sexual orientation, religion, beliefs, family and/or social structure, and ability, including disability; as well as socio-economic level, educational attainment, personality, marital and parental status, general life and work experience, and status within the general community. Recognising that each person is a unique and complex being is integral to understanding and responding effectively to healthcare needs at an individual, family or community level.

LA Policy / guidelines address the organisations requirements for care planning.

Elements

1. Guidelines for care planning are based on current professional standards and evidence-based practice.
2. Clinical guidelines are used to direct safe and appropriate care delivery and interventions.
3. Care planning addresses the diverse physical, spiritual, cultural, medical, psychological and social needs of patients.
4. Care planning addresses the specific needs of vulnerable patients and diverse population groups.
5. Patients and family where appropriate, are involved in the care planning process.
6. Holistic assessment of the patient informs the care plan.

H 1. Patients are informed of factors impacting on their health and a collaborative plan for promoting their individual wellbeing is discussed.

H 2. There are processes to manage and minimise risk to patients accommodated outside the specialty area.

H 3. The organisation defines its use of restrictive practices / restraint, including:
- (i) physical restraint
- (ii) chemical restraint
- (iii) seclusion
- (iv) locked doors.

EQuIP7 | FUNCTION 1 | CARE DELIVERY
STANDARD 1: PATIENT CARE • CRITERION 1.4

1.4: Care Planning

SA Care planning is based on the assessment of patient needs, in partnership with the patient and their family.

Elements

1. Care planning, decisions, actions and changes are documented in the patient health record and are regularly reassessed.
2. Patients and family participate in decisions about the appropriate setting for care delivery.
3. Care process mapping / clinical pathways is documented and undertaken by a multidisciplinary team where applicable.
4. Care is coordinated, planned and delivered by skilled and trained health professionals within a multidisciplinary team with an identified team leader.
5. Staff are provided with the opportunity for training to enhance their skills in the planning and delivery of appropriate services to patients and family with diverse needs and/or from diverse backgrounds.
6. Care is provided in response to patient needs in a timely manner.
7. The patient is regularly informed about their health status and provided with information that allows them to understand their care, care delivery options, and changes to their care plan.
8. Patients and family are informed of how to give feedback on the care provided.
9. Health professionals discuss the outcomes of care with the patient and their family, and this is documented.

H 1. The organisation ensures the appropriateness of care and interventions.

H 2. Care planning and delivery reflect the requirements of the patient's advance care directive where applicable.

H 3. Care planning ensures that services and/or interventions to be provided are appropriate.

H 4. Relevant health professionals are educated about the appropriate use of restraint.

H 5. Any restriction or restraint applied to the patient is closely monitored and assessed for safe removal or rescinding of the action.

1.4: Care Planning

MA Evaluation demonstrates the effectiveness of the care planning processes / systems and improvements are made where issues are identified.

Elements

1. Individual patient outcomes are assessed against:
   (i) the agreed care plan
   (ii) evidence-based guidelines
   (iii) the anticipated outcomes.
2. The organisation evaluates the overall effectiveness of care and interventions
3. The organisation evaluates the effectiveness of individual care episodes.
4. The organisation evaluates the appropriateness of the setting in which the care was delivered.
5. The organisation evaluates the care and services provided to patients with diverse needs and/or from diverse backgrounds.
6. The results of organisation-wide clinical audits are reviewed by relevant health professional groups and used to support the evaluation and improvement of health care.
7. The appropriateness of care, services and interventions are evaluated by health professionals and management, and patients, family and the community as practicable, and includes:
   (i) the use of key indicators
   (ii) feedback from patients and the community where applicable

H 1. Processes for managing patients accommodated outside the specialty area are evaluated.
H 2. Care planning meets the needs of high-risk patients.
H 3. Safety assessment and auditing of restrictive practices occurs regularly to ensure each episode of restraint conforms to the organisation's use of restraint according to regulatory standards.

STANDARD 1: PATIENT CARE

1.5: Rights and Responsibilities

It is the responsibility of the health care organisation to inform patients of both their rights and their responsibilities, in order to achieve the best possible outcomes of care.

The World Health Organization (WHO) states that *"Patients' rights vary in different countries and in different jurisdictions, often depending upon prevailing cultural and social norms. Different models of the patient-physician relationship—which can also represent the citizen-state relationship—have been developed, and these have informed the particular rights to which patients are entitled."*

Organisations should ensure they have a document (sometimes referred to as a 'Charter'), that explains the rights and responsibilities of patients, and/or their family.

Rights and responsibilities Charters should be aligned with the World Health Organization, the Office of the United Nations High Commissioner for Human Rights, or any local bodies, to ensure they comply with relevant legislation, guidelines, policy etc.

International consensus is that all patients have a fundamental right to privacy, to the confidentiality of their medical information, to consent to or to refuse treatment, and to be informed about relevant risk to them from medical procedures.

LA Policy / guidelines address patient rights and responsibilities.

Elements

1. Rights and responsibilities documents comply with relevant legislation, Charters and/or regulations.
2. Information about patient rights and responsibilities is provided to patients, family, staff and the community in appropriate formats / languages.
3. The management of personal and health-related information are consistent with relevant privacy legislation and which is readily available to staff.
4. Staff and other relevant stakeholders sign confidentiality agreements on appointment.
5. The organisation provides information on how patients and, when practicable, family can access advocacy and support services.
6. The procedure for patient access to their health records is communicated to patients and family.

H 1. Care is provided with respect to spiritual, religious and cultural preferences.

EQuIP7 | FUNCTION 1 | CARE DELIVERY
STANDARD 1: PATIENT CARE • CRITERION 1.5

1.5: Rights and Responsibilities

SA There are processes to ensure patient rights are upheld.

Elements

1. Staff and other relevant stakeholders are provided with orientation and ongoing education about their role with respect to:
   (i) patient rights and responsibilities
   (ii) how to maintain privacy and confidentiality while interacting with patients
   (iii) maintaining the dignity of patients
   (iv) maintaining confidentiality of patient personal and health-related information.
2. Staff discuss rights and responsibilities with the patient and, when practicable, their family using appropriate language and/or formats.
3. Feedback is sought from patients, family and the community regarding the organisation's management of rights and responsibilities.
4. Patients and family are provided with information about the use of personal mobile telephones / devices and maintaining privacy of staff and other patients.

MA Evaluation demonstrates the effectiveness of the rights and responsibilities processes / systems and improvements are made where issues are identified.

Elements

1. Patient privacy and confidentiality are monitored, breaches are analysed, and appropriate action is taken.
2. Feedback from patients, family and the community informs the organisation's evaluation of its management of rights and responsibilities.

STANDARD 1: PATIENT CARE

1.6: Consent

Consent is the first of the World Health Organization's Best Practice Protocols for clinical procedures safety, which were first published in 2004 and reformatted in 2012. Worldwide, consent for invasive investigations, treatment or procedures on patients is a fundamental expectation of healthcare providers.

Consent is a significant aspect of the assessment of patient needs both from a clinical and non-clinical perspective. Most countries have laws around consent to treatment and organisations should have information on relevant legislative requirements and guidelines.

Policies addressing consent should be in accordance with the legislation and relevant guidelines and organisation-wide practices must comply. Consent can include financial, procedural, ethics and/or research consent.

In this criterion, the term 'consent' covers a number of different legal requirements:

- The patient and/or family should be informed in broad terms of the nature of any invasive procedure which is to be performed. This consent protects the patient and also operates as a defence to legal action.
- The patient and/or family should be informed of material risks inherent in the procedure or treatment. This is part of the duty of care owed to the patient by the appointed clinician who provides treatment.
- Consent for collection of health information, and to any use of that information and/or disclosure by the organisation to third parties, as required under applicable jurisdictional privacy laws.

The patient and/or family must be provided with adequate information to allow informed financial consent.

LA Policy / guidelines outline the requirements for obtaining informed consent from patients.

Elements

1. Patient consent for care is documented in the health record.
2. Consent is obtained:
   (i) prior to delivery of care
   (ii) for any associated costs
   (iii) for the communication of patient information.
3. Patients and family are provided with information on recommended care and the risks involved, in appropriate formats / languages.
4. Health professionals and other relevant staff are educated about the consent policy / guidelines and how to obtain informed consent.

H 1. The organisation has defined the procedures / treatments that require documented informed consent including when significant changes to the treatment regime occur.

EQuIP7 | FUNCTION 1 | CARE DELIVERY
STANDARD 1: PATIENT CARE • CRITERION 1.6

1.6: Consent

SA There are processes for obtaining informed consent.

Elements

1. There is a process to manage:
   (i) when patient consent cannot be given at the appropriate time
   (ii) when the patient does not have the capacity to provide consent
   (iii) when provision for consent is to be given by someone other than the patient (a substitute decision maker (partner / family / legal guardian) when required.
2. Informed consent documentation includes the limits of the consent.
3. There is a process to manage when patients refuse / withhold consent, including communicating the withdrawal of consent to relevant healthcare professionals and other staff.
4. Details of the information provided to the patient in the process of obtaining informed consent is documented in the health record.

H 1. There is a process to ensure consent documentation is reviewed prior to any procedures and/or interventions.

MA Evaluation demonstrates the effectiveness of consent processes / systems and improvements are made where issues are identified.

Elements

1. The consent process complies with best practice.
2. Health record audits confirm informed consent is obtained prior to delivery of care.
3. Compliance with consent processes are monitored.

STANDARD 1: PATIENT CARE

1.7: Safe Care Delivery

Ensuring the correct patient receives the correct service must be a fundamental principle underpinning the operations of healthcare organisations.

Correct identification of the patient is fundamental to the delivery of safe, high quality care and services, and a primary factor of organisational risk management. The organisation must ensure that it fulfils all obligations and requirements with respect to its processes for identifying the patient, and that it has robust processes for identification, issuing a unique identifier and eliminating duplication or confusion of identity. Organisations providing services to patients must correctly identify the patient prior to providing a service.

Correct identification of patients is required:

- at admission or registration
- prior to commencement of care / intervention, and at relevant points during the process of care / intervention
- when handover or transfer of care processes and related documentation occurs
- prior to communicating health-related information electronically or over the phone
- prior to discharge from the organisation.

LA Policy / guidelines describe the requirements for the delivery of safe care for patients.

Elements

1. Correct patient identification occurs prior to any clinical intervention.
2. The organisation has documented systems for standardisation of patient identification.
3. Information is provided to patients and family about correct patient identification in appropriate language and/or formats.

H 1. There is a process for the management of instruments, countable items and other items used for surgery or procedures.

H 2. There are standardised checklists that define safe surgery.

EQuIP7 | FUNCTION 1 | CARE DELIVERY
STANDARD 1: PATIENT CARE • CRITERION 1.7

1.7: Safe Care Delivery

SA There is a system to ensure the delivery of safe care and services for all patients.

Elements

1. The system to ensure correct identification of patients includes:
   (i) verification of patient information
   (ii) matching patient information against documentation in the patient health record
   ...prior to any intervention.
2. Health professionals and other relevant staff are provided with orientation and ongoing education in correct patient identification.
3. The organisation supports staff, patients and family in the identification and reporting of incidents and near misses involving patient identification.

H 1. The system to ensure correct identification of patients, correct procedure and correct site in any medical intervention includes:
(i) marking the correct site / side for intervention
(ii) taking time out for team verification prior to the intervention
...and mitigates the associated risks.

H 2. Monitoring of each patient's physiological status during anaesthesia and surgery occurs according to professional practice guidelines and are documented in the patient's health record.

H 3. Patient post-surgical recovery is monitored and managed by appropriate health professionals.

H 4. Health professionals, non-clinical and support staff ensure that the diverse needs of patients and family are respected and met.

MA Evaluation demonstrates the effectiveness of the delivery of safe care to patients, and improvements are made where issues are identified.

Elements

1. Compliance with correct patient identification processes is monitored.
2. Incidents involving incorrect patient identification are analysed and trended, and further strategies to reduce incidents are implemented.
3. Outcomes of the evaluation of the system for ensuring correct patient identification, including incident management, are reported to the governing body.

H 1. Compliance with the organisation's policy / guidelines / checklists on the management of instruments, countable items and other items used for surgery or procedures is monitored.

H 2. Patients health status is monitored and documented regularly during the hospital stay and throughout each transition phase.

STANDARD 1: PATIENT CARE

1.8: Clinical Deterioration

All healthcare organisations should have a system for identifying, reporting and managing deteriorating patients. This is relevant for the deterioration of both physical and mental health status.

A medical emergency response plan sets out the procedure for reacting to clinical deterioration in a patient who is located outside of a critical care unit. The medical emergency response plan should be prominently displayed throughout the organisation, and education and training should be provided to all staff, appropriate to their role within the organisation.

Organisations should ensure that the medical emergency response plan also includes identification and action required by staff in the event of an acute reversible incident, such as choking, or a reaction to medication or food.

LA Policy / guidelines address the requirements for recognising and responding to deterioration of a patient's physical and/or mental health status and medical emergencies.

Elements

1. There is a system to identify and manage deterioration in a patient's health status.
2. There are processes to escalate the care of a deteriorating patient when necessary.
3. Medical emergency management plans are developed, reviewed and tested in consultation with relevant staff.
4. Medical emergency response plans and instructions are prominently displayed throughout the organisation.

H 1. Regular observations are recorded for each patient on standardised observation charts.
H 2. Responses to clinical deterioration supports the patients advance care directive.
H 3. The multidisciplinary team monitors and/or escalates responses to a decline in a patient's cognitive status.
H 4. The multidisciplinary team monitors and responds appropriately to a decline in a patient's mental health status.

SA There are processes to manage medical emergencies.

Elements

1. Equipment and/or resuscitation trolleys are standardised and made available by the organisation.
2. Rostering ensures that medical emergency respondents are available to meet organisational needs.
3. Staff adhere to the protocols in the medical emergency plan.
4. Relevant health professionals are trained in appropriate first response techniques including basic life support and records of the training are maintained.
5. There are processes for family to alert relevant health professionals if clinical deterioration is identified in a patient.

H 1. There is governance / committee oversight of medical emergency responses.
H 2. Relevant health professionals are trained in advanced clinical life support.

EQuIP7 | FUNCTION 1 | CARE DELIVERY
STANDARD 1: PATIENT CARE • CRITERION 1.8

1.8: Clinical Deterioration

MA Evaluation demonstrates the effectiveness of clinical deterioration processes / systems and improvements are made where issues are identified.

Elements

1. Identification and management of deteriorating patients is effective.
2. Records of emergency calls are maintained, and responses are timely.
3. There are demonstrated links between identification of deteriorating patients and escalation of care.
4. Staff training and competence in managing medical emergencies meet the needs of the organisation.
5. Outcomes of the evaluation of the organisation's responses to medical emergencies are reported to the governing body.

H 1. Scheduled audits of clinical responses to medical emergencies occur.
H 2. There is evidence of interdisciplinary response to the deterioration of patient clinical and cognitive health status.

STANDARD 1: PATIENT CARE

1.9: Clinical Handover

Clinical handover refers to the transfer of professional responsibility and accountability for some or all aspects of care for patient, to another person or professional group on a temporary or permanent basis. Effective clinical handover results in the safe transfer of care of patients.

Good handover and communication with ongoing providers, health professionals and family are fundamental to the operation of an effective healthcare system and exist concurrently with clinical documentation, letters of referral and transfer documentation. These functions of the healthcare process work in unison to form the continuum of care.

Outcomes for the patient are directly impacted by the quality of communication characterising clinical handover.

Processes for patient handover should consider:

- the handover situation to which it applies:
  - medical staff 'change of shift'
  - transfer of care between hospital teams and from hospital to community teams
  - transfer of care to general practitioner (GP)
  - transfer of care between facilities
  - handover in specific clinical situations, for example management of the deteriorating patient
  - communication with patient and family
- persons who should be involved in the communication, and appropriate responses where face-to-face briefings are not possible
- care information, including:
  - diagnoses and current condition of the patient
  - recent changes in condition or treatment
  - anticipated changes in condition or treatment
  - suggestions on what to watch for in the next interval of care
- print or electronic information that should be available to the incoming family / clinician.

LA Policy / guidelines address the requirements for clinical handover.

Elements

1. Common clinical handover scenarios within the organisation are planned.
2. All relevant patient health information is available at clinical handover and/or transfer of care.
3. Clinical handover ensures that all necessary information about the patient is communicated.
4. Transfer of patient care out of the organisation ensures that all necessary information about the patient is communicated.
5. Where clinically appropriate, the patient is involved in the clinical handover processes.
6. Processes for transfer of care ensure continuity of care and timely notification between referrers and health service providers.

H 1. Transfer and/or discharge information is discussed with the patient and the family, and a discharge summary is provided where relevant.
H 2. Transfer and/or discharge information is recorded in the patient health record.
H 3. Patient and/or family decision to discharge against medical advice is documented.

EQuIP7 | FUNCTION 1 | CARE DELIVERY
STANDARD 1: PATIENT CARE • CRITERION 1.9

1.9: Clinical Handover

SA Referral systems to other relevant health service providers are in place.

Elements

1. All relevant health information follows the patient through the referral system.
2. Arrangements with other health service providers and the family are made with patient consent and input and confirmed prior to transfer of care.
3. There is evidence to demonstrate that other health service providers receive timely notification about patients transferred to their care.
4. Formalised follow-up occurs for at-risk patients.

