

ACHS Performance Data System

Information for members

Performance and Outcomes Service
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Introduction

This document provides information about the Performance and Outcomes Service and the function of the ACHS Performance Data System.

For further copies of this document or for additional information relating to the Performance Data System please contact:

ACHS Performance and Outcomes Service

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Other publications:

- The ACHS Clinical Indicator User Manuals are published biannually with updated clinical indicators available for collection in the coming year.
- The ACHS Clinical Indicator Summary Guide is published annually with updated clinical indicators available for collection in the coming year.
- The Australasian Clinical Indicator Report is published annually and reports aggregate results for all published clinical indicators.

About the ACHS Performance and Outcomes Service

The role of the Performance and Outcomes Service (POS) is to coordinate the development, collection, collation, analysis, and reporting of healthcare organisation performance metrics. ACHS, through POS, has considerable information on over 330 clinical indicators with more than 600 healthcare organisations participating in the ACHS Performance Data Program. Information from these performance metrics is the largest source of data collected on the quality of healthcare in Australia and New Zealand.

What is the Performance Data System?

The Performance Data System is a data repository, analysis and reporting service provided to ACHS member organisations. It includes the clinical indicator program, a national clinical benchmarking service comprised of comparative information on the processes and outcomes of health care (<https://www.achs.org.au/our-services/pos>). Participating organisations can submit data for inclusion in an extensive database. Data are aggregated and analysed six-monthly, and results are provided in the form of comparative reports and a dashboard. The dashboard compares results across all contributing organisations as well as providing a comparison with similar organisations based on several variables.

The POS team also provides individual support to healthcare organisations, via telephone and e-mail. Consultancies can be arranged through the consulting division of ACHS (<https://www.achs.org.au/our-services/consulting>) and education can be provided by the ACHS Improvement Academy (<https://www.achs.org.au/improvement-academy>) on a range of topics related to performance improvement. The Performance Data System provides all the necessary products, tools and services required for members to participate. These resources are available via a secure website where members can also submit and download their performance data (<https://www.achs.org.au/our-services/pos>).

Who can subscribe?

Subscription to the Performance Data System is free for ACHS/ACHS International (ACHSI) accreditation members. All members are encouraged to submit indicator data to demonstrate continuous quality improvement. Non-ACHS accredited organisations may subscribe to the program, and a membership fee applies. Fees are based on a calendar year subscription.

What are clinical indicators?

A clinical indicator is a measure of the clinical management or outcome of care.¹ A well-designed indicator should screen, flag, or draw attention to a specific clinical issue. Usually rate-based, indicators identify the rate of occurrence of an event. Indicators do not provide definitive answers; rather they are designed to highlight potential problems that might need addressing, by identifying variations within healthcare data.² They are used to assess, compare, and determine the potential to improve care.³ Indicators are therefore tools to assist in assessing if a standard in patient care is being met.

There is growing recognition that the capacity to evaluate and report on quality is a critical component of system-wide improvement of healthcare delivery and patient outcomes.⁴ Organisations are frequently requested to provide data on many aspects of their facility, to a variety of stakeholders. Indicator results provide valuable information in assessing the performance of health services. The focus on performance management has emerged through increased competition, a more recent focus on quality improvement and safety and an increased demand for evidence of performance.

The use of indicators is an effective tool for measuring and managing the quality of clinical care, providing the relevant clinicians are involved and supported with adequate resources to undertake clinical audits. The reporting of indicator data to the ACHS/ACHSI is not a mandatory component of the accreditation process. However, organisations are required to demonstrate their achievements using data. To do this, the organisation may either use ACHS/ACHSI clinical indicators or other performance indicator metrics. Organisations may also need to demonstrate at the time of survey, evidence of improving performance through evaluation, supported by data.

ACHS/ACHSI has been involved in the development of clinical indicators in conjunction with Australian and New Zealand medical colleges, associations, and societies since 1989. In this time, the program has seen the development of Hospital-Wide and specific sets of clinical indicators.

Types of indicators

Clinical Indicators can be classified according to the aspects of care they address. A comprehensive view of healthcare performance can be built up by investigating information from a variety of sources about different aspects of care.

Indicators will measure either:

- Structure (what is needed)

¹ Collopy BT. Clinical indicators in accreditation: an effective stimulus to improve patient care. *Int J Qual Health Care* 2000; 12(3): 211-216.

² Campbell S, Braspenning J, Hutchinson A and Marshall M. Research methods used in developing and applying quality indicators in primary care. *Qual Saf Health Care* 2002; 12(3): 358-364.

³ Howley P and Gibberd R. Using hierarchical models to analyse clinical indicators: a comparison of the gamma-Poisson and beta-binomial models *Int J Qual Health Care* 2003; 15(4): 319-329.

⁴ Miller T and Leatherman S. The National Quality Forum: A 'Me-Too' Or A Breakthrough In Quality Measurement And Reporting? *Health Aff (Millwood)* 1999; 18(6): 233-237.

- Process (what is done)
- Outcome (what is achieved or expected).

According to Donabedian,⁵ these three areas of care are interlinked, in that sound structures facilitate good processes, which in turn produce positive outcomes, the endpoint of care. Donabedian postulated that quality improvement is enabled by receiving feedback about these three aspects of care and responding to that feedback. He called these measures, indicators of quality. Indicators of quality are not direct or definitive measures of quality in themselves. Rather as their name suggests they indicate areas of care requiring greater scrutiny.

Structure indicators

Structure indicators provide important information about the organisation's environment (infrastructure, physical layout and resources, human resources, and organisational framework) required for the provision of quality health care.

- An example of a structure indicator is:

Number of patients who undergo a procedure with an anaesthetist in attendance where there is a trained assistant to the anaesthetist.⁶

Process Indicators

Process indicators measure what is being done in providing the care. Process indicators provide quantitative data regarding the impact or effectiveness of systems, policies and procedures and can monitor changes over time when measured repeatedly.

- An example of a process indicator is:

Number of patients who have documentation of risks and benefits of the anaesthetic procedure(s) completed by an anaesthetist prior to transfer to the operating suite or procedure room.⁶

Outcome Indicators

Outcome refers to the result of care and outcome indicators provide quantitative data related to the outcomes of health system performance. It is often difficult to develop definitive outcome indicators and therefore surrogate outcome indicators may be used.

- An example of an outcome indicator is:

Number of patients undergoing treatment for postoperative nausea and vomiting in the post-anaesthesia recovery room.⁶

⁵ Donabedian A. The quality of care. How can it be assessed? *JAMA* 1988; 260(12): 1743-1748.

⁶ ACHS Performance and Outcomes Service. *Anaesthesia and Perioperative Care version 6: Clinical Indicator User Manual*. Sydney NSW; Australian Council on Healthcare Standards; 2015.

Clinical indicator development and review

The POS has a collaborative framework for developing ACHS/ACHSI clinical indicators which is based on:

- Established working relationships with medical colleges, associations, societies, and other relevant clinical organisations.
- A multidisciplinary approach to indicator development.
- Development of a broad range of CIs for use in acute and non-acute settings.
- Provision of clinical coding to align and automate indicators.
- Provision of regular analyses/reports to individual organisations.
- Publication of an annual report of indicator results and trends.

New indicator sets are developed when there is interest from specialty organisations. Each indicator set is regularly reviewed to ensure:

- it is relevant for clinicians
- it remains reflective of today's health care environment
- there is consensus of collection and reporting requirements
- the set remains useful for quality improvement.

For more information about the development process please contact the Performance and Outcomes Service on +61 2 9281 9955 or pos@achs.org.au.

Benefits of performance data

The benefits of participating in the Performance Data System include:

- A formal clinical audit processes inherent in the evaluation of care by the relevant clinicians. Clinician involvement is imperative if quality improvements are to be achieved.
- Strategic benchmarking program which provides comparison of results with national and peer group organisations and is the largest clinical data set of its kind in Australasia.
- The six-monthly dashboard reports enable early recognition of areas of potential improvement.
- The evidence addressing the utilisation of performance data and the associated involvement of relevant clinician groups supports accreditation through demonstration of achievement of appropriate levels of clinical quality.

Utilising performance data

There are 22 clinical indicator sets and over 320 CIs to choose from in the ACHS Performance Data System. The Program also supports the Australian Commission on Safety and Quality in Healthcare (ACSQHC) Clinical Care Standard indicators for local monitoring. There is no requirement that an organisation monitor a specific number of indicators, although demonstration in certain areas such as colonoscopy is mandated under the ACSQHC accreditation program. Organisations are required to consider indicators that relate to the health services they provide and are appropriate to their size and type of organisation.

The ability to effect improvements in patient care will depend on the relevance of the indicators being monitored. To identify indicators which are potentially relevant and appropriate, the following points should be considered:

- Will the information be useful and meaningful to clinicians in demonstrating how the service is performing and ways that it may be improved?
- Will the data be accessible to clinicians to allow for monitoring of the indicator?
- Are existing resources sufficient to allow for ongoing monitoring of the indicator?

The ability of the indicator data to influence and improve the standards of clinical care is dependent on the relevance of the indicator to current clinical practice (largely determined by the relevant medical college, society, or association), and the resources available to support clinicians in assessing the data and considering alterations to either individual or clinical unit practice. Utilisation of data occurs at local organisational and national levels.

Reporting performance data

Local organisational level

Utilisation of indicators is not mandatory within large parts of the accreditation process. However, all organisations are required to show evidence of monitoring, evaluation and improvement using clinical data. Monitoring relevant data within a benchmarking program is one method by which this can be achieved.