H 1. Discharge from units / departments providing intensive or specialised services is determined by established criteria.
H 2. Patient transfer to other organisations is based on their health care needs and/or their wishes.

MA Evaluation demonstrates the effectiveness of clinical handover and transfer of care processes, and improvements are made where issues are identified.

Elements

1. All necessary information about the patient is communicated during clinical handover and transfer of care.
2. Clinical transfer and/or transfer of care occurs in a timely manner.
3. The system to refer patients is effective.
4. Referral information is provided to patients and external health service providers in a timely manner.
5. The system to follow-up at-risk patients is effective.

H 1. Transfer and/or discharge processes are coordinated by the multidisciplinary team.
H 2. The system for transfer and/or discharge ensures patient safety.

STANDARD 1: PATIENT CARE

1.10: Ongoing Care

Ongoing care refers to the active and supportive management of care for people with chronic or complex conditions as well as the process that follows an admission to a healthcare organisation. All healthcare organisations involved in the ongoing care of patients should actively contribute to a seamless continuum of care for the patient and fulfil their responsibilities for their part of the process of ongoing care.

To achieve good health outcomes, many patients need care from more than one healthcare provider. Patients with chronic or complex conditions in particular require ongoing care, whilst others need some ongoing care and follow-up after an inpatient admission. The goal of care coordination is continuing care that appears seamless and achieves better health outcomes.

LA Policy / guidelines address the requirements for ongoing care of patients.

Elements

H 1. Processes are in place to ensure effective management of patients with chronic conditions who develop an unrelated health issue and/or deteriorate.
H 2. There are formal processes to efficiently coordinate ongoing care by multiple health service providers.
H 3. There are systems for screening, prioritisation and readmission of at-risk patients, and those with chronic conditions.
H 4. Written and verbal information is provided to patients about their chronic condition.

SA There are processes to ensure patients receive ongoing care where appropriate.

Elements

H 1. Care coordination and/or case management is available for appropriate patients and their family.
H 2. For patients with chronic conditions, processes are in place that reduce acute presentations and preventable admissions.
H 3. Education is available for patients with chronic conditions and their family on how to manage their condition.

MA Evaluation demonstrates the effectiveness of ongoing care processes, and improvements are made where issues are identified.

Elements

H 1. The ongoing care process is evaluated with patient and family involvement.
H 2. Evidence demonstrates that strategies developed to reduce acute presentations and preventable admissions are effective and based on best-practice.
H 3. Evidence demonstrates that screening, prioritisation and readmission of at-risk patients is effective.
H 4. Information and education provided for patients and their family requiring ongoing care, is relevant to their needs and promotes safe practice.

STANDARD 1: PATIENT CARE

1.11: End of Life Care

The goal of end-of-life care is to maximise quality of life through appropriate needs-based care for each person, with a focus on symptom control and comfort rather than cure. Use of a term such as 'comfort care' to describe end-of-life care is often used, as comfort is a familiar and unambiguous concept in everyday experience.

The end-of-life care pathway should address timely symptom control, support for families, and needs-based referral to specialist palliative care providers, and encompass both likely deterioration as well as the potential for active treatment, i.e. plan for death while remaining hopeful. Palliative care should be integrated with disease-modifying therapy as part of routine care.

Dying patients are cared for in many settings, including the home, community, hospice facilities, aged care facilities, hospital wards and intensive care units. Sometimes the process will involve moving in and out of facility-based care depending on needs at different stages of the journey. No matter what the setting(s), systems should be in place to support the consistent implementation of end-of-life policies organisation-wide.

Components of systems for end-of-life care include:

- decision making guidelines
- advance care planning
- recognition of cultural, spiritual and religious factors
- access to cultural, spiritual and religious resources
- referral to chaplaincy, spiritual or pastoral care
- care of the dying
- referrals to palliative care, pain management and/or other services
- conflict resolution
- legal requirements
- management of recognised risks
- mortality management.

LA Policy / guidelines address the requirements for end of life care.

Elements

H	1.	Patients are encouraged to discuss and document their preferences for ongoing management of their care in the event that they are unable to communicate those preferences.
H	2.	Documented patient directives for ongoing management of care are available in the health record.
H	3.	The management of patient end-of-life care is consistent with documented advance care plans / directives.
H	4.	Processes for the management of death and related issues address diverse spiritual, cultural, and social beliefs.
H	5.	The organisation has access to palliative care, symptom and pain management and/or other support services.
H	6.	The organisation has processes to identify the primary caregiver for a patient in an end-of-life situation.
H	7.	There are processes for the timely transfer of deceased persons to mortuary and/or appropriate facilities.
H	8.	Consent is obtained prior to transfer of the deceased.

EQuIP7 | FUNCTION 1 | CARE DELIVERY
STANDARD 1: PATIENT CARE • CRITERION 1.11

1.11: End of Life Care

SA End of life care addresses the needs of the patient and their family.

Elements

H	1.	When clinically indicated, patients are referred to palliative care, symptom / pain management services and/or other support services.
H	2.	Processes are in place for the management of a sudden or unexpected death.
H	3.	There is a support system to assist family, patients and staff affected by a death and related issues.
H	4.	There is a process to appropriately manage the deceased person according to: (i) advance care directives, including organ & tissue donations where relevant (ii) spiritual and cultural backgrounds (iii) ethical considerations (iv) family considerations.

MA Evaluation demonstrates the effectiveness of end of life care processes, and improvements are made where issues are identified.

Elements

H	1.	Compliance with policy, procedures and guidelines addressing end-of-life-care, including cultural sensitivity and staff education, is monitored.
H	2.	There is evidence of compliance with advance care plans / directives occurs in all instances where preferences have been documented.
H	3.	Clinical review committees, including morbidity / mortality and case review, evaluate the appropriateness of referrals to palliative care, pain management services, and/or other support services.
H	4.	Processes surrounding dying and death are ethical and based on best practice.

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STANDARD 2: CARE SERVICES

2.1: Health Records

During an episode of care, there are likely to be more than one contributor to a health record. Each healthcare provider must understand and take responsibility for the integrity of his or her entries. All professional interactions with the patient, including telephone conversations, and all treatments including minor details or minimally invasive interventions, should be documented. Healthcare providers must recognise the health record as a communication tool, rather than a document for personal notes.

The organisation must ensure that whether its patient records are paper-based, electronic or a combination of both, and whatever the nature of the health information entered in the record, such as paper forms, scans, images, photographs, it has a system capable of creating, monitoring, retrieving, transporting and storing records in a secure, accurate and timely manner.

Staff should receive training in health records management appropriate to their positions and responsibilities.

A patient's health record is instrumental in supporting the transfer of information internally when a patient is transferred within the care setting, during clinical handover or for the escalation of care. Records may also be used for communication with external healthcare providers to facilitate ongoing care, and be used for audit activities, investigation of complaints, and system improvements.

Privacy legislation applies when creating, storing or communicating all patient health information.

LA Policy / guidelines describe the requirements of the content and management of patient health records.

Elements

1. Each patient has their own health record.
2. Patient health records are created according to relevant guidelines.
3. Each patient health record has a unique identifier that is recorded in a central index.
4. Health professionals use the health record to document and communicate all aspects of care delivery.
5. Health records are monitored to ensure:
   (i) entries made to patient health records are clear, legible and timely
   (ii) additional documents included and/or scanned into patient health records are legible
   (iii) only approved abbreviations are used in patient health records
   (iv) there are no blank spaces between entries in patient health records
   (v) all entries in patient health records are signed and dated.
6. Relevant diagnostic test results are available in the patient health record.
7. Health professionals are provided with relevant orientation and ongoing education on the organisation's processes for health record creation and documentation.
8. Staff are advised of their responsibilities to facilitate patient access to their health records.
9. Patients are advised about how to access their health record.
10. Requests by patients for access to health records are met within a set period.

H 1. There is a process to document and authenticate telephone orders / communications between health professionals in the health record.

H 2. Clinical classification / coding is undertaken for all inpatient admissions.

EQuIP7 | FUNCTION 2 | CARE SUPPORT SERVICES
STANDARD 2: CARE SERVICES • CRITERION 2.1

2.1: Health Records

SA There are processes to ensure the safety and security of health records.

Elements

1. There is a health records management system that ensures:
   (i) health records are stored safely and securely
   (ii) there is timely and accurate retrieval and transport of health records stored on or off-site.
   (iii) the movement of any medical records is tracked
   (iv) patient privacy when information is communicated
   (v) health records retention schedules are specified.
   (vi) destruction of health records occurs while maintaining patient privacy.
2. Relevant staff are trained in health records management.
3. Patient health records are only accessible by authorised persons.
4. All components of the health record are accounted for at a central point and are monitored.
5. The health record is linked to other health information systems using the unique identifier.

H 1. Coding and reporting timeframes meet internal and external requirements.

H 2. Suitably qualified staff participate in the analysis of data including clinical classification / coding information.

MA Evaluation demonstrates the effectiveness of health record documentation and management and improvements are made where issues are identified.

Elements

1. Health records documentation and management meet medico-legal requirements, professional documentation standards, guidelines and/or codes of practice.
2. Health record audits identify:
   (i) the clinical content of patient health records supports safe, high quality care
   (ii) health records are complete and legible
   (iii) inclusion of reports and information from reviews, tests and other clinical investigations into the health record is timely
   (iv) requests for copies of health record documents are completed within an acceptable time.
3. Checks for patients with multiple identifiers occurs and merging of duplicate health records is managed appropriately.
4. Tracking and monitoring of health records occurs.

H 1. Coding of patient medical records and subsequent reporting processes are evaluated.

H 2. The content and completeness of patient health records are regularly assessed, as part of ongoing monitoring and performance improvement processes.

STANDARD 2: CARE SERVICES

2.2: Medication Management

Safe, high quality care and effective patient outcomes depend upon the correct management of medicines, including the prescription, dispensing, and/or administering of medicines. The use of medicines remains the most common intervention in health care. At the same time, medication incidents are one of the most frequently reported event categories.

A healthcare organisation is responsible for ensuring that it has a culture for medication management and reporting systems within the organisation that enables the identification and notification of as many medication errors, near misses and adverse drug events and/or reactions as possible. This is essential if potential risks are to be identified, evaluated and acted upon.

All organisations, including those that do not prescribe and/or dispense medicines, will need to consider the management of medicines on the premises, as well as ways to assist patients to understand the importance of compliance with medicine regimes.

Organisations should also consider the medicines prescribed by other services when assessing their patients.

LA Policy / guidelines define the requirements for recording patient medicines and for medication management.

Elements

1. There is an appropriate and standardised format for documenting patient medicine related information throughout the organisation.
2. A standardised list of approved abbreviations for medicines is used throughout the organisation.
3. Patient current medicines are documented as soon as practicable following admission, and prior to transfer of care.
4. A multidisciplinary body oversees the organisation-wide medication management system.
5. Health professionals are provided with orientation and ongoing education on medication management, including safe practice, risk reduction and correct documentation.
6. Health professionals are trained in medication management practices relevant to their role and responsibilities.
7. There are processes to ensure the safe use of high-risk medicines throughout the organisation.

H 1. Health professionals have access to published guidelines for medication management.
H 2. Written and verbal information is provided to patients about their medicines.
H 3. Medicines permitted for self-administration are monitored by health professionals and stored according to manufacturer's guidelines.
H 4. The prescribing, ordering, and transcribing of medicines are guided by policies and procedures.
H 5. The hospital defines the elements of a complete order or prescription.
H 6. The hospital identifies qualified health professionals permitted to prescribe and/or order medicines.

EQuIP7 | FUNCTION 2 | CARE SUPPORT SERVICES
STANDARD 2: CARE SERVICES • CRITERION 2.2

2.2: Medication Management

SA There are processes to ensure patient safety in the management of medicines.

Elements

1. Medication review occurs as soon as practicable following admission of the patient.
2. Medication reconciliation occurs following admission of the patient, and prior to transfer of care.
3. Manufacturer's instructions are followed for the correct handling of medicines.
4. Medicines are stored and disposed of securely and safely.
5. Temperature sensitive medicines are stored safely according to manufacturer's guidelines.
6. Procedures are implemented to reduce the risk and severity of medication incidents.
7. The organisation supports health professionals, patients and family in the identification and reporting of medication incidents, near misses and adverse drug reactions.

H 1. There is a system in place to ensure the safe dispensing of medicines.
H 2. Administration of medicines occurs only by qualified health professionals.
H 3. Relevant health professionals provide education for patients and their family about prescribed medicines, to encourage ongoing safe and appropriate use of medicines.
H 4. Staff are educated on processes for collecting and reporting information on medication incidents, including medication errors and near misses.

MA Evaluation demonstrates the effectiveness of medication management processes / systems and improvements are made where issues are identified.

Elements

1. Medication documentation complies with organisational requirements.
2. Medication review and reconciliation occurs in a timely manner.
3. The system for distribution, storage and disposal of medications is complied with.
4. Education and training in medication management is delivered to appropriate health professionals.
5. Medication incidents, near misses and adverse drug reactions are analysed and trended and reported to the governing body.

H 1. The information and education on prescribed medicines provided for patients and family is evaluated.
H 2. Outcomes of audits of the medication management system, including incident management, are reported to the governing body.

STANDARD 2: CARE SERVICES

2.3: Infection Control

Care in a health facility should not provide greater risks to the patient than the risks associated with the reason for admission to the facility. Healthcare-associated infections can be serious and life-threatening. Care workers and equipment can be vectors for the transmission of a number of pathogens.

An organisation-wide infection prevention and management system should be implemented, based on a comprehensive, multidisciplinary plan addressing all relevant aspects of infection control. It is vital that the plan be supported by the organisation's governing body, and that all necessary resources are made available and utilised.

Infection represents a significant risk for the organisation, and there must be effective systems in place to minimise as far as possible, the occurrence of healthcare-associated infections, to respond to outbreaks and to manage patients with infections and infectious diseases. This will assist in creating and maintaining a safe environment for patients, families, staff, contractors and other visitors.

LA Policy / guidelines describe infection control requirements.

Elements

1. There is an organisation-wide infection control plan that is appropriate for the services provided.
2. There are initiatives to encourage hand hygiene.
3. Standard transmission precautions are utilised.
4. There is a process for identifying and reporting notifiable diseases.
5. Outbreak management processes are addressed.
6. Personal protective equipment (PPE) supports occupational exposure prevention and management.
7. There are processes to manage spills of blood and body fluids.
8. There are processes to ensure safe management of sharps.
9. The organisation ensures the cleanliness and hygiene of its facilities, including:
   (i) waiting rooms
   (ii) food preparation areas
   (iii) eating areas, including cafeterias and staff lunchrooms
   (iv) toilets
   (v) non-clinical waste storage areas.
10. There is an effective surveillance system to monitor and report healthcare-associated infections.

H 1. The infection control plan addresses:
   (i) antimicrobial stewardship
   (ii) appropriate use of antibiotics
   (iii) aseptic technique
   (iv) cleaning services
   (v) food safety and kitchen cleaning
   (vi) linen handling and laundry services
   (vii) relevant equipment and plant.

H 2. The organisation ensures cleaning, disinfection, sterilisation, storage, and handling of sterile equipment / devices including attention to stock rotation, is compliant with policy and regulatory standards.

EQuIP7 | FUNCTION 2 | CARE SUPPORT SERVICES
STANDARD 2: CARE SERVICES • CRITERION 2.3

2.3: Infection Control

H 3. Hospital staff involved in reprocessing instruments and equipment are trained according to regulatory and/or legislative guidelines.

H 4. The system to manage single-use devices conforms with relevant legislation, regulations and/or codes of practice.

H 5. External service providers, students and visitors are advised of the organisation's infection control and safety requirements.

SA There is an effective infection control system that incorporates the requirements of the infection control plan.

Elements

1. The infection control plan is approved, supported and appropriately resourced by the governing body and/or its delegated authority.
2. Health professionals are supplied with equipment, resources and an environment that enables them to comply with the infection control plan.
3. A vaccination program is available for staff.
4. The organisation provides appropriate resources to support cleaning and hygiene requirements.
5. The infection control system, including the infection control plan, is managed and monitored by a multidisciplinary infection control committee and/or team.
6. There are documented risk reduction and containment measures for identified infections.
7. Infection risks, control strategies and safety requirements are communicated to patients and family, external service providers and other visitors.
8. Health professionals and other staff are provided with orientation and ongoing education about infection risks, control strategies and their responsibilities in preventing infection, relevant to their role and responsibilities.

H 1. There are verified processes to manage a sudden influx of patients and/or family with transmissible infections that have been implemented and tested.

H 2. Infection prevention strategies are integrated into all stages of healthcare planning, including health facility planning, construction, and refurbishment.

H 3. A planned and documented schedule of regular maintenance and/or monitoring of the environmental factors associated with infection control occurs.

2.3: Infection Control

MA Evaluation demonstrates the effectiveness of infection control processes / systems and improvements are made where issues are identified.

Elements

1. Compliance with all aspects of the infection control plan is monitored.
2. Education and training in infection prevention and control is effective.
3. Infection control strategies are regularly reviewed.
4. Safety requirements to minimise infection and reduce the risk of harm to patients, staff and visitors are monitored.
5. Communication of infection risks, control strategies and safety requirements to patients, family, external service providers and other visitors is effective.
6. The quality and reliability of organisation-wide cleaning and hygiene practices meets the needs of the organisation.
7. Outcomes of the evaluation of the organisation's infection control system are reported to the governing body.