Six-monthly dashboard reports in Metrik, powered by Sisense, provide quantitative data identifying variation from total aggregate and a multitude of peer group rates. The heatmap in the dashboard highlights results which are statistically significantly different to all other organisations submitting data for that indicator, where the results are undesirably lower or higher than the expected rate. Trend rates and benchmarking provided in comparison with stratified peers allows an organisation to gain context to their data, enabling them to enact relevant changes where needed.

National or International Level: The Australasian Clinical Indicator Report

In the Australasian Clinical Indicator Report, the data is assessed from a national perspective providing a statistical analysis of aggregated results for each of the published indicators. The results provide health policy planners with relevant information, particularly results addressing access issues, and professional organisations, such as medical colleges and societies, with information highlighting variation in practice which may assist in improving standards of care.

How do we structure indicators?

All ACHS/ACHSI clinical indicators follow a similar structure. An example is given below:

INFC AREA 4: Vancomycin resistant enterococci (VRE)

Rationale

According to the Australian Group on Antimicrobial Resistance (AGAR), the prevalence of VRE infection is rising in Australia. These healthcare-associated infections (HAIs) are commonly seen in high-risk areas such as intensive care units, haematology and oncology units and dialysis centres.

[\(See Background for more information\)](#)

Reporting period

1 January – 30 June

1 July – 31 December

Inclusions

- Only vancomycin resistant enterococci (VRE) laboratory confirmed bloodstream infections are to be **INCLUDED**.

Exclusions

- VRE colonisations are to be **EXCLUDED**.

Data cleaning rules

- Nil

Definition of terms

A **healthcare-associated infection (HAI)** is an infection that occurs as a result of a healthcare intervention. Infections identified > 48 hours after the admission and not incubating on admission or ≤ 48 hours after discharge should be reported as HAIs. Infections identified ≤ 48 hours after the admission need further evidence to be confirmed as HAIs. Please refer to the Australian Commission on Safety and Quality in Health Care

(ACSQHC)⁷ and National Health and Medical Research Council (NHMRC) Australian Guidelines for the Prevention and Control of Infection in Healthcare⁸ for further clarification.

For the purpose of CI 4.1:

AIHW's definition at <http://meteor.aihw.gov.au/content/index.phtml/itemId/181162> is used for 'bed days' or 'patient days' calculated by counting the total patient days of those patients separated during the specified period, including those admitted before the specified period. Patient days of those patients admitted during the specified period who did not separate until the following reference period are not counted.

For the purpose of CI 4.1:

ICU bed days are defined as the total number of occupied bed days in the intensive care unit (ICU).

Indicator(s) within this Area

CI 4.1: VRE infection within the ICU (L)

Numerator	Number of ICU associated new vancomycin resistant enterococci (VRE) healthcare-associated infections, during the 6-month reporting period.		
Denominator	Number of ICU bed days, during the 6-month reporting period.		
Desirable rate:	High <input type="checkbox"/>	Low <input checked="" type="checkbox"/>	Not specified <input type="checkbox"/>
Indicator type:	Structure <input type="checkbox"/>	Process <input checked="" type="checkbox"/>	Outcome <input type="checkbox"/>

Background

In 1986, the first noted cases of Vancomycin Resistant Enterococci (VRE) were reported in the United Kingdom and France.¹⁻³ Since then, the incidence of HAIs as a result of VRE has increased sharply and been prevalent in the United States, Australia and other areas of Europe.^{1,2} Considering that vancomycin had been in use for more than 30 years prior to the first reported case of resistance, this came as a shock to the medical and scientific community.² Their belief that resistance to glycopeptides was unlikely to occur dissipated with the wide-spread transmission of VRE in the United States and European hospitals over the subsequent decades.²

According to the Australian Group on Antimicrobial Resistance (AGAR), the prevalence of VRE infection is rising in Australia, but not at the same rate as seen internationally.¹ It is believed that this could be partly due to the effective management of colonised patients prior to the transmission of this infection.¹ The most common forms of VRE isolates causing HAIs that

1. Implementation Guide for Surveillance of *Staphylococcus aureus* Bacteraemia. Australian Commission on Safety and Quality in Health Care; 2013. https://www.safetyandquality.gov.au/wpcontent/uploads/2012/02/SAQ019_Implementation_guide_SAB_v10.pdf

2. Australian Guidelines for the Prevention and Control of Infection in Healthcare, National Health and Medical Research Council; 2010. <https://www.nhmrc.gov.au/printpdf/book/export/html/51607>

result in hospital-associated morbidity and mortality are *Enterococcus faecium* and *Enterococcus faecalis*.³ These HAs are commonly seen in high-risk areas such as:

- Intensive Care Units
- Haematology and Oncology Units
- Dialysis Centres.^{1,4,5}

"The emergence of resistance to various antimicrobial agents, specifically to vancomycin, has become a major clinical and epidemiological threat".⁶ This resistance usually occurs with the heavy use of glycopeptides and broad-spectrum antibiotics in the aforementioned high-risk areas.^{5,6} The treatment options for enterococcal sepsis are limited due to the emergence of vancomycin resistance.⁵ The most clinically relevant resistant phenotypes are:

- *vanA* – acquired high-level resistance to vancomycin and teicoplanin
- *vanB* – acquired moderate level resistance to vancomycin and *in vitro* susceptibility to teicoplanin.^{1,5,7,8}

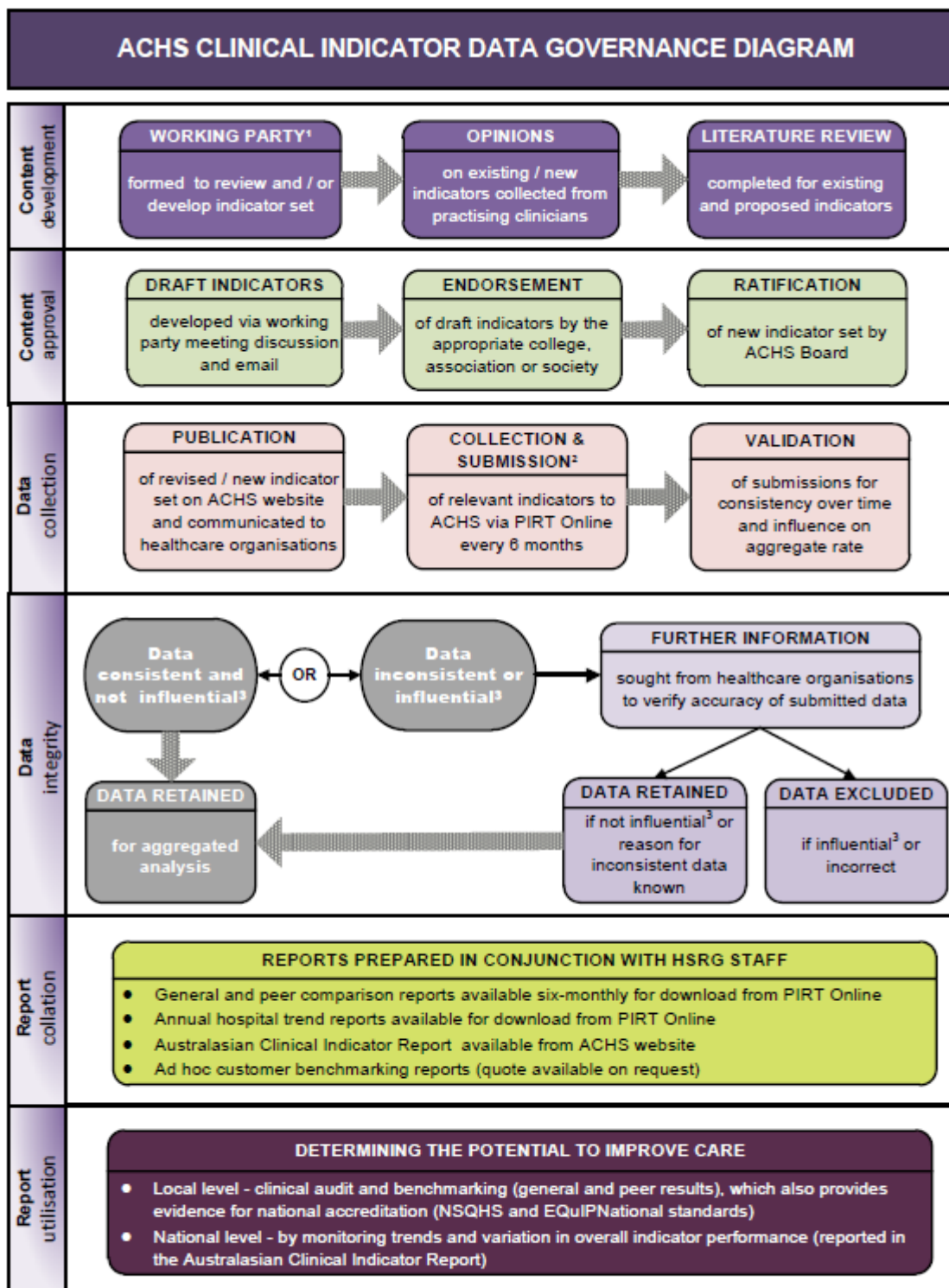
In order to reduce the transmission of this infection in hospitals, it is recommended that screening for VRE occur in an outbreak situation, which is in line with the HCO's guideline. Once the laboratory has confirmed the presence of VRE infection, it is imperative that the key personnel be notified to initiate the appropriate contact precautions.⁵ The process to prevent the transmission of infection for those admitted and transferred between wards should involve:

- Medical practitioner(s) responsible for the care of the patient
- Nurse in charge of the ward or unit
- Infection control personnel
- Other personnel specified in the healthcare organizations VRE policy.⁵