H 1. Maintenance and monitoring of environmental factors relevant to infection control are evaluated.

H 2. The hospital evaluates infection risks, rates, and trends in health care-associated infections to reduce the risks of future infections.

EQuIP7 | FUNCTION 2 | CARE SUPPORT SERVICES
STANDARD 2: CARE SERVICES • CRITERION 2.3

STANDARD 2: CARE SERVICES

2.4: Health Promotion

Health promotion is the process of enabling individuals and groups to better understand, control and improve their health, via the use of activities designed to address identified risk factors and encourage behavioural and lifestyle improvements.

Health promotion is concerned not only with strengthening the skills and capabilities of individuals but also with actions directed towards changing social, environmental and economic conditions in order to improve individual and population health. The aim is to promote healthier lifestyles, to prevent and control common risk factors, and to encourage individuals to "take ownership" of their health. The development of a set of underlying health promotion principles and goals may assist the organisation in the development of its program.

The organisation's health promotion activities should be appropriate for its community, which will differ between public and private organisations. In the context of public health facilities, the organisation's 'community' consists of those people accessing or collaborating with the organisation: its patients and families, its staff, and relevant bodies or groups with which the organisation interacts.

In the context of private hospitals, the majority of their health promotion education and activities may only be suitable for staff.

LA Policy / guidelines address the requirements for health promotion.

Elements

1. The organisation identifies and monitors current and emerging health priority areas.
2. The organisation complies with its statutory requirements for reporting on public health matters.
3. Evidence-based health promotion and education resources relevant to the scope of the service, are available for patients, family and the community.
4. Health surveillance data appropriate to the organisation are collected.
5. Opportunistic health promotion strategies are undertaken in partnership with patients, family, staff and the community.

H 1. The hospital offers health education to patients in line with services provided.

H 2. There are targeted health promotion and early intervention strategies that are focused on prevention and harm minimisation.

EQuIP7 | FUNCTION 2 | CARE SUPPORT SERVICES
STANDARD 2: CARE SERVICES • CRITERION 2.4

2.4: Health Promotion

SA The organisation optimises the delivery of health promotion and interventions to patients and family.

Elements

1. There is an action plan to manage current and emerging health priority areas.
2. Staff and other key stakeholders are informed of population health principles and participate in evidence-based health promotion activities.
3. The organisation works in collaboration with relevant healthcare and community bodies to utilise resources effectively and support health promotion activities.
4. Where appropriate, the organisation utilises its healthcare and community collaborations to provide health education to patients, family, staff and the community.

H 1. The hospital defines the role of its health care staff / health professionals in health prevention and promotion practice.

H 2. Patients are supported to make informed choices about their health and wellbeing by health promotion, education, and early intervention programs.

MA Evaluation demonstrates the effectiveness of health promotion strategies, and improvements are made where issues are identified.

Elements

1. The distribution of health promotion information to patients, staff, family and the community is reviewed.
2. The outcomes of health promotion strategies meet the requirements of patients and/or staff.
3. The action plan to manage current and emerging health priority areas meets the needs of patients and the organisation.
4. The collection, analysis and use of health surveillance data meets the needs of the health promotion program.
5. Healthcare and community collaborations supports health education programs.

H 1. The outcomes of health promotion strategies are evaluated for their effectiveness in improving the health and wellbeing of patients, staff and the community.

STANDARD 2: CARE SERVICES

2.5: Skin Integrity

Organisations should ensure that the occurrence of healthcare-associated, non-surgical breaks in skin integrity is prevented whenever possible and minimised at all times.

A break in skin integrity can occur as the result of health care itself, can affect a wide variety of patients (neonates, the frail aged, the immobile and/or insensate, those with reduced sensory perception, individuals undergoing lengthy procedures), and can occur in all environments and situations involving bed care, the use of support devices or physical interaction (emergency departments, wards, transport vehicles, operating theatres, day hospitals, community nursing).

However, patients may present with compromised skin in any healthcare setting. Assessment and management of pre-existing breaks in skin integrity must be built into the patient's care plan whether or not it is the primary cause of his or her admission.

LA Policy / guidelines address the requirements for maintaining skin integrity.

Elements

- **H** 1. Risk assessment processes occur:
  - (i) on admission
  - (ii) at transitions of care
  - (iii) following changes in health status
  - (iv) prior to commencement of high-risk procedures.
- **H** 2. Strategies for the prevention of pressure injuries and preservation of skin integrity are followed by relevant staff.
- **H** 3. Processes for the management of wounds include consideration of, and strategies for, managing pain.
- **H** 4. Health professionals are provided with orientation and ongoing education on the preservation of skin integrity and wound prevention and management.
- **H** 5. Written and verbal information is provided to patients and family about recognising potential risks to skin integrity or to wounds, including wound infections.

SA The organisation optimises the delivery of skin integrity management interventions to patients and family.

Elements

- **H** 1. Health professionals are trained in the correct use of evidence-based risk assessment processes/ tools to assess skin integrity.
- **H** 2. Multidisciplinary wound prevention and management programs are implemented and adapted to local needs and healthcare settings.
- **H** 3. Wound documentation systems that supports continuity of care and assessment of progress towards goals are implemented.
- **H** 4. Patients and family are advised how they can alert relevant staff to any changes in skin integrity or to wounds, including wound infections.

EQuIP7 | FUNCTION 2 | CARE SUPPORT SERVICES
STANDARD 2: CARE SERVICES • CRITERION 2.5

2.5: Skin Integrity

MA Evaluation demonstrates the effectiveness of skin integrity management strategies, and improvements are made where issues are identified.

Elements

- **H** 1. The system for skin integrity preservation and wound management is evaluated.
- **H** 2. The incidence of skin integrity breaks, including pressure injury rates where applicable, is analysed and trended.
- **H** 3. Education and training in the preservation of skin integrity, wound prevention and management, and the use of evidence-based processes / tools are evaluated.

STANDARD 2: CARE SERVICES

2.6: Falls Management

Falls-related injury is one of the leading causes of morbidity and mortality in older people; falls and fall-related injuries are the reason for four in every five injury-related hospital admissions among people aged 65 years and over. However, there is a danger in assuming that falls risk is limited to the frail aged; it is possible for young and relatively fit people to suffer isolated falls due to trip hazards, light-headedness, and temporary confusion in the face of an acute illness, or medication.

Falls prevention requires a multifactorial approach to achieve the following objectives:

- to identify patients at high risk of falling
- to take precautions appropriate to individual patients to reduce falls
- to take precautions to minimise injuries from falls that cannot be prevented
- to respond to immediate injuries and assist patients to gain strength and confidence following a fall.

The possibility of a fall and the potential need for assistance post-fall is relevant for every healthcare organisation, including day procedure centres and community health centres. However, the focus will vary between organisations and wards.

Policies and guidelines for falls prevention for the whole organisation should include:

- roles and responsibilities
- education for patients and staff
- available equipment
- risk assessment of patients on admission or when changes occur in their health status
- environmental hazards and plans to minimise their impact
- post-falls responses
- falls reduction strategies
- standard reporting systems
- falls data, event monitoring and their review.

Individual risk assessment should take into account the specific circumstances of each patient episode of care.

LA Policy / guidelines address the requirements for fall prevention, harm minimisation and falls management.

Elements

H 1. Healthcare providers use an evidence-based risk assessment process / tool to regularly assess patients for risk of falls:
(i) on admission
(ii) following a change of risk factor / clinical status
(iii) at transitions of care
(iv) after a fall
...and the level of risk is conveyed to the patient, family, and clinical team.

H 2. Health professionals and other relevant staff are provided with orientation and ongoing education in falls prevention / minimisation.

H 3. Written and verbal information is provided to patients and family on falls prevention.

EQuIP7 | FUNCTION 2 | CARE SUPPORT SERVICES
STANDARD 2: CARE SERVICES • CRITERION 2.6

2.6: Falls Management

SA The organisation optimises the delivery of fall prevention interventions to patients and family.

Elements

H 1. Appropriate evidence-based multidisciplinary falls reduction strategies are implemented according to identified risk factors.

H 2. Patients and, where practicable, family are involved in the development of an individualised falls prevention / management plan which addresses risk factors identified during assessment.

H 3. Relevant health professionals are trained in falls injury risk assessment, prevention and management, and the use of falls prevention equipment.

H 4. The organisation supports staff, patients and family in the identification and reporting of falls incidents and near misses.

H 5. Falls and fall injury prevention equipment is available for patients following appropriate education and training for use.

H 6. Falls risk is considered as part of discharge planning for at-risk patients.

MA Evaluation demonstrates the effectiveness of fall prevention strategies, and improvements are made where issues are identified.

Elements

H 1. The system for falls prevention / minimisation is evaluated.

H 2. Patient individual falls prevention and management plans are reviewed, and their effectiveness is evaluated.

H 3. Falls and fall injury data are analysed and trended.

H 4. Staff education and training in falls prevention / minimisation and falls injury management are evaluated.

H 5. The information, education and training provided to patients and family on falls prevention and management is evaluated.

STANDARD 2: CARE SERVICES

2.7: Nutrition

Good nutrition is a vital aspect of patient wellbeing. Poor nutrition during an episode of care can significantly retard recovery and prolong length of stay and, in extreme cases, cause the development of malnutrition. While food services are sometimes viewed as an appropriate area for 'cost-cutting', the organisation should consider both the health impact of poor nutritional care and the increased expenditure associated with longer episodes of care.

Good nutrition management, conversely, will support patient recovery and wellbeing, and should be considered an aspect of patient care. The organisation should develop and implement an overall management plan for nutrition, appropriate to the size and scope of the organisation, and which includes strategies for the treatment and prevention of malnutrition.

Delivering quality nutritional care can be a complex process and may require multidisciplinary oversight. While dietitian involvement is preferable, at a minimum the organisation should draw upon current best-evidence when developing its nutrition management policy / guidelines and procedures.

LA Policy / guidelines address the requirements for the nutritional care needs of patients.

Elements

H	1.	Relevant health professionals use a validated nutrition risk screening tool to assess patients: (i) on admission (ii) weekly thereafter (iii) following a change of health status.
H	2.	The organisation has a strategic and coordinated approach to delivering patient-centred nutritional risk screening and care for those with malnutrition.
H	3.	Food, fluid and nutritional care is considered as part of an intervention and medical treatment plan, and is developed in collaboration with the patient and/or family where relevant.
H	4.	Health professionals and other relevant staff are provided with orientation and ongoing education about their roles and responsibilities in delivering nutritional care and preventing malnutrition.

SA The organisation optimises the delivery of nutritional care interventions to patients.

Elements

H	1.	A multidisciplinary team oversees the organisation's nutrition management strategy to ensure that the provision of food and fluid to patients is consistent with best practice.
H	2.	Strategies to deliver food and fluids to patients requiring physical assistance are implemented, according to the patient requirements.
H	3.	Referrals to nutrition-related services occur in a timely manner.
H	4.	The organisation supports staff, patients and family in the identification and reporting of nutrition-related incidents and near misses.

2.7: Nutrition

MA Evaluation demonstrates the effectiveness of nutritional care strategies, and improvements are made where issues are identified.

Elements

H	1.	Compliance with policy / guidelines for the delivery of nutritional care is monitored and evaluated.
H	2.	Education for staff, patients and/or family on nutritional care and malnutrition is evaluated.
H	3.	Incidents contributing to deterioration in patient nutritional status are analysed and trended.
H	4.	Evaluation outcomes of nutritional care including preventing malnutrition and incident management, are reported to the governing body.

STANDARD 2: CARE SERVICES

2.8: Blood Management

The transfusion of blood or blood components / products is a high-risk procedure and the organisation must have systems in place that support safe and effective blood management and actively reduce the risk of errors. Many evidence-based standards, guidelines and circulars are available for blood and blood component / product management and blood component therapy, that also define the appropriate use of red blood cells, platelets, fresh frozen plasma (FFP) and cryoprecipitate.

The organisation should draw upon these while also ensuring that its systems are in accordance with all relevant jurisdictional legislation, standards and guidelines. The organisation should also have a local emergency blood management plan in accordance with the requirements of its jurisdiction and/or relevant health authorities.

LA Policy / guidelines address the requirements for the management of blood and blood products.

Elements

H 1. Blood management strategies include:
- (i) patient identification at the time of sample collection
- (ii) completion of the request form, safe collection, identification and labelling of the patient sample
- (iii) prescription and documentation of blood and blood product therapy
- (iv) obtaining and documenting informed consent
- (v) managing patients who refuse administration of blood or blood products
- (vi) the timely availability and safe administration of blood and blood products
- (vii) monitoring and review of the appropriateness of blood and blood product therapy
- (viii) patient blood management including blood conservation strategies and alternatives to blood or blood product therapy
- (ix) reporting and management of adverse effects of blood and blood product therapy.

H 2. Storage conditions and transportation of samples and blood and blood products include:
- (i) validating, monitoring and recording of temperature for all blood fridges
- (ii) maintenance standards for all blood fridges
- (iii) the response to blood fridge alarms
- (iv) delivery, placement and removal of blood and blood products from any blood fridge / controlled storage / pneumatic tubes / other transportation systems
- (v) policy for monitoring blood and blood product usage and wastage.
- (vi) a documented audit trail.

EQuIP7 | FUNCTION 2 | CARE SUPPORT SERVICES
STANDARD 2: CARE SERVICES • CRITERION 2.9

2.8: Blood Management

SA The organisation optimises the management of blood and blood product for patients and family.

Elements

H 1. The sample and blood and blood product management system ensures:
- (i) verification of patient identification at the time of sample collection
- (ii) timely and safe collection and labelling of samples
- (iii) documented indication and prescription for blood and blood products
- (iv) the patient and family are informed of the risks, benefits and appropriateness of the blood and blood product for their clinical situation, and consent for administration is obtained
- (v) timely availability of blood and blood products
- (vi) verification of correct patient and blood or blood product, and safe administration of blood and blood products.

H 2. The system for the safe transportation and storage of samples and blood and blood products includes:
- (i) a blood and blood products inventory register
- (ii) allocated responsibilities for responding to storage alarms and taking corrective action
- (iii) documentation accompanying samples and blood and blood products
- (iv) labels being checked each time the blood or blood product is handled
- (v) monitoring blood and blood product usage and wastage.

H 3. Relevant health professionals are provided with orientation and ongoing education on procedures for safe sample and blood and blood product management, including:
- (i) patient identification and sample collection
- (ii) storage and transportation of samples and blood and blood products
- (iii) blood and blood product therapy prescription and safe administration.

H 4. The organisation supports health professionals, patients and family in the identification and reporting of blood-related incidents, near misses and adverse reactions.

MA Evaluation demonstrates the effectiveness of blood and blood product management, and improvements are made where issues are identified.

Elements

H 1. The sample and blood and blood product management system is evaluated.

H 2. The system for transportation and storage of samples and blood and blood products is evaluated.

H 3. The blood and blood products inventory register is evaluated.

H 4. The appropriateness of transfusion decisions is evaluated.

H 5. Sample and blood and blood product errors, near misses and adverse events are analysed and trended, and further strategies to reduce sample and blood and blood product incidents are implemented.

H 6. Education and training in safe sample and blood and blood product management are evaluated in consultation with relevant staff.

H 7. Evaluation outcomes of the blood management system, including incident management, are reported to the governing body.

STANDARD 2: CARE SERVICES

2.9: Organ and Tissue Transplant Services

The organisation's commitment to organ and tissue donation will be evident in the policies, processes, resources and education provided for this often lifesaving procedure.

In respect of living donor transplantation, jurisdictional protocols developed by the relevant authority on human organ transplants should be consulted. In circumstances where a patient wishes to donate his or her whole body or specific organs / tissue for scientific research or teaching purposes, arrangements should be made with relevant organ and tissue donation agencies or body bequest programs, according to what exists in the jurisdiction.

Organisations should also have systems in place to support access to organ and tissue donor / transplant coordinators. Donor coordinators play a pivotal role in coordinating the organ and tissue donation process.

This criterion will not be applicable to all health services.

Where organ and tissue donation is administered by a jurisdictional department, this criterion will be relevant; however, the elements should be viewed from the perspective of how the organisation works with the jurisdictional department and compliance with the processes of the program.

LA Policy / guidelines address the requirements for the management of organ and tissue transplants.

Elements

H 1. The hospital informs patients and families about how to choose to donate organs and/or other tissues.

H 2. The hospital provides patients and families guidance with the process of organ and tissue donation and transplants.

SA The organisation optimises the management of organ and tissue transplant services for patients and family.

Elements

H 1. There are processes to support staff, patients and family involved in organ and tissue donation.

H 2. Relevant health professionals are trained in organ and tissue donation processes.

MA Evaluation demonstrates the effectiveness of organ and tissue transplant services, and improvements are made where issues are identified.

Elements

H 1. The system for managing patient organ and tissue donations and/or transplant services is evaluated.

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STANDARD 3: PERFORMANCE IMPROVEMENT

3.1: Quality Improvement

Implementing processes that assist an organisation to become safe and accountable, consistently providing a healthcare environment conducive to better health outcomes for patients requires attention to systems and the analysis of collected data.

Quality improvement and the management of risks in health care should be part of both strategic and operational planning in every area and service of healthcare delivery. Clinical practice, equipment design and procurement, personnel management and financial planning are crucial facets of developing a quality improvement and risk management profile that defines a safe and viable organisation.