References

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2. Cattoir V, Leclercq R. Twenty-five years of shared life with vancomycin-resistant enterococci: is it time to divorce? J Antimicrob Chemother. 2013;68(4):731-42.
3. Lu C-L, Chuang Y-C, Chang H-C, Chen Y-C, Wang J-T, Chang S-C. Microbiological and clinical characteristics of vancomycin-resistant *Enterococcus faecium* bacteraemia in Taiwan: implication of sequence type for prognosis. J Antimicrob Chemother. 2012;67(9):2243-9.
4. Queensland Health. Screening and Clearance of Multi-resistant Organisms (MRO) June 2012 10th December, 2013. Available from: http://www.health.qld.gov.au/chrsp/policy_framework/guideline_4_MRO.pdf.
5. South Australia Health. Guidelines for the Management of Patients with Vancomycin-resistant *Enterococcus* (VRE) Colonisation/Infection. Management of Multi-Resistant Organisms [Internet]. August 2012 12th December, 2013. Available from: <http://www.health.sa.gov.au/INFECTIONCONTROL/Default.aspx?tabid=115>.
6. Hayakawa K, Marchaim D, Martin E, Tiwari N, Yousuf A, Sunkara B, et al. Comparison of the clinical characteristics and outcomes associated with vancomycin-resistant *Enterococcus faecalis* and vancomycin-resistant *E. faecium* bacteremia. Antimicrob Agents Chemother. 2012;56(5):2452-8.
7. Centre for Healthcare Related Infection Surveillance and Prevention. Protocol for the management of patients with vancomycin resistant *Enterococcus* (VRE) April 2013 10th December, 2013. Available from: <http://www.health.qld.gov.au/directives/docs/ptl/qh-hsdptl-029-2.pdf>.
8. Healthcare Infection Surveillance Western Australia (2012). HISWA Surveillance Manual. Perth WA: HISWA.

Performance Data Governance



¹ Nominated representatives from relevant key health bodies (medical and health professional colleges, associations, and societies), consumer organisations, Health Services Research Group, and ACHS staff

² First 12 months of a revised / new indicator set is considered a field study and monitored closely

³ Statistically influences aggregated data

Data Reporting

Data collection periods

There are two reporting periods each year:

- January to June: organisations must submit their data by **20 August**.
- July to December: organisations must submit their data by **20 February**.

The collection, analysis, and reporting system

Program members are supplied with comprehensive information on how to collect the data, supplied in the clinical indicator user manuals. Further support is provided by POS team members via phone and email. ACHS/ACHSI is not prescriptive about how an organisation collects the data, for example some indicators are collected via manual audit of medical records, while others can be generated from internal computer systems, such as adverse event or risk management systems. Organisations should ensure they collect the information in strict accordance with the definitions in the user manual. This contributes to the consistency of the data.

Organisations are required to submit their data using the Metrik tool. This tool is an online website where data can be submitted and where the analytics and benchmarking can be viewed. It is accessible via your ACHS/ACHSI username and password.

Reports to individual healthcare organisations

The Metrik dashboard is updated on a six-monthly basis after each data submission and is designed with simplicity and ease of use in mind. The dashboard provides information to identify statistically significant differences between the individual organisation, all organisations and peer groups. Outlier data is easily flagged in the heatmap diagram for follow up and to facilitate communication of results to relevant clinicians and management.

The reports also provide for each individual indicator the going trend (including 20th and 80th percentiles) as well as the spread of the data and breakdown by quartiles in a box and whiskers plot. Your data (the green dot) is then able to be compared with your peers. The dropdown menus on the side for dashboard allow for deeper peer comparison, by set stratification, organisational stratification, rurality, and location. The graphical description and results automatically update based on your peer comparison.

The dashboards are updated approximately four to six weeks after the end of the data submission period. A sample dashboard is provided in Appendix 1.

Published reports

The ACHS/ACHSI publication, the Australasian Clinical Indicator Report (ACIR), is published annually and reports aggregated results on all indicators at both a national and international level.

The publication identifies:

- The aggregate rates.

- The 20th and 80th percentiles – the rates at which the top 20% of organisations are already performing and regarded as the goals to achieve depending on whether the desired rate is low or high.
- The trends in incidence since establishment of the national data set.
- Significant variation of rates of performance.
- Rate differences between various strata – public and private, metropolitan, non-metropolitan and states.

Custom benchmarking reports

The POS team is also able to provide corporate groups with custom benchmarking reports which allow comparison of indicator rates within a specific group of organisations, for example, an area health service or a private hospital group. These reports are typically supplied in excel format, allowing members to perform further analysis if required. They will be available in dashboard format soon.

Reports to the relevant college, association, or society

To assist in the development and review of indicators, reports are developed for the medical colleges, associations, societies, and other relevant clinical organisations that participate in updating clinical indicators. The reports describe any statistically significant differences between strata such as, public/private sector healthcare organisations, non-metropolitan/metropolitan and location. Each college, society or association is also invited to comment on the results and remark on any variations in practice. Expert commentaries from colleges are published each year in the Australasian Clinical Indicator Report.

Interpreting the clinical indicator reports

Organisations may review the results of the comparative reports to see if there is any statistical difference between their rate and the general or peer comparison rate. When differences are identified, organisations should question why there is a difference. By reviewing results with risk management in mind, organisations can prioritise areas for quality improvement. Indicators flagged as significantly different should be investigated at the organisational level to determine the reason for this difference.

It is important to remember that variations in the data can be found in almost every indicator. There will almost always be a range of performance identified. There are many reasons for these variations, and it is not always possible to identify the reasons for the variation. If variation is found however, it is essential that healthcare providers thoroughly examine the cause and implement action for improvement if required. The indicators are not case, or risk adjusted (due to the lack of a large, anonymised pool of matched peers across social strata), however the peer group stratifications are regularly reviewed to ensure similar organisations are being compared.

To investigate results and implement change, an organisation should follow a quality improvement process such as the Plan, Do, Check, Act cycle or Clinical Practice Improvement Method. In combination with other quality improvement strategies, indicators can allow for successful probing of potential and actual problems. Other data sources that can be used in combination with the indicators may include:

- adverse events and/or complication data
- incident reports
- consumer complaint data

- staff or patient satisfaction survey data.

What clinical areas does the dataset cover?

Currently the ACHS has 22 clinical indicator sets. Below is a listing of the current indicator sets and the areas which they cover.

Anaesthesia & Perioperative Care version 7

- Pre-anaesthesia period
- Intraoperative period
- Patient recovery period
- Postoperative period
- Obstetric anaesthesia care

Cancer Care version 1.2

- Access
- Assessment
- Treatment
- Outcomes
- Follow-up
- Support services

Day Patient version 6.1

- Preadmission preparation
- Procedure non-attendance
- Procedure cancellation
- Episode of care adverse events
- Unplanned return to the operating room
- Unplanned transfer / admission
- Discharge
- Departure
- Post-discharge follow-up

Emergency Medicine version 7.1

- Waiting time
- ST-segment elevated myocardial infarction (STEMI) management
- Emergency department mental health presentations
- Critical care
- Sepsis management
- Discharge communication
- Pain management
- Unplanned re-attendance

Gastrointestinal Endoscopy version 3.3

- Failure to reach caecum / neo-terminal ileum
- Colonoscopy adverse outcomes
- Adenoma detection
- Oesophageal perforation after dilatation
- Aspiration following GI endoscopy
- Sedation in GI endoscopy

Geriatric Care version 1

- Functional Assessment and planning
- Medications
- Discharge
- Unplanned readmissions

Hospital in the Home version 6

Patient safety, selection, communication, and care co-ordination

Service interruption

Unexpected deaths

Gynaecology version 8.1

Blood transfusion

Injury to a major viscus

Laparoscopic management of an ectopic pregnancy

Thromboprophylaxis for major gynaecological surgery

Hysterectomy

Hospital-Wide version 13.5

Hospital readmissions

Return to operating room

Pressure injuries

Inpatient falls

Patient deaths

Blood transfusion

Thromboprophylaxis

Minimum standards for rapid response system (RRS) calls

Surgery

Risk Assessment

Infection Control version 5.2

Infection surveillance

Surgical antibiotic prophylaxis (SAP)

Haemodialysis access-associated bloodstream infection surveillance

Vancomycin resistant enterococci

Staff immunisation

Occupational exposures to blood and / or body fluids

Intensive Care version 6

Access and exit block

Intensive care patient management

Intensive care patient treatment

Central line-associated bloodstream infection

Utilisation of patient assessment systems

Empathetic practice

Mental Health version 9

Diagnosis and care planning

Physical examination of patients

Prescribing patterns

Electroconvulsive therapy

Use of seclusion and restraint

Major critical incidents

Mental Health Act status

Continuity of care

Community care

Maternity version 9.1

Outcome of selected primipara
Vaginal birth after caesarean section (VBAC)
Perineal Trauma
Exclusive Breastfeeding
Postpartum haemorrhage and blood transfusions
Foetal growth restriction (FGR)
Apgar score
All admission of term neonate to a neonatal intensive care nursery (NICN) or special care nursery (SCN)
Severe acute maternal morbidity

Paediatrics version 5.2

Appropriateness
Adverse events
Documentation
Paediatric anaesthesia

Radiation Oncology version 5

Consultation process
Treatment planning
Treatment delivery

Ophthalmology version 6.1

Cataract Surgery
Intraocular glaucoma surgery
Retinal detachment surgery
Planning records for intraocular lens implantation