There are some essentials that characterise a quality improvement program irrespective of the QI framework used by the organisation, its size, type or complexity. It would be expected that:

- staff members accountable for taking action are identified and informed
- risk management and patient safety are considered in all decision making
- improvement teams are multidisciplinary
- quality activities are informed by appropriate data collection
- staff are familiar with quality objectives and processes, ideally through formal training, but in the absence of this, through orientation and mentoring
- there are channels through which concerns about quality of care and/or processes can be directed
- identified goals for the healthcare system are considered and integrated into planning.

LA Policy / guidelines address the requirements for continuous quality improvement.

Elements

1. Continuous quality improvement supports the organisation's vision, values and strategic direction.
2. An integrated, organisation-wide quality improvement system is developed, documented and implemented.
3. Annual planning includes identification of key quality improvement objectives.
4. The governing body demonstrates its commitment to continuous quality improvement.

SA Quality improvement is planned, continuous, and responsive to the risk management system and the strategic plan.

Elements

1. The organisation supports health professionals and other staff in identifying and responding to opportunities to improve the quality of care and service delivery.
2. Leaders in quality improvement are identified and developed across the organisation to drive ongoing improvement.
3. Health professionals and other staff are provided with orientation and ongoing education about the organisation-wide quality improvement system and their responsibilities for quality improvement.
4. The organisation supports patients to participate in quality improvement activities.

EQuIP7 | FUNCTION 2 | CARE SUPPORT SERVICES
STANDARD 3: PERFORMANCE IMPROVEMENT • CRITERION 3.1

3.1: Quality Improvement

MA Evaluation demonstrates the effectiveness of the quality improvement system and its component activities, and improvements are made where issues are identified.

Elements

1. The quality improvement system and its component activities are monitored to ensure effectiveness.
2. Qualitative and quantitative data are collected, analysed and used to plan and drive improvement.
3. Improvement strategies are implemented across the organisation to ensure safe practice and a safe environment.
4. Health professionals, other staff and relevant stakeholders including patients and family are involved in the evaluation of the quality improvement system.
5. Outcomes of quality and safety initiatives are reported to staff, patients, family, the community, and the governing body.

STANDARD 3: PERFORMANCE IMPROVEMENT

3.2: Risk Management

Risk is defined as the effect of uncertainty on objectives. A healthcare organisation's objectives vary according to multiple factors: clinical, financial, health and safety or environmental, and they apply at the strategic, organisation-wide, unit, project and process levels.

Risk management is a coordinated activity that directs and controls the organisation regarding risk, while a risk management framework is the systematic application of management policies, procedures and practices to the activities of communicating, consulting, establishing the context, and identifying, analysing, evaluating, treating, monitoring and reviewing risk.

By associating the management of risk with objectives of all kinds and across all organisational levels, a synthesis of risk and function occurs establishing an integrated organisation-wide system, or risk management framework. This framework ensures that information about risk derived from the risk management process is satisfactorily reported and used as the basis for future decision making and accountability. The risk management framework should link to strategic and business planning and support assessment of new and/or altered services.

LA Policy / guidelines address the requirements for managing risks.

Elements

1. The organisation identifies specific strategies for managing risk.
2. An integrated, organisation-wide risk management system addressing corporate and clinical risk is developed, documented and implemented.
3. Annual planning includes the identification of key organisational risks, and controls to mitigate risk.
4. The governing body demonstrates its commitment to managing risk within the organisation.

SA There is integration between quality improvement, risk management and strategic planning.

Elements

1. A risk management approach is used when considering and developing new and modified services.
2. Risk identification and risk analysis are undertaken using qualitative and quantitative data and strategies are developed and implemented to respond to risk.
3. The organisation supports health professionals and other staff in identifying and responding to opportunities to manage risk.
4. Health professionals and other staff are provided with orientation and ongoing education about the risk management system and their responsibilities for identifying and managing risk.
5. Patient, family and community feedback is used to inform risk management processes.
6. There are processes to ensure that timely action is taken to manage risks identified by health professionals, other staff, patients, family and other visitors.

EQuIP7 | FUNCTION 2 | CARE SUPPORT SERVICES
STANDARD 3: PERFORMANCE IMPROVEMENT • CRITERION 3.1

3.2: Risk Management

MA Evaluation demonstrates the effectiveness of risk management processes / systems and improvements are made where issues are identified.

Elements

1. The risk management system is effective.
2. Implemented risk mitigation strategies are monitored for effectiveness.
3. Health professionals, managers and other staff use data from risk management processes to plan and implement improvements to care and services.
4. Outcomes of risk analysis and management are reported to the governing body.

STANDARD 3: PERFORMANCE IMPROVEMENT

3.3: Incident Management

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, while a near miss is an incident that did not cause harm, loss or damage, but had the potential to do so.

A degree of risk is an inherent component of the provision of health care, and organisations must openly recognise this while striving to always reduce that risk. The right of the patient to safe, high quality health care is fundamental, and a vital aspect of the provision of safe services is the management of incidents.

Incidents, including near misses, must be:

- identified
- reported
- investigated

...and all appropriate steps taken in order to prevent their recurrence.

Organisations should have effective systems for the management of healthcare incidents and near misses as and when they occur, so that their causes may be investigated, and improvements made to processes and cultures in order to prevent recurrence.

LA Policy / guidelines address the requirements for incident management.

Elements

1. There is an incident management process that monitors all incidents / near misses.
2. Patients are provided with information about incident management processes, and how to access advocacy support.
3. There is documented delineation of responsibilities and lines of communication in the event of an incident.

SA There is an integrated incident management system.

Elements

1. The integrated incident management system includes:
   (i) documented delineation of responsibilities
   (ii) documented lines of communication
   (iii) processes to guide the immediate response to an incident
   (iv) identification, risk rating and review of incidents, including near misses
   (v) in-depth investigation of serious incidents / sentinel events, including Root Cause Analysis where necessary
   (vi) appropriate corrective action
   (vii) support for patients, family and staff involved in incidents
   (viii) dissemination of outcomes of investigations and action taken to relevant patients, staff and other stakeholders.
2. Health professionals and other staff are provided with orientation and ongoing education about incident management and their responsibilities in incident reporting.
3. The organisation supports the identification and reporting of near misses by staff, patients and family.

EQuIP7 | FUNCTION 2 | CARE SUPPORT SERVICES
STANDARD 3: PERFORMANCE IMPROVEMENT • CRITERION 3.1

3.3: Incident Management

MA Evaluation demonstrates the effectiveness of incident management processes / systems and improvements are made where issues are identified.

Elements

1. Health professionals, other staff and relevant stakeholders including patients and family are involved in the evaluation of the incident management system.
2. Incidents are trended and analysed.
3. The support provided for patients, family and staff involved in incidents meets their needs.
4. Outcomes of incidents and the organisation's response are reported to the governing body.

STANDARD 3: PERFORMANCE IMPROVEMENT

3.4: Feedback and Complaints

The provision of feedback by patients and their families can offer unique perspectives on patient and community needs, and draw attention to both successes and flaws in the systems, processes and services operating within organisations. Valid complaints, properly managed, should lead to the patient-driven improvement of those systems, processes and services, while positive feedback and compliments provide an opportunity to highlight the achievements of the organisation's operation and, the same way acknowledge staff.

Feedback to an organisation is often in the form of a compliment directed at the services or the staff. This acknowledgement should be passed on to all relevant parties, including being communicated to management. Compliments from those accessing a health service identify the successes of the facility and its staff, and should be circulated both internally and externally to the organisation. This helps to reinforce positive functional operations and contributes to a constructive view of the culture and overall capacity of the organisation.

Conversely, many complaints are received by staff in a spontaneous, verbal manner, and the appropriate response may include:

- acknowledgement of the complainant's concern
- an explanation if the staff member(s) can give it
- a note of the complaint made in the health record of the patient concerned
- facilitation of a discussion between the complainant and the relevant clinician(s)
- an apology if warranted
- the provision of information as to how the complaint can be formally lodged, should the complainant wish to proceed
- notification of effective resolution strategies.

Effective complaints management should be a part of the organisation's integrated framework. The data collected by the complaints management system should be collated and trended, to allow any 'hot-spots' for complaints to be identified and all necessary changes made.

Complaints data are a valuable source of information for organisations, particularly as they can draw attention to problem areas that are not being reported as 'incidents. Trending of data over time will allow organisations to judge the effectiveness of existing systems, and prompt necessary changes.

LA Policy / guidelines address the requirements for feedback and complaints management.

Elements

1. The organisation has a process for receiving and managing feedback, including complaints.
2. Patients and family are informed of the process for giving feedback or making a complaint, including the process for escalating complaints and how to access advocacy services.
3. The system for the management of complaints includes:
   (i) registration of the complaint
   (ii) assessing the severity of a complaint
   (iii) review, including formal review of serious complaints
   (iv) response in a timely manner
   (v) support and/or advocacy for patients, family and staff involved in a complaint
   (vi) communication of outcomes to the complainant and others involved.

EQuIP7 | FUNCTION 2 | CARE SUPPORT SERVICES
STANDARD 3: PERFORMANCE IMPROVEMENT • CRITERION 3.1

3.4: Feedback and Complaints

SA Feedback, including complaints, is managed to ensure improvements to the system of care.

Elements

1. Feedback received about care and services is made available to staff, patients and management.
2. Feedback is sought from patients and family regarding the organisation's management of complaints.
3. There is a system to implement the recommendations from the review of feedback and complaints.
4. Health professionals and other staff are provided with orientation and ongoing education regarding:
   (i) complaints management
   (ii) patient and family feedback
   (iii) the use of feedback and complaints to drive improvement.
5. Relevant staff are trained in methods of conflict and complaint resolution.

MA Evaluation demonstrates the effectiveness of the feedback and complaints processes / systems and improvements are made where issues are identified.

Elements

1. Complaints are monitored and trended, and risks are identified.
2. The support and access to advocacy provided for patients, family and staff involved in complaints meets their needs.
3. Health professionals, other staff and relevant stakeholders including patients and family are involved in the evaluation of the feedback and complaints management system.
4. Outcomes of feedback and complaints management are reported to the governing body and staff.

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STANDARD 4: CORPORATE MANAGEMENT SYSTEMS

4.1: Clinical and Corporate Management

Governance is the system by which organisations are directed and controlled. In the provision of care, it is a leadership responsibility to set organisational agendas for, and monitor, both corporate and clinical governance.

The organisation should define which body carries legal accountability and/or scope of organisational responsibility for the functions covered.

Organisations should regularly review their governance and assurance arrangements to assess if all the threads of quality, performance and governance are aligned and integrated. Consideration should be given to whether committee structures, their terms of reference, relationships and their 'supports' (staff, advisors, systems and processes) are all fit for the purpose and flexible enough to cope with changing priorities and risks.

LA Policy / procedures address the role of the governing body.

Elements

1. Members of the governing body receive formal orientation and ongoing education regarding the duties and responsibilities of their role.
2. There is an organisational chart that reflects the structure and lines of reporting.
3. The organisation has identified the community that it serves.
4. The governing body plans the type of clinical services needed to meet the needs of its community and provides direction for those services.
5. There is clinical governance of the organisation's clinical services.
6. Patient, family and stakeholder participation is representative of the community that the organisation serves.
7. Leaders and managers actively promote the organisation's values and respectful behaviours.
8. Terms of reference, membership and procedures are in place for meetings of the governing body and relevant Committees.
9. Minutes of committee and governing body meetings are recorded and confirmed, and decisions and actions are implemented.
10. The organisation has a budget development and review process.
11. The governing body regularly shares information about its activities and decisions with relevant staff and stakeholders.
12. The organisation's activities comply with relevant by-laws, articles of association and/or policies and procedures.

H 1. Each department / service identifies the services they provide.
H 2. Hospital leaders facilitate effective communication throughout the hospital.
H 3. Staff are provided with information about patient, family and community participation.

EQuIP7 | FUNCTION 3 | GOVERNANCE
STANDARD 4: CORPORATE MANAGEMENT SYSTEMS • CRITERION 4.1

4.1: Clinical and Corporate Management

SA Governance is assisted by formal structures and delegation arrangements.

Elements

1. The system for the recruitment and appointment of senior managers defines the accountability of managers for the provision of safe services.
2. There are clear lines of accountability / delegations within the organisation.
3. A system has been implemented to govern decision making with ethical implications.
4. The governing body or its delegated authority monitors, assesses, and records issues referred for ethical consideration in a timely manner.
5. Patients, family and other stakeholders are provided with relevant information and training to enable them to fully participate in committee activities.
6. The organisation has sound financial management practices, including an independent audit process.
7. Financial processes are consistent with legislative and government requirements.
8. Useful, timely and accurate financial reports are provided to the governing body and those with delegated financial authority.

H 1. Clinical services are coordinated across all units / departments.
H 2. Patients, families and stakeholders are consulted about effective ways of participating with the organisation and partnerships are established.
H 3. Relevant staff are trained in how to implement patient, family and community group participation strategies.

MA Evaluation demonstrates the effectiveness of governance processes / systems and improvements are made where issues are identified.

Elements

1. The performance of the governing body, and the performance of its members provides the organisation with competent leadership.
2. Reports on the quality of care and services and risk management are received and responded to.
3. The organisations performance results are made available to the patients, the community and relevant stakeholders as appropriate.
4. Formally constituted committees are monitored for effectiveness.
5. Organisational structures and processes are reviewed to ensure effective service delivery.
6. The identified lines of accountability / delegations are followed as required.

H 1. The vision and values of the organisation are evaluated.
H 2. The hospital's clinical services meet the needs of patients and the community.
H 3. The organisation's facilitation of patient, family and stakeholder participation, including committee membership, meets the needs of the organisation.
H 4. Education and training of staff in patient, family and community group participation is evaluated.
H 5. Outcomes of patient, family and community involvement in the evaluation of the health service are communicated to the governing body.

STANDARD 4: CORPORATE MANAGEMENT SYSTEMS

4.2: Strategic and Operational Planning

Strategic planning is a process which articulates the organisation's vision and values, and planned objectives; that is, what it intends to achieve for its community.

The process of strategic planning is a function of the governing body but ideally involves internal and external stakeholders.

Organisational strategy defines what an organisation seeks to do and how it plans to do it. While a formal plan may guide overall direction, strategy development is a continuous process, enabling the organisation to respond to changes in its environment as appropriate.

Note: In the context of EQuIP7, internal stakeholders may include health professionals and any other staff, patients and families, while external stakeholders may include referring health professionals, the community, including community organisations or individuals with an interest in the health service, and individuals who may have been a patient at one time.

LA Strategic and operational plans are documented.

Elements

1. A strategic plan has been developed which reflects the organisation's vision and values.
2. Operational plans reflect the organisation's objectives and guide day-to-day activities.
3. There is a planned approach to the development of facilities and services.
4. Organisational and service planning reflects strategic objectives.
5. Service delivery needs of the organisation's community are analysed and considered when developing strategic and operational plans.
6. Clinical and non-clinical service planning addresses projected service demands.
7. Planning identifies priority areas for care / service development and the most efficient use of resources including physical assets.
8. Strategic and operational planning is supported by documented change and risk management strategies.
9. Allocation of resources is based on the service requirements identified in the strategic and operational planning processes.

EQuIP7 | FUNCTION 3 | GOVERNANCE
STANDARD 4: CORPORATE MANAGEMENT SYSTEMS • CRITERION 4.1

4.2: Strategic and Operational Planning

SA Strategic and operational planning and development occurs with collaboration by relevant stakeholders.

Elements

1. The organisation identifies ways of encouraging participation in the planning, delivery and evaluation of care and services.
2. Relevant staff are educated in how patients and family can participate in the planning, delivery and evaluation of the health service.
3. Planned changes are clearly communicated to relevant stakeholders.
4. Relationships with relevant external organisations are formally recognised in the planning process.

MA Evaluation demonstrates the effectiveness of strategic and operational planning and development and improvements are made where issues are identified.

Elements

1. Progress towards achieving the vision and objectives of the strategic plan is regularly monitored, and remedial action is taken as required.
2. Strategic and operational plans meet the needs of the organisation, the community and other stakeholders where relevant.
3. Changes driven by the strategic plan are monitored for effectiveness.

STANDARD 4: CORPORATE MANAGEMENT SYSTEMS

4.3: Corporate Information

Corporate records are an organisation's 'memory'. They provide evidence of actions and decisions and represent a vital asset to support daily functions and operations. Records support policy formation and managerial decision making, protecting the interests of the organisation as well as the rights of staff and patients, and help in the delivery of services in a consistent and equitable way. They also support consistency, continuity, efficiency and productivity in program delivery, management and administration.

Effective corporate records management will be maintained via a consistent, organisation-wide records creation and storage system that is in accordance with the requirements of legislation, organisational policy, and all relevant standards and guidelines. The system should also ensure that access to records is appropriately restricted, and that records are created, monitored, retrieved, transported and stored in a secure, accurate and timely manner. Relevant staff should receive training in corporate records management appropriate to their positions and responsibilities.

Policy, by-laws, guidelines and procedures represent the translation of legislation, relevant standards, and codes of practice and ethics into a framework that allows the organisation to meet its obligations to the community it serves:

- Policy is a documented statement shaped by legislative requirements that formalises the approach to tasks and concepts, and which is consistent with organisational objectives.
- Policy is a documented statement shaped by legislative requirements that formalises the approach to tasks and concepts, and which is consistent with organisational objectives.
- By-laws are rules, regulations and/or legislation adopted by the organisation for the regulation of both its internal and external affairs.
- Guidelines are principles that guide or direct action.
- Procedures are a set of documented instructions conveying the approved and recommended steps for a particular act or sequence of acts.