Oral Health version 5.1

Returns to the dental centre
Endodontic treatment
Children's dental care
Preventative Services

Pathology version 5

Chemical pathology
Haematology
Anatomical pathology
Microbiology
Point of care testing
Whole of service
Immunopathology

Radiology version 7

Adverse patient events
CT dosimetry
Patient identification and consent
Critical test result notification
Report turnaround time

Rehabilitation Medicine version

7

Timely assessment of function on admission

Timely establishment of an initial
multidisciplinary rehabilitation plan

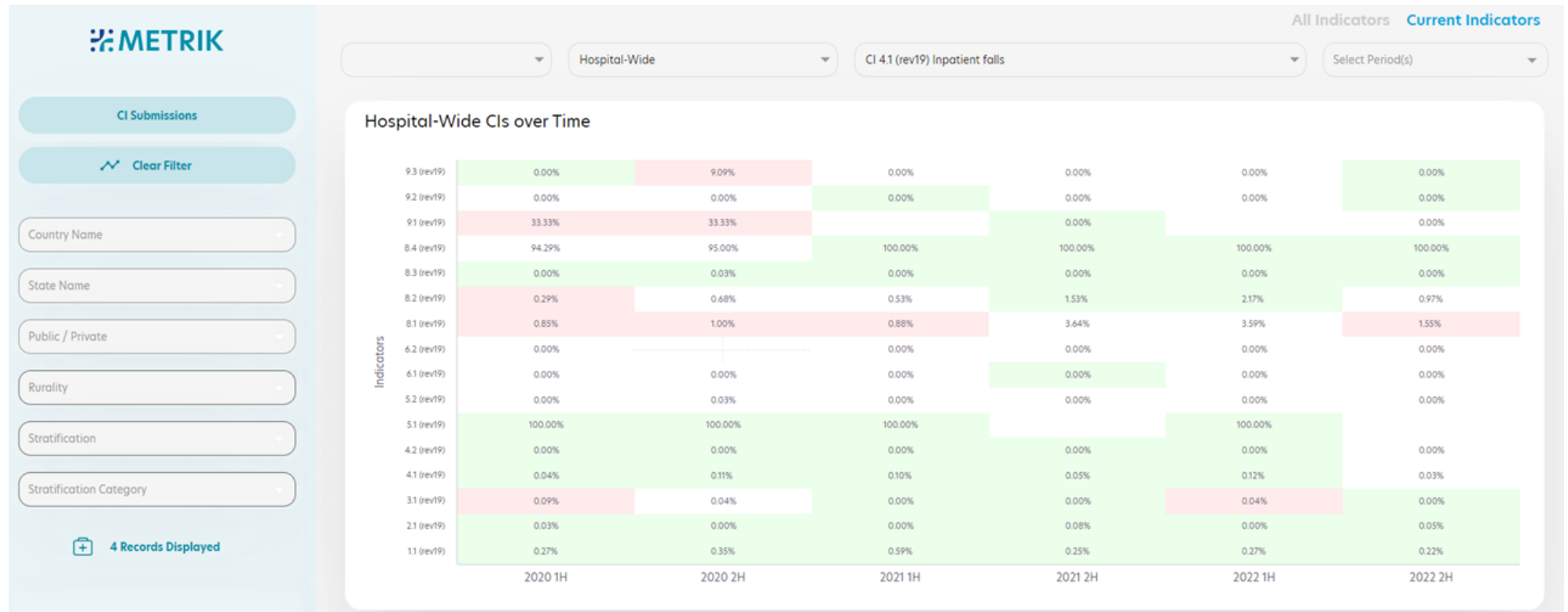
Functional gain achieved by rehabilitation
program