LA There is a process to develop corporate and clinical policies, procedures and/or guidelines.

Elements

1. Development of corporate and clinical policies, procedures and/or guidelines reference relevant:
   (i) legislation
   (ii) standards
   (iii) professional guidelines
   (iv) codes of practice
   (v) codes of ethics
   (vi) by-laws
   (vii) evidence
   (viii) current issues
   (ix) operating and management requirements.
2. There is a process to update policies and procedures when there are changes to practice and services in clinical and non-clinical areas.
3. Relevant stakeholders including staff, patients and family are involved in the development of new and revised local policy and procedures.

EQuIP7 | FUNCTION 3 | GOVERNANCE
STANDARD 4: CORPORATE MANAGEMENT SYSTEMS • CRITERION 4.1

4.3: Corporate Information

4. Policies and procedures for all key functions of the organisation are:
   (i) documented
   (ii) risk-rated
   (iii) authorised
   (iv) dated and version controlled
   (v) implemented
   (vi) regularly reviewed.
5. A system is implemented that:
   (i) audits compliance with relevant legislation / regulations
   (ii) informs relevant staff of new or amended legislation / regulations
   (iii) familiarises staff with relevant legislation / regulations applicable to their area of responsibility.
6. There is a process for the rescinding of superseded policies and the distribution and implementation of reviewed policies and procedures.

SA There is an organisation-wide system for document control.

Elements

1. There is governance and accountability for corporate records management.
2. Standardised record creation and tracking complies with relevant guidelines.
3. There is a corporate records management system that ensures:
   (i) the secure, safe and systematic storage of data and records
   (ii) timely and accurate retrieval and transport of records stored on or off-site
   (iii) appropriate retention and destruction of records
   ...according to all relevant legislation, standards, guidelines and/or codes of practice.
4. The security of corporate records is assured through restricted access.
5. Corporate records created by the organisation are supported by appropriate record systems.
6. Relevant staff are trained in corporate record keeping and records management.

MA Evaluation demonstrates the effectiveness of policy / guideline development and the management of corporate information, and improvements are made where issues are identified.

Elements

1. The system for policy and procedure development and implementation complies with documented organisational requirements.
2. Compliance with policies and procedures is monitored.
3. The system for ensuring implementation of, and compliance with, key or amended legislative requirements is monitored.
4. Corporate records management meets legal requirements.
5. Compliance with corporate record keeping and records management is monitored.
6. Corporate records creation occurs according to guidelines.
7. Tracking and monitoring of corporate records occurs.

STANDARD 4: CORPORATE MANAGEMENT SYSTEMS

4.4: Information Management

The planning and execution of the ICT management system should reflect the organisation's information needs and available resources and build towards identified strategic goals.

There should be an integrated approach to the planning, use and management of information and communication technology (ICT), in order to create a secure, reliable framework for the organisation's data and information.

Organisations produce a substantial volume of data and information, which need to be collected, validated, managed, analysed, communicated and stored in a safe and effective manner.

File formats, the storage media chosen, how the system is backed up, access restrictions and other factors will be influenced by legislation governing retention and confidentiality issues, and whether the information will be shared with other departments, organisations and data systems.

LA Policy / guidelines address the organisations information and communication technology (ICT) requirements.

Elements

1. Planning addresses current and future information and ICT system needs.
2. Data are available for:
   (i) research
   (ii) development
   (iii) improvement activities
   (iv) education
   (v) corporate and clinical decision making
   ...and staff are informed of the data collected that are relevant to their position.
3. The integrated ICT system supports the collection, aggregation and analysis of data.
4. Responsibility and accountability for action on data and information are clearly defined.
5. Licences are purchased as required.
6. There is a documented plan for managing ICT risks and crises.
7. The organisation has a plan for the management of information.
8. Information that is stored is secure and privacy is assured.

SA Data, information and communication technology (ICT) are supported to meet the needs of the organisation.

Elements

1. There is a system of ICT operational support that includes:
   (i) the provision of appropriate resources for the collection, analysis and use of data
   (ii) backup of data on a regular basis
   (iii) planned preventive maintenance of ICT
   (iv) continual monitoring of ICT systems to identify potential suspicious activities, and/or to facilitate virus detection
   (v) effective classification and indexing to facilitate data storage and retrieval
   (vi) implementation and testing of the strategy and plan for disaster recovery / business continuity.

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STANDARD 4: CORPORATE MANAGEMENT SYSTEMS • CRITERION 4.1

4.4: Information Management

2. Guidelines on the collection, validation, protection, storage and use of data and information is available to staff.
3. Reference and resource materials are available for use by staff.
4. Relevant staff have access to decision support software and/or tools and are trained in their use.
5. There are systems to provide information to authorised stakeholders that are consistent with relevant privacy legislation.
6. There is a schedule of contribution to relevant external databases and registers.
7. Liaison with external bodies improves the quality of information supplied and received.
8. The organisation ensures that staff education and training in ICT is appropriately resourced.
9. Orientation and education on information systems, including relevant ICT is provided to staff, and includes:
   (i) the correct use of ICT relevant to the organisation and staff roles
   (ii) the organisational requirements for contributing to external databases and registers
   (iii) training on data and information management
   (iv) training on the management and appropriate use of:
      a. personal mobile devices
      b. social media
      c. email
      ... used in the course of healthcare delivery.

MA Evaluation demonstrates the effectiveness of information and ICT systems, and improvements are made where issues are identified.

Elements

1. Systems used for the validation and protection of data and information are efficient.
2. Systems used for the security and protection of ICT meets organisational needs.
3. The system supports data use and reporting processes and the timeliness of availability of information and reports.
4. Compliance with the information and ICT plans are monitored.
5. Monitoring and analysis of clinical and non-clinical data and information occurs to ensure accuracy, integrity and completeness of data.
6. Access to reference and resource materials is monitored, analysed and prioritised to ensure the needs of staff are met.
7. The preventive maintenance and repair system for ICT is regularly reviewed to ensure the needs of the organisation are met.
8. The risk and crisis management system for ICT is regularly tested.
9. Staff education and training in the use of ICT is monitored to ensure it meets the needs of staff and the organisation.
10. The organisation reviews the results from external databases and registers, and improves care and services as indicated.

STANDARD 4: CORPORATE MANAGEMENT SYSTEMS

4.5: Contracted Services Management

External service providers may supply regular, periodic or one-off services to both clinical and nonclinical areas of the organisation. Outsourced services, including contracted services, may be governed by decisions and policy from a higher level, such as a head office or jurisdictional authority.

Increasingly, tendered services are commissioned using online processes; policies need to be updated to reflect this. In the private sector, policies should reflect jurisdictional legislation and any belief systems, structural frameworks, financial drivers or other goals that will guide service provision for the business.

In addition to the commissioning of regular services by a single organisation from another, a range of collaborative business models may be used to ensure service provision for an individual health service; examples include fund pooling, service devolution, service coordination and outsourcing.

Depending on relevant policies, different types of agreements may be used to manage and administer external suppliers, including memoranda of understanding, formal contracts and service agreements.

Contracts and agreements need to abide by jurisdictional legislation. A process to determine which contracts need legal oversight during their preparation must be agreed upon and documented by the governing body. Agreements with high value or risk should have legal oversight. Many government departments provide templates for service agreements, and these will vary depending upon the business structures entering into the agreement.

LA The organisation has defined and documented the requirements for managing external service providers.

Elements

1. The organisation utilises effective procurement processes to engage external service providers.
2. There are documented agreements with all external service providers that include performance measures.
3. Arrangements with external service providers include agreed dispute resolution mechanisms.

H 1. External service provider's contracts include standard items relevant to hospital requirements.
H 2. Contracts are linked to relevant policies / guidelines and standards.

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STANDARD 4: CORPORATE MANAGEMENT SYSTEMS • CRITERION 4.1

4.5: Contracted Services Management

SA There are processes to ensure external service providers comply with agreed arrangements.

Elements

1. The organisation reviews its arrangements with its external service providers according to a pre-determined schedule.
2. External service providers can demonstrate compliance with relevant regulatory requirements.
3. The level of performance demonstrated by external service providers meets the standards specified by the organisation.
4. External service providers supply evidence of evaluation of the services that they are providing to the organisation either directly or through a third party.

H 1. The hospital has identified a process for the procurement of contracted services.
H 2. The hospital has identified a process for managing agreed contracts.

MA Evaluation demonstrates the effectiveness of the management of contracted services / external service providers and improvements are made where issues are identified.

Elements

1. Procurement processes are monitored and reviewed to ensure they meet organisational needs.
2. Agreements with external service providers are reviewed to ensure they contain all information about the services to be provided.
3. The organisation evaluates the performance of external service providers through agreed performance measures, including clinical outcomes and financial performance where appropriate.

H 1. External Service provider contracts are evaluated to ensure they meet the needs of the organisation.

STANDARD 4: CORPORATE MANAGEMENT SYSTEMS

4.6: Laboratory Services

Organisations should ensure that when diagnostic tests are required, that relevant laboratory services are available, whether within the health care facility or accessed externally, and that diagnostic test results are received and managed to ensure appropriate follow-up.

Patients are usually referred for diagnostic tests because the health professional is seeking information that may affect the choices that the patient, the health professional, and others involved in the care episode may make about the care and treatment to be provided.

The organisation should have a system that immediately notifies health professionals about clinically significant results, both in and out of normal business hours, in order to notify the patient quickly so that appropriate action can be taken.

The timeliness of notification can reduce the likelihood of an adverse patient outcome.

LA Policies / guidelines address the organisation's requirements for diagnostic laboratory services.

Elements

- H 1. Diagnostic laboratory services are available in a timely manner.
- H 2. Health professionals are orientated and educated on the software and/or systems to access and review diagnostic test results.
- H 3. The collection, handling, transportation, and preparation of specimens is consistent with the diagnostic services requirements.
- H 4. The clinical laboratory works with the organisation to ensure compliance with:
  - (i) infection control
  - (ii) safe manual handling
  - (iii) management of biohazard materials and waste.
- H 5. The hospital has documented confirmation that the laboratory services have been subject to a quality assessment in line with relevant licencing, regulations and/or accreditation standards.

SA The organisation appropriately manages patient diagnostic test results.

Elements

- H 1. Clinical laboratory services are managed by a qualified health professional.
- H 2. Results of clinical diagnostic tests are available in a timely manner.
- H 3. There is a system to ensure all diagnostic test results have been reviewed, acted upon and incorporated into the patient health record.
- H 4. There is appropriate and timely consultation with health care professionals following a clinically significant test result.
- H 5. There is a process to manage the out of hours review of diagnostic test results.

MA Evaluation demonstrates the effectiveness of the management of patient diagnostic test results and improvements are made where issues are identified.

Elements

- H 1. Access to and availability of diagnostic laboratory services is evaluated.
- H 2. Management of patient test results is evaluated, including through patient feedback on access to results.

STANDARD 4: CORPORATE MANAGEMENT SYSTEMS

4.7: Diagnostic Imaging Services

Organisations should ensure that when diagnostic imaging is required, that relevant radiology services are available, whether within the health care facility or are accessed externally, and that diagnostic imaging results are received and managed to ensure appropriate follow-up.

Organisations should also ensure that where the diagnostic imaging service is a part of the healthcare facility, that there is appropriate oversight of the rooms in which the equipment is used to ensure safety for patients and staff.

Sources of radiation are essential to modern health care. Radiation is a vital diagnostic tool, such as in imaging departments and potential exposure needs to be managed according to the relevant code(s) of practice.

There are three main concepts in protecting patients and staff from radiation. They are:

- **Time**: The amount of radiation exposure received is proportional to the time exposed. Minimise the time spent handling radioactive substances or with radiation producing equipment.
- **Distance**: The intensity of radiation drops rapidly the further away from the source. Maximise distance from sources of radiation at all times. This includes, for example, using tongs instead of bare hands to handle radioactive samples.
- **Shielding**: Increasing shielding around a radiation source will reduce exposure.

These three concepts use the ALARA (As Low As Reasonably Achievable) principle for limiting exposure to radiation and this principle should be considered at all times where there is risk of exposure.

All organisations should be familiar with the radiation protection standards and guidelines. These generally pertain to exposure and dosage. All licences and safety arrangements should be in place.

LA Policies/guidelines address the organisation's requirements for diagnostic imaging services.

Elements

H 1. Diagnostic imaging services are available in a timely manner.
H 2. Health professionals are orientated and educated on the software and/or systems to access and review diagnostic imaging results.
H 3. The diagnostic imaging service provider works with the organisation to ensure compliance with:
(i) infection control
(ii) safe manual handling
(iii) management of biohazard materials and waste.
H 4. The hospital has documented confirmation that the diagnostic imaging service has been subject to a quality assessment in line with relevant licencing, regulations and/or accreditation standards.

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STANDARD 4: CORPORATE MANAGEMENT SYSTEMS • CRITERION 4.1

4.7: Diagnostic Imaging Services

SA The organisation appropriately manages the diagnostic imaging service.

Elements

H 1. Diagnostic imaging services are managed by a qualified health professional.
H 2. Results of diagnostic imaging are available in a timely manner.
H 3. There is a system to ensure all diagnostic imaging results have been reviewed, acted upon and incorporated into the patient health record.
H 4. There is appropriate and timely consultation with health care professionals following a clinically significant diagnostic imaging result.
H 5. There is a process to manage the out of hours review of diagnostic imaging results.
H 6. The diagnostic imaging service has a radiation safety management plan which:
(i) is coordinated with external authorities
(ii) includes a personal radiation monitoring system and all relevant room monitoring
(iii) ensures patient radiation is kept to a minimum while maintaining good diagnostic quality
(iv) ensures staff exposure to radiation is kept as low as reasonably achievable (ALARA)
(v) ensures a radiation safety report is provided where required.

MA Evaluation demonstrates the effectiveness of the management of diagnostic imaging services and improvements are made where issues are identified.

Elements

H 1. Access to and availability of diagnostic imaging services is evaluated.
H 2. Management of patient diagnostic imaging results is evaluated, including through feedback on access to results.

STANDARD 4: CORPORATE MANAGEMENT SYSTEMS

4.8: Research

Research, whether medical, scientific or informational, is undertaken in order to increase knowledge and, ultimately, to improve the care given to the patient and to have a positive impact on the community as a whole. While all organisations are encouraged to undertake research appropriate to their size and function, this criterion requires that, in those organisations that do so, there is appropriate oversight and that the participating patients and staff are protected.

It is important that organisations understand the difference between research and the continuous quality improvement that should support all organisational systems and processes. Research is, in general, a far more substantive and formally conducted activity, often involving formal, external collaborations, and requiring effective governance due to the associated risk. However, some quality improvement projects are sufficiently substantial to be regarded as "research" within the context of this criterion.

In general, an organisation would be considered to be conducting research if a project met two or more of the following criteria:

- the project was funded by a body outside the organisation
- it required approval by a Human Research Ethics Committee (HREC) or an Animal Research Ethics Committee
- its objective was to develop a marketable product that might be adopted by other organisations (e.g. a wound care solution, alternative bandaging technique, software tool)
- it was coordinated by an external health authority, such as a Ministry / Department of Health
- there was an intention to publish the outcomes in a peer-reviewed journal
- the conduct of the project impacted non-participating staff and/or patients.

LA Policy / guidelines address the organisation requirements for managing research.

Elements

H	1.	The organisation fosters and encourages clinical and health services research aimed at improving outcomes for patients.
H	2.	The organisation defines which research requires ethics approval and under what conditions ethics approval will apply.
H	3.	Research policy / guidelines are readily available to staff and patients.
H	4.	Formal agreements with collaborating and/or funding agencies are in place.
H	5.	The governing body demonstrates its responsibility for the governance of research.

EQuIP7 | FUNCTION 3 | GOVERNANCE
STANDARD 4: CORPORATE MANAGEMENT SYSTEMS • CRITERION 4.1

4.8: Research

SA The organisation appropriately governs the conduct of research.

Elements

H	1.	The organisation's research program and/or its involvement in clinical trials are managed to ensure the safety and wellbeing of relevant patients.
H	2.	The respective responsibilities of all parties involved in research are identified and documented.
H	3.	Research ethics approval processes are transparent and consistent with relevant guidelines and scientific review standards.
H	4.	Where relevant, the organisation's research ethics committee is adequately resourced.
H	5.	The organisation's research ethics oversight processes are clearly defined.
H	6.	Stakeholders and researchers work in partnership with the organisation to make decisions about research priorities, policy and practices.

MA Evaluation demonstrates the effectiveness of the management of research and improvements are made where issues are identified.

Elements

H	1.	The system for ensuring effective research governance is evaluated, and improvements are made as required.
H	2.	The organisation's research program and/or its involvement in clinical trials are evaluated with respect to the safety and wellbeing of relevant patients, and results are reported to the governing body.
H	3.	The organisation's: (i) research-related reporting (ii) internal ethics processes (iii) management of clinical trials, where relevant, including any specimens or medications ...are evaluated.
H	4.	Research outcomes are reported to the governing body, and made readily available to staff and relevant stakeholders.

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Standard 1: Patient Care 7

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Standard 2: Care Services 33

FUNCTION 2 | CARE SUPPORT SERVICES
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STANDARD 5: WORKFORCE SYSTEMS

5.1: Workforce Management

The health workforce ranges from workers with no formal qualifications providing support services through to highly qualified specialists working in technology intensive positions, and also includes nonclinical staff.

Workforce planning is the systematic and ongoing process of analysing the organisation's workforce needs and determining what actions are necessary to ensure that the right people with the right skills are available when needed, at the present time and into the future.

The workforce strategic plan should be proportional to the role, function and size of the organisation, and cover all key elements of workforce needs. It should recognise and respond to the changing environment, and address both the long-term needs of the organisation and the appropriate response to an immediate staffing shortfall.

Pre-employment screening is an essential risk management process. It is essential that there is a robust process for checking the claimed qualifications, credentials and experience of all potential appointees, whether local or foreign based.

Where casual staff are sourced from agencies, it is important to confirm that all agency staff have themselves been screened and have met the standards of the contracting organisation. Formal checking of applicants should include:

- references
- all claimed qualifications, skills and experience
- all necessary licences and registrations
- where appropriate, criminal history and working with children clearance.

There should be an orientation and integration programs for new staff Generally, an orientation program should introduce staff to the organisation, while an integration program introduces them to their specific role and duties. However, the content of each program will vary according to nature of the organisation, the care and services provided, and the identity and qualifications of the participants. Organisations should ensure the annual performance review of all staff, including all health professionals. The review should actively involve both the manager and the staff member, and be conducted in a positive manner.

LA Policy / guidelines address the requirements for workforce planning, recruitment, selection, appointment and management.

Elements

1. The organisation's workforce planning ensures the skill mix of clinical and support staff and reflects current and future needs of patients and staff.
2. The workforce strategic plan is clearly linked to the organisation's strategic direction and goals.
3. Workforce management functions and responsibilities are clearly identified and documented.
4. The number and skill mix of staff is commensurate with organisational need and the provision of safe, high quality care.
5. There are contingency plans to manage long- and short-term workforce shortages, including unplanned shortages.
6. Recruitment, selection and appointment processes ensure that staff have the necessary licences, registration, qualifications, skills and experience to fill their defined roles.
7. Organisation-wide policy / guidelines address the:
   (i) credentialing and, where relevant, registration of health professionals
   (ii) defining and reviewing the scope of clinical practice of all health professionals
   (iii) the safe introduction of new interventions and treatments.
8. The appointment system for health professionals includes a process for confirming the credentials of applicants, consistent with relevant standards and guidelines, and with organisational policy.

EQuIP7 | FUNCTION 3 | GOVERNANCE
STANDARD 5: WORKFORCE SYSTEMS • CRITERION 5.1

5.1: Workforce Management

9. The process for defining, reviewing and recommending the scope of clinical practice is consistent with relevant standards and guidelines, and with organisational policy, and reflects the role and capabilities of the organisation.
10. The process for the safe introduction of new interventions and treatments is consistent with relevant standards and guidelines, and with organisational policy.
11. Health professionals and other staff are provided with a written description outlining their position, role, responsibilities and accountabilities at commencement of employment.
12. Health professionals and other staff comply with published codes of professional practice relevant to their professional role, and the organisation's Code of Conduct.

H 1. Where relevant, the organisation ensures that student requirements for training are met.

H 2. The organisation recruits, trains and supports volunteers where appropriate.

SA Workforce management processes ensure that the skill mix and competence of staff meet the needs of the organisation.

Elements

1. There is a process to ensure relevant pre-employment checks / screening occurs for all potential employees.
2. There is a system and program for the orientation and integration of all staff.
3. Accurate and complete personnel records, including evidence of pre-employment screening, qualifications and completed mandatory and non-mandatory training, are maintained and kept confidential.
4. Strategies are in place to ensure safe, high quality treatment and care if prescribed levels of skill mix of clinical and support staff are not available.
5. Strategies are implemented to ensure safe working hours and minimisation of fatigue.
6. The recruitment, selection and appointment system responds to changing service requirements.
7. There is an organisation-wide process for the performance review of all staff to ensure that:
   (i) position descriptions including accountabilities and responsibilities are regularly reviewed
   (ii) health professionals and other staff are competent and accountable for their work
   (iii) there is active participation of both the manager and the individual in performance review
   (iv) areas for improvement and additional education needs are identified
   (v) opportunities for professional development are identified.
8. Outcomes of health professionals' performance reviews are linked to the system for defining the scope of clinical practice and, where appropriate, communicated to relevant external authorities.
9. There is a process to ensure that professional and other licensed staff provide verified documentary evidence to demonstrate their continuing registration with the relevant regulatory body as required throughout their employment.
10. There is a process to identify mandatory training for health professionals and other staff.
11. There is a process for managing a complaint or concern about a health professional, including ensuring the immediate safety of patients.
12. There is a process for managing a complaint or concern about non-clinical staff, including contractors.

H 1. All units / departments comply with the organisation's recruitment, selection and appointment processes.

H 2. The volunteer recruitment system supports an adequate number and mix of volunteers to provide appropriate services.

H 3. There are processes to ensure effective management of staff and/or volunteers at unit / department level.

5.1: Workforce Management

MA Evaluation demonstrates the effectiveness of workforce management processes / systems and improvements are made where issues are identified.

Elements

1. The workforce
   (i) policy
   (ii) plan
   (iii) goals
   (iv) strategic direction
   ... meets the needs of the organisation.
2. The recruitment, selection, and appointment system assists to maintain necessary staffing levels.
3. The orientation and integration system is regularly reviewed.
4. Strategies for fatigue prevention and management for all staff are effective.
5. The ongoing performance management and review system is effective and involves staff and contracted staff participation.
6. The process for managing a complaint or concern about a health professional, including the steps taken to ensure the immediate safety of patients, is monitored and reviewed.
7. The process for managing a complaint or concern about non-clinical staff, including contractors, is monitored and reviewed.
8. The system for the credentialing, re-credentialing, registration where relevant, and appointment of health professionals is monitored and reviewed.
9. The credentials of health professionals are assured prior to appointment.
10. Re-credentialing processes occur as required.
11. The organisation's system for the safe introduction of new interventions and treatments meets organisational needs.
12. The scope of clinical practice is defined on appointment and reviewed prior to the introduction of new interventions or treatments.
13. Outcomes of the management of identified issues with credentialing, defining the scope of clinical practice and introducing new interventions and treatments are reported to the governing body.

H 1. The management of staff and/or volunteers at unit / department level is evaluated.

H 2. Unit / department workforce plans are evaluated to ensure they meet the needs of the organisation.

STANDARD 5: WORKFORCE SYSTEMS

5.2: Workforce Support

An effective learning and development system will serve the dual purpose of ensuring that the organisation employs appropriately trained and competent staff, while providing opportunities for staff to develop their careers and acquire new skills.

Appropriate support systems that promote staff wellbeing will assist the organisation to create a positive working environment. Support systems need be neither elaborate nor expensive, but should focus upon motivating staff and acknowledging their contributions to the organisation.

Supporting staff through an employee assistance program will demonstrate a caring workplace. In the event of staff illness or distress, organisation will be able to support that person through the provision of time off or compassionate leave or through referral to relevant services.

Other aspects of employee assistance could include:

- vaccination for Hepatitis B
- pathology testing with minimal or no charges
- supply of first aid and follow-up
- the provision of a flu vaccination may assist both the organisation and the staff member, as the occurrence of sick leave due to flu symptoms may be reduced
- counselling for staff involved in traumatic incidents associated with work.

The organisation should strive to create a workplace culture where rights are respected, and responsibilities understood and enacted. Legislation will often address rights and responsibilities in the area of employment conditions, while the organisation itself and relevant external bodies may define further rights and responsibilities with respect to individual conduct and inter-personal behaviour in the workplace.

In addition to the management of staff with respect to their defined positions, the organisation will have broader responsibilities for managing and resolving workplace issues, staff grievances, and instances of inappropriate staff and volunteer behaviour. The organisation should strive to create a working environment free of discrimination, harassment and bullying, and ensure that staff are aware of how to proceed if they are the target of such inappropriate behaviour. All instances of such behaviour should be investigated and resolved, with disciplinary action taken if necessary.

LA Policy / guidelines support the learning and development program that addresses organisational and staff needs.

Elements

1. There is an evidence-based learning and development system available to staff, that:
   (i) identifies the needs of both the organisation and staff through staff consultation
   (ii) ensures staff remain competent to perform their work
   (iii) provides mandatory training in accordance with legislative and policy requirements
   (iv) meets new and changing staff needs in a timely manner
   (v) responds to changes in the organisation's environment.
2. The organisation ensures that education and training are delivered by appropriately qualified individuals and/or to an appropriate standard.
3. Staff are provided with appropriate supervision by experienced, trained and qualified staff.
4. Staff meet their requirements for self-directed professional development.

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STANDARD 5: WORKFORCE SYSTEMS • CRITERION 5.1

5.2: Workforce Support

SA Support systems promote staff wellbeing and a positive work environment.

Elements

1. The workplace rights and responsibilities of management and staff are clearly defined, communicated and respected.
2. Staff are consulted about workplace support services and workplace relations, and managers facilitate staff access to those services.
3. There is a process for identifying and managing staff behaviour that is inappropriate or creates risk.
4. Information about grievance processes is readily available to management and staff.
5. The organisation supports flexible work arrangements.
6. There is a system that motivates staff and identifies the value of staff through appropriate acknowledgement.
7. Management and staff work cooperatively and, where appropriate, in consultation with relevant external bodies to achieve effective workplace relations.
8. There is a transparent system to identify, manage and resolve workplace issues, which includes a consultation process.

MA Evaluation demonstrates the effectiveness of workforce support processes / systems and improvements are made where issues are identified.

Elements

1. The learning and development system meets organisational and staff needs.
2. The education and training delivered by the organisation is regularly evaluated with staff participation.
3. The supervision of staff meets the requirements of the organisation and the staff under supervision.
4. The system to record and monitor completion of mandatory training and professional development is evaluated.
5. Staff access to assistance programs and support services is monitored.
6. Staff are involved in the evaluation of support systems.
7. The management and resolution of workplace issues, including grievances, is monitored to ensure satisfactory outcomes.

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FUNCTION 2 | CARE SUPPORT SERVICES
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STANDARD 6: SAFE ENVIRONMENT

6.1: Safety Management

The organisation should implement a comprehensive and integrated safety management system that mitigates and manages the risk associated with care and service delivery and the healthcare environment.

The system should create a framework for the safe conduct of work, both clinical and non-clinical, and include processes to protect patients, staff, contractors and other visitors to the organisation. The system should be developed with staff consultation, to ensure the identification of risks associated with specific tasks and safe work processes to prevent injury should be developed and supported by appropriate education and training.

Effective safety management will consider specific organisational circumstances, and include strategies to manage identified high-risk tasks.

Safety management systems should:

- consider the organisation's:
  - location and function
  - design and layout
  - patient cohort
  - identified health and safety risks
- reflect all relevant legislation, standards, guidelines, and codes of practice
- be supported by policy and procedures that define responsibility and accountability for safety management, and which address high-risk tasks and associated safety measures, and other issues impacting safety within the organisation, including (but not limited to):
  - injury prevention and management strategies
  - manual tasks
  - dangerous goods and hazardous substances
  - needlestick injury and bodily fluid exposure
  - provision of protective clothing and equipment.

LA Policy / guidelines address the requirements for environmental safety management.

Elements

1. Environmental safety management includes:
   (i) workplace health and safety
   (ii) workers compensation
   (iii) the suitability of the physical environment
   (iv) manual tasks
   (v) management of dangerous goods and hazardous substances
   (vi) other identified high-risk practices.
2. There is an organisation-wide system to identify, assess and document:
   (i) health and safety risks / hazards
   (ii) risks associated with manual tasks in both clinical and non-clinical areas
   (iii) safe work practices / safety rules for all relevant procedures and tasks
   (iv) processes to eliminate risks or implement controls.
3. Service planning includes health and safety together with injury prevention strategies.
4. There is an injury prevention and management program that reflects relevant legislation.

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STANDARD 6: SAFE ENVIRONMENT • CRITERION 6.1

6.1: Safety Management

5. There are processes for the procurement, storage, management and disposal of dangerous goods and hazardous substances.
6. A register of all dangerous goods and hazardous substances, and for the disposal of all hazardous waste, is maintained.

SA Safe work practices / safety regulations address the physical and environmental conditions under which work is carried out.

Elements

1. Staff are involved in decisions that affect workplace health and safety and wellbeing.
2. Staff with formal workplace health and safety responsibilities are appropriately trained.
3. External service providers are supplied with relevant information and comply with the organisation's health and safety requirements.
4. Staff are provided with orientation and ongoing education in workplace health and safety and their responsibilities.
5. Workplace health and safety requirements are communicated to family and visitors as required.
6. Staff are trained in correct work practices to minimise the risk of injury.
7. Procedures for the handling and use of dangerous goods and hazardous substances address:
   (i) availability of Safety Data Sheets
   (ii) personal protective equipment (PPE)
   (iii) the environment in which dangerous goods and hazardous substances are to be stored and used
   (iv) the limits of occupational exposure.

H
1. Where ionizing radiation is used there is a radiation safety and a laser safety management plan which:
   (i) is coordinated with external authorities
   (ii) includes a personal radiation monitoring system and all relevant room monitoring
   (iii) ensures patient radiation is kept to a minimum while maintaining good diagnostic quality
   (iv) ensures staff exposure to radiation is kept as low as reasonably achievable (ALARA)
   (v) ensures a radiation safety report is provided to the ethics committee on any research project involving irradiation of human subjects.

MA Evaluation demonstrates effective environmental safety management, and improvements are made where issues are identified.

Elements

1. There is evidence that safety management audits demonstrate the effectiveness of the safety management system.
2. The design and layout of the organisation's current physical environment ensures that it is appropriate for the tasks being conducted and that all necessary safety measures are developed and implemented.
3. The injury prevention and management system is effective.
4. The ability of the workforce to perform its functions safely is monitored and reviewed in consultation with relevant staff.
5. Education and training in workplace health and safety is reviewed with staff consultation.

H
1. Compliance with the radiation safety plan is monitored, evaluated and reported to the governing body.

STANDARD 6: SAFE ENVIRONMENT

6.2: Assets Management

In addition to managing the safety of the healthcare environment, the organisation is responsible for managing its assets, goods and general services so as to create and maintain a safe environment for the delivery of care and services, and to ensure the safety and wellbeing of patients and family, staff, contractors and other visitors.

Organisations should implement a comprehensive management system that supports the safety and maintenance of its buildings; their surrounds, including roads and walkways; plant and other equipment, including medical devices; and supplies and consumables; and which addresses workplace design, signage and fire safety.

A healthcare organisation may occupy a building or buildings that have been purpose-built, or that are refurbished facilities. In either of these circumstances, planning and design must be compliant with relevant legislation, and consider the safety of those accessing the facilities for any reason.

The organisation may also have responsibility for the design and/or maintenance of roads and walkways within its grounds. Smaller organisations may not themselves be responsible for roads and walkways abutting their facilities, but should interact with relevant local authorities to ensure the safety of their surroundings.

The organisation should have processes for ensuring that its plant and equipment are chosen with consideration of function, safety, cost and effectiveness, and installed, operated and maintained according to the manufacturers' instructions.

Utilities are the basic services that the organisation uses to function, including water, power, ventilation, medical gases and suction systems, and communications systems. The management of utilities should aim to be both effective and sustainable, underpinned by strategies to prevent waste and increase efficiency. Any failure in the supply or function of a utility will severely impact the organisation's ability to deliver care and maintain a safe environment, and consequently the management of utilities should be integrated with the organisation's business continuity / resilience plan and its emergency management.

The organisation's management of its assets, goods and general services should be supported by a well-planned and well-resourced system of preventive maintenance and cleaning. Maintenance of buildings, plant and equipment should not be purely reactive: the organisation should implement a planned and coordinated system of preventive maintenance, in order to retain all assets in good working order, to extend the working life of critical and expensive equipment, and to reduce the risk associated with poorly operating equipment. All stages of preventive maintenance, from planning to completion, should be documented.

LA Policy / guidelines address the requirements for managing the organisation's assets.

Elements

1. There are systems to manage:
   (i) buildings / workplaces
   (ii) internal road systems and walkways
   (iii) plant
   (iv) medical devices
   (v) other equipment
   (vi) supplies
   (vii) consumables
   (viii) utilities
   (ix) workplace design
   (x) fire safety.
2. Purchase and supply procedures ensure that products are available or that appropriate alternatives are supplied.
3. Plant and other equipment are installed and operated in accordance with manufacturer specifications.

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STANDARD 6: SAFE ENVIRONMENT • CRITERION 6.1

6.2: Assets Management

4. Plant logs are maintained and are in accordance with manufacturer requirements.
5. Clear, well-located internal and external signage meets the needs of patients, visitors and staff.
6. Disability access and facilities meet legislative requirements and/or are based on recognised guidelines.

H 1. Medical devices are:
(i) trialled
(ii) selected
(iii) installed
(iv) operated
(v) maintained
(vi) repaired
(vii) calibrated
...by competent, qualified people.

SA There is a system to plan, manage and operate / use the organisations identified assets.

Elements

1. There is a documented, planned and coordinated preventive maintenance system.
2. There is a system to ensure the safe and consistent supply of electricity, gas and water including backup supply if needed.
3. Disability and cultural signage includes the use of multilingual / international symbols and is appropriate to the needs of the community and the organisation.
4. The organisation supports staff, patients, family and other visitors in identifying and reporting incidents and near misses relating to buildings, roads, walkways, plant, medical devices, equipment, consumables and supplies.