Discharge destination

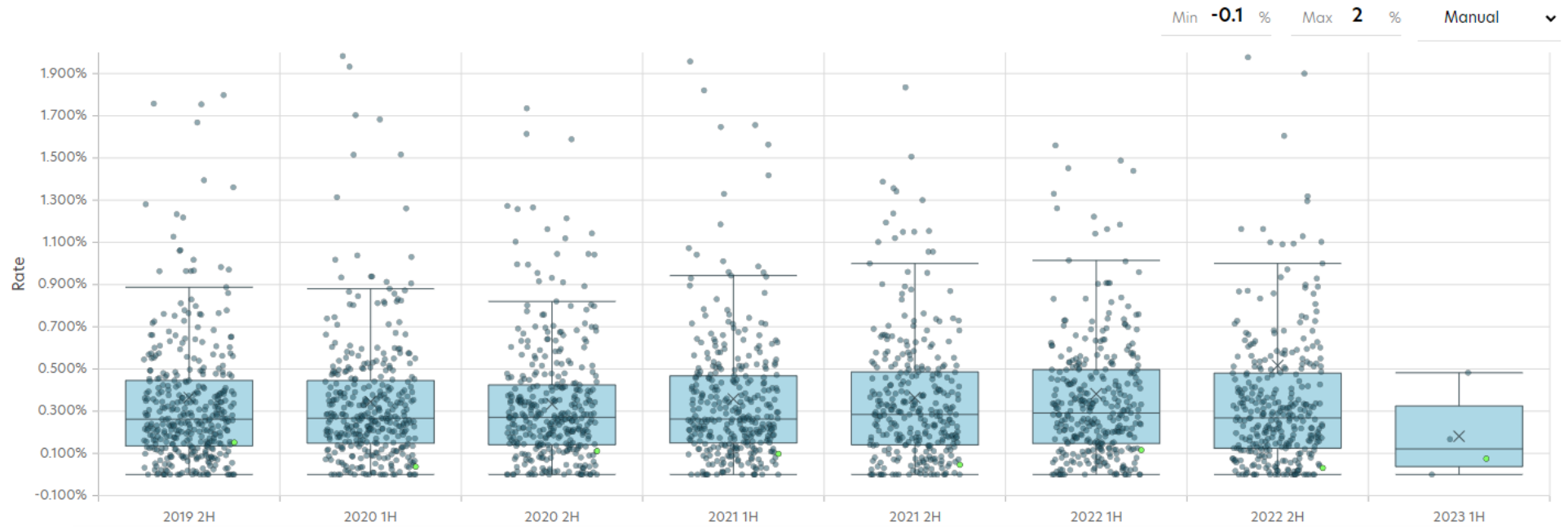
Rate of fallers

Rehabilitation Intensity

Appendix 1: Sample Dashboard

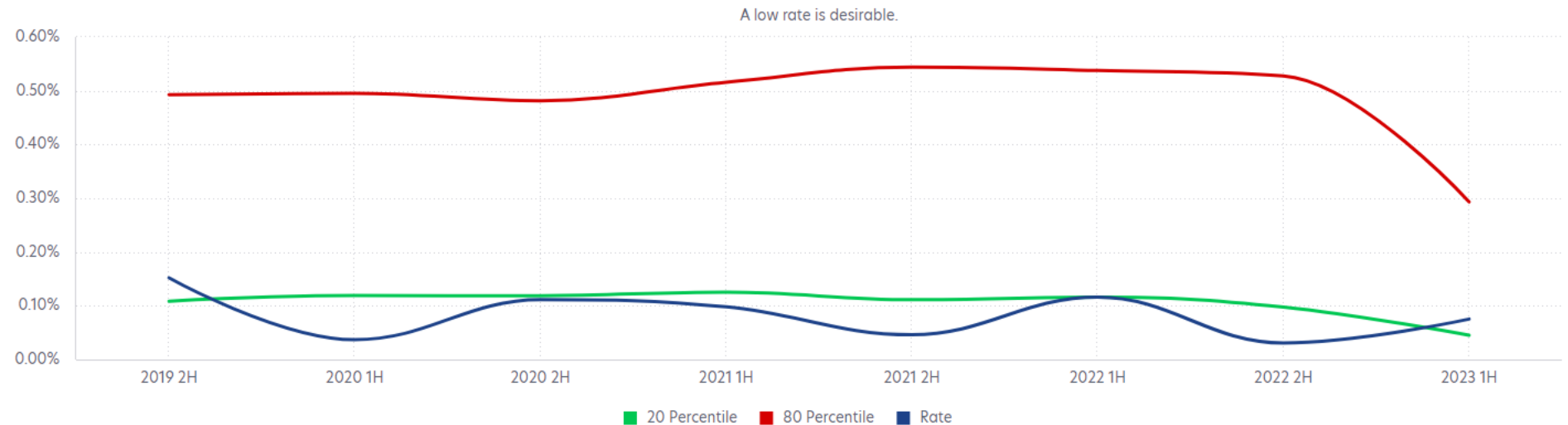


Clinical Indicator vs. Benchmark



Period	2019 2H	2020 1H	2020 2H	2021 1H	2021 2H	2022 1H	2022 2H	2023 1H
Your Rate	0.152%	0.037%	0.111%	0.098%	0.046%	0.116%	0.031%	0.075%
Aggregate Rate	0.275%	0.293%	0.288%	0.323%	0.305%	0.311%	0.286%	0.329%
Min	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%
Q1	0.136%	0.148%	0.141%	0.151%	0.141%	0.147%	0.125%	0.056%
Median	0.262%	0.266%	0.270%	0.263%	0.284%	0.292%	0.268%	0.121%
Q3	0.445%	0.440%	0.425%	0.468%	0.486%	0.491%	0.477%	0.246%
Max	4.169%	3.411%	1.735%	3.846%	3.008%	6.410%	49.057%	0.482%

CI 4.1 (rev19) Inpatient falls over Time



Should you require further assistance in interpreting the reports, or in how to use the data results for quality improvement activities please contact the POS team on 02 9281 9955 or e-mail pos@achs.org.au