H 1. There is a system for the recall of medical devices, including loan / trial equipment, where appropriate.
H 2. Relevant staff are trained in the safe and appropriate use of medical devices and other equipment.
H 3. Regular testing of emergency water and electrical systems occurs.

MA Evaluation demonstrates the effectiveness of asset management processes / systems and improvements are made where issues are identified.

Elements

1. The safety and accessibility of the buildings / workplaces roads and walkways is monitored.
2. The safe and consistent operation of plant and equipment are monitored.
3. Maintenance and/or replacement of buildings, roads, walkways, plant and other equipment is planned, prioritised and budgeted for.
4. The quality and reliability of electricity, gas and water supply meets the needs of the organisation.
5. The organisation regularly evaluates whether its signage meets community needs.

H 1. The acquisition, use, maintenance, storage and appropriate recall processes for medical devices are monitored and evaluated.

STANDARD 6: SAFE ENVIRONMENT

6.3: Waste Management

Within a healthcare organisation, waste management requires not only the collection and disposal of waste, but also the control of all associated risks, including that of infection. Strictly maintained processes for waste segregation, storage and handling will increase safety and decrease costs: the correct disposal of hazardous waste can cost up to twenty times more than the disposal of general waste, so it is in the organisation's interest to ensure that waste disposal streams are correctly maintained. Clear signage is required, and staff education should address correct processes and individual responsibilities.

Waste generated from the mismanagement of resources such as electricity and water will also impact on the environment, and needs to be considered within this criterion.

Effective waste management will have multiple goals including:

- to protect the health and safety of patients, staff and visitors
- to maintain a safe working environment
- to reduce waste handling and disposal volumes / costs without compromising health care
- to minimise the environmental impact of waste generation / disposal.

Efficient use of utilities and other resources, and the effective management of waste including via reduction / reuse / recycle strategies, will simultaneously generate cost savings for the organisation and assist it to meet its responsibilities for a sustainable environment.

LA Policy / guidelines address the requirements for managing waste.

Elements

1. Waste management streams are identified, and signage is displayed.
2. Staff are provided with orientation and ongoing education in their responsibilities in waste and environmental management.
3. External service providers comply with any requirements for the correct handling, transport and disposal of waste.
4. Guidelines direct the efficient and sustainable use of energy, water and other utilities.

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STANDARD 6: SAFE ENVIRONMENT • CRITERION 6.1

6.3: Waste Management

SA Waste management systems support a safe environment.

Elements

1. Controls are implemented to direct the identification, handling, separation and segregation of clinical, radioactive and hazardous and non-hazardous waste.
2. There is a system to assess, separate, handle, transport and dispose of all waste streams.
3. Waste management systems are coordinated with external authorities.
4. Recycling, reducing and reusing processes support sustainability, resource conservation, and waste and environmental management.
5. There is an organisational plan to monitor and reduce carbon emissions.

MA Evaluation demonstrates the effectiveness of waste management processes / systems and improvements are made where issues are identified.

Elements

1. The waste and environmental management system is monitored, and waste is measured to show a reduction in generated waste.
2. The use of energy, water and other utilities is monitored, and benchmarked annually against previous usage levels.
3. Outcomes of environmental monitoring and management are reported to the governing body and staff.

STANDARD 6: SAFE ENVIRONMENT

6.4: Emergency and Disaster Management

The intent of this criterion is to ensure that healthcare organisations have systems, policies and procedures and training programs in place that identify and manage potential emergency situations that may arise either internally or externally, in terms of consequence, exposure, probability and preventative actions. Organisations should demonstrate development and implementation of appropriate emergency response systems in consultation with external emergency response organisations and other relevant bodies.

An external emergency or disaster may necessitate preparation for the reception of a significant number of victims and/or the allocation and transport of personnel and resources to an external site. An internal emergency or disaster can be caused by factors that may be internal or external to the organisation, may adversely affect patients, visitors and staff, and requires an immediate response.

Business continuity / resilience is defined as management and planning for the continued availability of essential services during and after an emergency, including all the functions and resources associated with the provision of these services. Business continuity planning should focus upon the analysis of risk, and then address those threats most likely to interrupt services. Good risk management will increase the organisation's resilience, and minimise potential downtime.

The response of an organisation to an emergency will depend upon the type of organisation, the severity of the incident and the number of staff affected.

LA Policy / guidelines address the requirements for managing emergencies and disasters.

Elements

1. The organisation understands its role in responding to disasters.
2. Likely emergencies are identified, and response and evacuation plans, and instructions are prominently displayed.
3. Communication systems are in place to assist in the management of any emergencies or disasters.
4. A business continuity / resilience plan has been developed.
5. Staff are provided with orientation and ongoing education in emergency management and the correct response to emergencies.
6. Emergency practice / drill exercises including fire safety and evacuation are regularly conducted.
7. External service providers comply with the organisation's requirements for the prevention of emergencies.
8. There is documented evidence that an authorised external provider undertakes a full inspection for fire risks on the premises at least once within each EQuIP cycle or in accordance with legislation.

H 1. The hospital has identified potential internal emergencies and disasters that may require a response.

H 2. The hospital has identified potential external emergencies and disasters that may require a response.

EQuIP7 | FUNCTION 3 | GOVERNANCE
STANDARD 6: SAFE ENVIRONMENT • CRITERION 6.1

6.4: Emergency and Disaster Management

SA Emergency and disaster management supports a safe environment.

Elements

1. There are systems for prevention, preparedness and response to internal emergencies.
2. Internal and external emergency management plans are developed, reviewed and tested in consultation with relevant authorities.
3. The organisation regularly tests its plan for business continuity / resilience.
4. There is an appropriately trained fire officer / team.
5. Relevant staff have access to first aid equipment and supplies and are trained in their use.
6. Where appropriate, disaster response procedures and preparations are coordinated with the relevant external authorities and other healthcare organisations.
7. There is a documented fire action plan to implement recommendations from the fire inspection report.

H 1. There are systems for preparedness and response to external emergencies, including triage and deployment of medical teams where appropriate.

H 2. There are systems for preparedness and response to internal emergencies, including the early detection, suppression, mitigation, and safe exit from the hospital.

MA Evaluation demonstrates effective management of emergencies and disasters, and improvements are made where issues are identified.

Elements

1. The emergency management system is regularly reviewed to ensure it meets the requirements of the organisation.
2. The organisations' disaster response system is regularly tested and reviewed.
3. The organisations' business continuity / resilience plan is regularly reviewed to ensure services are managed in the event of an incident.
4. Staff training and competence in managing emergency procedures, including evacuation, is regularly performed and the percentage of currently trained staff is recorded.

H 1. The identified internal and external emergencies are reviewed regularly to ensure all relevant events are identified.

STANDARD 6: SAFE ENVIRONMENT

6.5: Security Management

The healthcare setting is associated with certain security risks to patients and staff which must be identified and managed. Patients have the right to be confident in their safety and physical security while they are within the healthcare setting or being transferred between facilities.

Staff within a healthcare organisation will also be exposed to specific security risks. The organisation should consult with relevant staff in the identification of these risks, and in the implementation of strategies to mitigate risk and enhance the safety of staff.

Patients should:

- be protected by robust processes for checking the identity, background and credentials of staff
- be protected from incidents of violence or aggression during an episode of care
- have their physical security managed while being transported between units / departments or facilities, or when relevant between the organisation and their home.

Staff security should:

- be planned and managed in consultation with relevant staff
- include risk assessment of specific actions, including (but not limited to):
- working alone
- working off-site for any reason
- travelling between sites
- conducting home visits.

Healthcare settings carry a heightened risk for incidents of violence and aggression. The organisation should strive to implement systems and processes which prevent as far as possible the occurrence of violence and aggression, and which mitigate the risk that an incident will result in physical or psychological harm.

The term 'violence and aggression' encompasses any incident in which an individual is assaulted, threatened or abused. Such an incident may involve verbal, physical or psychological abuse, threats or other intimidating behaviours, intentional physical attacks, aggravated assault, threats with an offensive weapon, sexual harassment, or sexual assault.

LA Policy / guidelines address the requirements for managing security of staff, patients and other visitors.

Elements

1. Major security risks are identified, assessed, prioritized, and eliminated or controlled.
2. Service planning includes strategies for security management.
3. Staff are provided with orientation and ongoing education in security risks and their responsibilities.
4. External service providers are supplied with relevant information and comply with the organisation's security controls.

H 1. Security management processes are developed in consultation with the employees performing each identified function.

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STANDARD 6: SAFE ENVIRONMENT • CRITERION 6.1

6.5: Security Management

SA Security systems include the physical security of people, buildings and assets, and information.

Elements

1. There is an organisation-wide system to assess security risks, determine priorities and eliminate risks or implement controls.
2. There is an organisation-wide violence and aggression management and minimisation program.
3. Where appropriate, there is a system to manage security risks associated with staff working off-site.
4. Staff are consulted in decision making that affects organisational and personal risks.
5. Relevant staff are trained in the correct response to incidents of violence and aggression, including de-escalation strategies.
6. Security management plans are coordinated with relevant external authorities.

H 1. There are processes to minimize the risk to staff working alone and staff working offsite.

H 2. Back up protocols are in place to support staff on patient home visits, taking into consideration issues such as:
   (i) roadside assistance for vehicle travel
   (ii) 'call in' to staffed office with monitoring of return times
   (iii) in remote locations, GPS, monitoring and duress alarm availability connected to a 24-hour monitoring centre (such as a commercial security contractor) and emergency response times, for example.

H 3. Appropriate emergency support equipment is made available to staff, for example mobile phones, or other communication equipment suitable to the location of the service.

H 4. Where appropriate, there is a system to manage safety and security during the intra-facility transportation of patients.

MA Evaluation demonstrates the effectiveness of security management processes / systems and improvements are made where issues are identified.

Elements

1. Compliance with the organisations' policy / guidelines for managing security risks is monitored.
2. The security management system is evaluated in consultation with external authorities when appropriate.
3. The violence and aggression management and minimisation program is regularly reviewed, and outcomes are reported to relevant staff.
4. The timeliness and appropriateness of the response to security incidents is monitored and trended.

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GLOSSARY

Definitions in this glossary are for use in the context of ACHS EQuIP7.

access	The various pathways and processes via which the patient may obtain health care services
accessibility	The ability of patients and families or potential patients to obtain required or available services when needed within an appropriate time
accountability	Responsibility and requirement to answer for tasks or activities. This responsibility may not be delegated and should be transparent
accreditation	A public recognition by a healthcare accreditation body of the achievement of accreditation standards by a healthcare organisation, demonstrated through an independent external peer assessment of that organisation's level of performance in relation to the standards
advance care plan/ directive	Instructions that consent to, or refuse, specified medical treatments. It becomes effective in situations where the patient is no longer able to make their own treatment decisions
admission	The point in the care journey at which an organisation acknowledges a person as a patient, and accepts responsibility for his or her care. In some contexts, the term 'registration' may be used rather than admission. The point at which admission is considered to have occurred, and the processes by which it happens, varies considerably according to the nature of an organisation. In the first instance, admission refers to the administrative process by which an individual's details are entered into the organisation's systems so that the care journey may begin. However, it is important to recognise that, depending upon the nature and sector of the organisation, admission does not necessarily require the provision of accommodation, or access to a specific facility.
adverse event	An incident that results in harm to a patient, where harm includes disease, injury, suffering, disability or death
adverse reaction	Unexpected harm arising from a justified treatment
analysis	Breakdown of the essential features into simple elements, such as a summary, outline or identification of the essence of an issue
antimicrobial	A chemical substance that inhibits or destroys bacteria, fungi or parasites. These include antibiotics, antivirals and disinfectants
appropriate	A service that is consistent with a patient's expressed requirements and is provided in accordance with current best practice. In the context of EQuIP7: is suitable, or fitting, to do
appropriateness	Doing what is necessary, and not doing what is not necessary. Occurs when patients receive appropriate and necessary care, interventions and services in the most appropriate setting
artificial nutritional support	Parenteral and/or enteral nutrition therapy (parenteral nutrition: intravenous administration of nutrients into a central or peripheral vein; enteral nutrition: feeding provided through the gastrointestinal tract via a tube, catheter, or stoma that delivers nutrients distal to the oral cavity)
as required	As an action becomes necessary
assessment	A process by which the characteristics and needs of patients, groups or situations are evaluated or determined so that they can be addressed. Assessment forms the basis of a plan for services or action. While assessment may be known by different names and occurs in a broad variety of contexts, such as triage in an Accident and Emergency Department, comprehensive assessment by an healthcare team, or screening and intake by a community health or outreach service, the process remains consistent and as defined above
benchmarking	The continuous measurement of a process, product, or service compared to those of the toughest competitor, to those considered industry leaders, or to similar activities in the organisation in order to find and implement ways to improve it. One of the foundations of both total quality management and continuous quality improvement. Internal benchmarking occurs when similar processes within the same organisation are compared. Competitive benchmarking occurs when an organisation's processes are compared with best practices within the industry. Functional benchmarking refers to benchmarking a similar function or process, such as scheduling, in another industry
business plan	The current action plan for achieving organisation goals
by-laws	Rules, regulations or legislation adopted by the organisation for the regulation of both its internal and external affairs
care plan	The documentation of items agreed to in a care planning process. This should include: ▪ the date of development ▪ participants in the development of care plan ▪ patient-stated and agreed issues or problems ▪ patient-stated and agreed goals ▪ agreed actions and the name of the person or service responsible for each action ▪ timeframe for attaining goals and actions ▪ planned review date ▪ patient acknowledgement of the care plan (signed or verbal) ▪ actual review date
change management	The process of managing the effective implementation of organisational strategies, ensuring that permanent changes in goals, behaviours, relationships, processes and systems are achieved to the organisation's advantage

clinical audit	A systematic independent examination and review to determine whether actual activities and results comply with planned arrangements.
clinical classification	The process of translating data, such as diseases, conditions, injuries and interventions, from a patient file into a coded format using a relevant classification system
clinical governance	The system by which the governing body, managers and health professionals share responsibility and are held accountable for patient care, minimising risks to patients and for continuously monitoring and improving the quality of clinical care
clinical handover	The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients to another person or professional group on a temporary or permanent basis
clinical indicator	A measure of the clinical management and/or outcome of care that should screen, flag or draw attention to a specific clinical issue. Clinical indicators identify the rate of occurrence of an event and are used to assess, compare and determine the potential to improve care
clinical pathway	Sometimes called a care map, a patient management tool that organises, sequences and times the major patient care activities and interventions of the entire interdisciplinary team for a patient with a particular diagnoses or procedure
code of practice	A published document that sets out commonly agreed sets of guidelines and informs all parties of responsibilities and expectations under the code. Codes of practice can be: ▪ voluntary agreements where a group of companies or an industry sector agree to abide by a particular code ▪ quasi-regulation where the code may be developed by industry in cooperation with government, or ▪ co-regulation where the code describes required performance or behaviour or specify acceptable means of meeting broader performance-based obligations and there are penalties for non-compliance with the code
community	A group of people who share a common interest or background (e.g. cultural, social, political, economic, health), which may also be, but is not necessarily, geographic
competence	A guarantee that an individual's knowledge and skills are appropriate to the service provided and an assurance that the knowledge and skill levels are regularly evaluated
complaint	Expression of a problem, an issue, or dissatisfaction with services that may be verbal or in writing
confidentiality	Guaranteed limits on the use and distribution of information collected from individuals or organisations

consent, informed	A process of communication between a patient and their health professional that results in the patient's authorisation or agreement to undergo a specific medical intervention. This communication should ensure the patient and/or family has an understanding of all the available options and the expected outcomes such as the success rates and/or side effects for each option
consent, acknowledgement of	In the absence of a completed consent form, an acknowledgement of consent in the patient's file, signed by the patient or family and the treating health professional, stating that the proposed treatment, the benefits and risks and any costs involved have been explained to the patient and family
contract	A mutual agreement between two or more competent parties that creates a legally supportable obligation to do or not do something specified
coordinate	To bring together in a common, ordered and harmonious action or effort
corporate governance	The processes by which the organisation is directed, controlled and held to account. It encompasses the systems, processes and arrangements by which authority, accountability, stewardship, leadership, direction and control are exercised in an organisation. It influences how objectives are set and achieved, how risk is monitored and assessed and how performance is optimised
credentialing	The formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of health professionals for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments
credentials	Documentation that an individual's knowledge, skills, competence and qualification comply with specific requirements
criteria	Specific steps to be taken or activities to be done, to reach a decision or a standard
culture, organisational	The prevailing pattern of beliefs, attitudes, values and behaviours within an organisation
current best-practice	An approach that has been shown to produce superior results, selected by a systematic process, and judged as exemplary, or demonstrated as successful. It is then adapted to fit a particular organisation
data	Unorganised facts from which information can be generated
data collection	A store of data captured in an organised way for a specific defined purpose
data integrity	Accuracy, consistency and completeness of data
data security	Protection of data from intentional or unintentional destruction, modification or disclosure

defining the scope of clinical practice	The process that follows on from the credentialing of health professionals which involves delineating the extent of, and limits to, an individual's clinical practice within a particular organisation based on that individual's credentials, competence, performance and professional suitability, and the needs and the capability of the organisation to support the individual's scope of clinical practice
delegation	The devolution of authority appropriate to individual roles and responsibilities within an organisation for the operation of clinical and non-clinical services. A formal delegation system ensures that clear lines of accountability exist, particularly where temporary delegations are enacted
deteriorating patient	A patient with worsening of pre-existing symptoms or the onset of an acute condition. Applies to any patients receiving medical or mental health care and is determined by observing and documenting changes in their clinical circumstances. This includes both the absolute change in physiological measurements and abnormal observations, as well as the rate of change over time for an individual
disaster recovery	A disaster recovery strategy is a set of pre-determined procedures that provides for substitute operations and a quick return to normal after any disruption
discharge	The release of a patient from care or movement of a patient from one healthcare organisation to another
document control system	A planned system for controlling the release, change and use of important documents within an organisation, particularly policies and procedures. The system requires each document to have a unique identification, to show dates of issue, updates and authorisation. Issue of documents in the organisation is controlled and all copies of all documents are readily traceable and obtainable
diverse background	The breadth of social, economic, physical and cultural factors that influence an individual patient's experience and perspective. This encompasses culturally and/or linguistically diverse backgrounds as well as disabilities
diverse needs	The range of patient needs that may be found within the community that an organisation serves, and which may form a barrier to health care if not addressed by the organisation in meeting its duty of care. Such needs may be cultural, physical, linguistic, economic or health status related
education	Systematic instruction and learning activities to develop or bring about change in knowledge, attitudes, values or skills
effective	Producing the desired result
effectiveness	Care, intervention or action that is relevant to the patient's needs and based on established standards. This care, intervention or action achieves the desired outcome
efficiency	Achieving desired results with the most cost-effective use of resources
electronic records	A record on electronic storage media that is produced, communicated, maintained and/or accessed by means of electronic equipment. An Electronic Health Record (EHR) is a repository of information regarding the health status of a patient, in computer processable form

elements	In the context of EQuIP7, elements dentify what should be in place to achieve the criterion at a certain level: a description of what is required to achieve the criterion. These provide prompts for improvement and best practice
employee assistance program	A proven strategy for assisting employees and their families with personal and work-related problems, difficulties and concerns which they may experience from time to time and can affect work performance
end-of-life care	A quality management approach that evaluates the individual holistic needs of a patient, their families and carers, and coordinates appropriate care. It recognises the interdependent physical, social, emotional, cultural, spiritual, and religious aspects of care and includes the combination of broad health and community services that care for a person at the end of their life
environmental sustainability	Development that meets the needs of the present without compromising the ability of future generations to meet their own needs. The ability to maintain the balance between non-living organisms and resources, such as water, timber and solar energy, and living organisms such as humans, animals and plants
error	Unintentionally being wrong in conduct or judgement. Errors may occur by doing the wrong thing (commission) or by failing to do the right thing (omission)
ethics	Acknowledged set of principles which guide professional and moral conduct
evaluation	Assessment of the degree of success in meeting the goals and expected results (outcomes) of the organisation, services, program or patients
evidence	Data and information used to make decisions. Evidence can be derived from research, experimental learning, indicator data, and evaluations. Evidence is used in a systematic way to evaluate options and make decisions
evidence based	The use of systematically reviewed, appraised clinical research findings to aid the delivery of optimum care to patients; the transfer of knowledge from research into health care practice
external entity	A body / establishment external to the organisation
externally based references	Reference and research information generated outside the organisation, such as journals, internet information, research databases, library resources, etc.
feedback	A communication from a patient or family relaying how delivered products, services and messages compare with patient and family expectations
flexible work practices	Working arrangements that assist employees to meet personal responsibilities, such as caring for a child or other family member. These may include: ▪ changes in hours of work ▪ changes in patterns of work, or ▪ changes in location of work
follow-up	Processes and actions taken after a service has been completed

formalised follow-up	Documented processes and actions after a service has been completed
governance	The set of relationships and responsibilities established by a healthcare organisation between its executive, workforce and stakeholders (including patients, families and the community). It incorporates the set of processes, customs, policy directives, laws, and conventions affecting the way a healthcare organisation is directed, administered or controlled. Governance arrangements specify the mechanisms for monitoring performance
governing body	A body that carries legal accountability and/or scope of organisational responsibility for the services provided, such as an individual owner or a group of senior managers, a governing body of directors, a board, a group of senior managers and/or a chief executive appointed by a government agency
guidelines	Principles guiding or directing action. Clinical practice guidelines are systematically developed statements to assist health professional and patient decisions about appropriate health care for specific circumstances. Guidelines in the EQuIP7 Guides provide essential information for the achievement of the EQuIP7 standards
healthcare associated infections	Infections acquired in healthcare facilities (nosocomial infections) and infections that occur as a result of healthcare interventions (iatrogenic infections), and which may manifest after people leave the healthcare facility
healthcare provider	A team or individuals who, in cooperation with the patient, assume responsibility for all aspects of an episode of care in response to the diagnosis and needs of the patient
health priority areas	Identified health areas which contribute significantly to the burden of illness and injury, which have potential for health gains and reduction in the burden of disease
Health professional	A healthcare provider that is trained as a health professional. Health professionals include registered and non-registered practitioners, or a team of health professionals providing health care who spend the majority of their time providing direct clinical care. The term encompasses medical practitioners, nurses, midwives, dentists, paramedics and allied health professionals such as physiotherapists, occupational therapists, speech pathologists, dieticians, radiographers, social workers, psychologists, pharmacists and all others in active clinical practice, but excludes health professionals-in-training and junior practitioners who must work under supervision
health workforce	The workforce that provides health care to patients, ranging from workers with no formal qualifications, through to highly qualified specialists working in a technology intensive setting
iatrogenic	Arising from or associated with health care rather than an underlying disease or injury
incident	An event or circumstance which could have or did lead to unintended and/or unnecessary harm to a person, and/or complaint, loss or damage

include(s)	A list that provides examples and is not limiting
indicator	Performance measurement tool, screen or flag that is used as a guide to monitor, evaluate, and improve the quality of services. Indicators relate to structure, process and outcomes
infection control management plan	A documented plan that outlines the structure of an infection control program, its overall aims and objectives, associated quality management activities, program evaluation criteria and time frames for review. The document should address the governance of infection control and identify: ▪ who is at risk and from what ▪ the hazards involved ▪ the procedures for minimising risk, and ▪ appropriate measures for infection control, based on standard precautions and when required, additional precautions
information management	The process of planning, organising, analysing and controlling data and information. The management of information applies to both computer-based and manual systems
information privacy	The right of a person to control the use and disclosure of information that reveals their identity, health information or health status
information system	A system that provides access to information using hardware, software, supplies, policies, procedures and people
information technology	Mechanical and electronic devices designed for the collection, storage, manipulation, presentation and dissemination of information
integrated governance	An additional approach that aims to strengthen and streamline healthcare organisation governance arrangements by focusing on quality as the driver of change and placing clinical governance at the heart of governance arrangements. Considered a key building block of good governance in healthcare
Integrity (data)	The characteristic of data and information being accurate and complete
interoperability	The ability of information systems to reliably exchange information without error
intervention	Any act performed to prevent harming of a patient or to improve the mental, emotional or physical function of a patient
IT security	A tangible set of physical and logical mechanisms which can be used to protect information held in hard copy, computer systems and information and telecommunication infrastructure, from unauthorised access
IT system	A group of interacting, interrelated or interdependent elements forming or regarded as forming a collective entity
jurisdiction	The authority that makes decisions and judgments that become law, to which the organisation must abide by

leadership	The ability to provide direction and cope with change. It involves establishing a vision, developing strategies for producing the changes needed to implement the vision, aligning people and motivating and inspiring people to overcome obstacles
legibility	Data or information that is decipherable or readable
legislation	The body of laws made by Parliament. These consist of: Acts of Parliament; and Regulations, Ordinances, Rules which are also called 'subordinate' or 'delegated' legislation
management	Setting targets or goals for the future through planning and budgeting, establishing processes for achieving those targets and allocating resources to accomplish those plans. Ensuring that plans are achieved by organising, staffing, controlling and problem-solving
malnutrition	A state of nutrition in which a deficiency or excess (or imbalance) of energy, protein, and other nutrients causes measurable adverse effects on tissue / body form (shape, size and composition) and function and clinical outcome
manual handling / tasks	A task comprised wholly or partly by any activity requiring a person to use any part of their musculoskeletal system in performing their work. These tasks can include: ▪ lifting, lowering, pushing, pulling, carrying or otherwise moving, holding or restraining any person, animal or item ▪ repetitive actions ▪ sustained work postures, and ▪ exposure to vibration
medication error	Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional or patient
medication management	The processes of dispensing, prescribing, storing, administering and monitoring the effects of medicines
medico legal requirements	Requirements of or relating to both medicine and law
mission	A broad written statement in which an organisation states what it does and why it exists. The mission sets apart one organisation from another
monitor	To check, supervise, observe critically, measure or record the progress of an activity, action or system on a regular basis in order to identify change and/or track change
morbidity	A diseased state or symptom or the incidence of disease: the rate of sickness in a specified community or group
mortality	The number of deaths in a given time or place or the proportion of deaths to a given population

multidisciplinary	Care or a service given with input from more than one discipline or profession
near miss	An incident that did not cause harm, but had the potential to do so
needs	Physical, mental, emotional, social, spiritual or religious requirement for well-being. Needs may or may not be perceived or expressed by those in need. They must be distinguished from demands, which are expressed desires, not necessarily needs
non-clinical information	Information that is not direct, personal patient information
nutrition care	Interventions, monitoring, and evaluation designed to facilitate appropriate nutrient intake based upon the integration of information from the nutrition assessment
nutrition screening	The process of identifying patients with characteristics commonly associated with nutrition problems who may require comprehensive nutrition assessment and may benefit from nutrition intervention
nutrition assessment	A comprehensive approach to gathering pertinent data in order to define nutritional status and identify nutrition-related problems. The assessment often includes patient history, medical diagnosis and treatment plan; nutrition and medication histories, nutrition related physical examination including anthropometry, nutritional biochemistry, psychological, social, and environmental aspects
objective	Target that must be reached if the organisation is to achieve its goals. It is the translation of the goals into specific, concrete terms against which results can be measured
ongoing care	The active and supportive management of care for people with chronic or complex conditions as well as the process that follows an admission to a healthcare organisation
open disclosure	The open discussion of incidents that resulted in harm to a patient while receiving health care. The criteria of open disclosure are an expression of regret and a factual explanation of what happened, the potential consequences and the steps being taken to manage the event and prevent recurrence
operational plan	A short-term plan that details how aspects of a strategic plan will be accomplished
organisation	All sites / locations under the governance of, and accountable to, the governing body / owner(s)
orientation	A formal process of informing and training staff on entry into a position or organisation, covering the policies, processes and procedures applicable to that healthcare organisation
outcome	Results that may or may not have been intended that occur as a result of a service or intervention

patient master index	Permanent listing or register of health information held by an organisation on patients who have received or are scheduled to receive services
personal information	Information or an opinion (including information or an opinion forming part of a database), whether true or not, and whether recorded in a material form or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion
policy	Written statement/s which act as guidelines and reflect the position and values of the organisation on a given subject. All procedures and protocols should be linked to a policy statement
Practical / practicable	When 'practical' is at the convenience of the organisation; when 'practicable' is as soon as is possible
pressure ulcer / wound	A localised injury to the skin and/or underlying tissue, usually over a bony prominence and caused by unrelieved pressure, friction or shear. Pressure ulcers occur most commonly on the sacrum and heel but can develop anywhere on the body. Pressure injury is a synonymous term for pressure ulcer
prevention and management	A systematic approach adopted by all sections of an organisation to ensure appropriate identification and actions for patients at risk of an illness or condition
procedure	A set of documented instructions conveying the approved and recommended steps for a particular act or sequence of acts
process	A series of actions, changes / functions that bring about an end or a result
psycho-social	Pertaining to a combination of psychological and social factors
quality activities	Activities which measure performance, identify opportunities for improvement in the delivery of care and service, and include action and follow-up
quality framework	An overarching approach to quality improvement that promotes integration of risk management with quality improvement strategies and informs decision making and planning
quality improvement	Ongoing response to quality assessment data about a service in ways that improve the processes by which services are provided to patients
quality use of medicines	The judicious, appropriate, safe and effective use of medicines
records	All records of information within the organisation, clinical and non-clinical
records management	Field of management responsible for the efficient and systematic control of the creation, receipt, maintenance, use and disposition of records
record safety	The physical safety of records such as from light, humidity, vermin, fire and moisture
record storage	The function of storing records for future retrieval and use
recruitment and selection	Process used to attract, choose and appoint qualified staff
referral	The process of directing or redirecting a patient to an appropriate specialist or agency for definitive treatment
relevant	In the context of EQuIP7 relevant refers to when something is connected with a matter; when there is a logical connection
research	An active, diligent and systematic process of inquiry in order to discover, interpret or revise facts, events, behaviours, or theories, or to make practical applications with the help of such facts, laws or theories
patient and family participation	The process of involving patients and their family meaningfully in decision making about their own health care, health service planning, policy development, setting priorities and quality issues in the delivery of services
patient health record	Term used to describe the data and reports about a patient, however stored. The patient file may be made up of records in different media, for example electronic and paper-based
risk	The effect of uncertainty on objectives which may be positive and/or negative. Objectives can have different aspects, such as financial, health and safety, and environmental goals, and can apply at different levels, such as strategic, organisation-wide, project, product and process. Risk is often expressed in terms of a combination of the consequences of an event and the associated likelihood of occurrence
risk management	Coordinated activities to direct and control an organisation with regard to risk, such as activities that identify, control and minimise threats to the ongoing efficiency, effectiveness and success of its operations to deliver desired outcomes
risk management framework	A set of components that provide the foundations and organisational arrangements for designing, implementing, monitoring, reviewing and continually improving risk management throughout the organisation. The framework should be embedded within the organisation's overall strategic and operational policies and practices
root cause analysis	A systematic process whereby the factors which contributed to an incident are identified
scope of clinical practice	Delineating the extent of an individual health professional's clinical practice within a particular organisation, based on the individual's credentials, competence, performance and professional suitability, and the needs and the capability of the organisation to support the health professional's scope of clinical practice. This occurs after the process of credentialing
sentinel event	An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events signal the need for immediate investigation and response

services	Products of the organisation delivered to patients or units of the organisation that deliver products to patients
skill mix	The mix of posts, grades or occupations within an organisation. It may also refer to the combinations of activities or skills needed for each job within the organisation
skin integrity	The integrity of skin can be affected by a number of factors, including age, poor nutrition, dehydration, medications, cognitive and mobility impairment and certain medical conditions. A break in skin integrity can occur as the result of health care itself, can affect a wide variety of patients (neonates, the frail aged, the immobile and/or insensate, those with reduced sensory perception, individuals undergoing lengthy procedures), and can occur in all environments and situations involving bed care, the use of support devices or physical interaction (emergency departments, wards, transport vehicles, operating theatres, day hospitals, community nursing).
staff	Term which includes employed, visiting, sessional, contracted or volunteer personnel
staff development	See training
stakeholder	Individuals, organisations or groups that have an interest or share in services
standard	A desired and achievable level of performance against which actual performance is measured
statutory notifications	Any notification required by an act of parliament
statutory requirements	Any requirement laid down by an act of parliament
strategic plan	A formalised plan that establishes an organisation's overall objectives and that seeks to position the organisation in terms of its environment
strategy	A long-term plan of action designed to achieve a particular objective
surveillance	The ongoing, systematic collection, analysis and interpretation of health-related data essential to the planning, implementation and evaluation of public health practice, closely integrated with the timely dissemination of these data to those responsible for prevention and control
system	The resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish an objective
tracking	Creating, capturing and maintaining information about the movement and use of something, such as records or files, or instruments.
training	The development of practical skills that should be related to the professional development needs of the individual and organisation and may be incorporated into professional development programs
unique identifier	Universal number or code that uniquely identifies a person or other discrete entity
validation	To make sound, ratify, confirm, substantiate or to give legal force to. Validity deals with the relationship of the data obtained to the purpose for which it accomplishes, or measures what it seeks to measure
values	Principles and beliefs that guide an organisation and may involve social or ethical issues
vision	Description of what the organisation would like to be
waiting list	A register which contains essential details about prospective patients who have been assessed as meeting the inclusion criteria of the organisation
when required	Required at the time
where required	Required in certain circumstances

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The ACHS acknowledges the individuals and organisations who have committed their knowledge, experience and more significantly, their time, to this complex task.

The EQuIP7 Core Standards Working Group

Working Groups consist of experts in health care and are consulted on each draft throughout the standards development process.

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The EQuIP7 Core Standards were pilot tested in four Australian organisations, and four international organisations, using a desk-top audit process.

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The EQuIP7 Hospital Standards Pilot Organisations

The EQuIP7 Hospital Standards were pilot tested in 12 international hospitals, using both local and Australian based assessors. ACHS Standards are pilot tested to ensure that each standard is relevant, understandable, measurable, beneficial and achievable (RUMBA), in accordance with the ISQua External Evaluation Association requirements.

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The revision of EQuIP programs is led by the ACHS Standards Committee, whose role it is to steer the direction and content of the standards review, and to advise on the applicability of the standards for implementation and accreditation assessment.

The Standards Committee is a sub-committee of the ACHS Board and reports its recommendations, through the committee Chair, directly to the ACHS Board.

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