Government of Western Australia
Department of Health

Policy Frameworks
MP 0134/20
Effective from: 1 July 2023

National Safety and Quality Standards Accreditation Procedure

This procedure supports the application of MP 0134/20 *National Safety and Quality Standards Accreditation Policy* (the policy).

1. Scope

Compliance with this procedure and related documents is mandatory for all public health services required to be accredited to national safety and quality standards (the Standards) under the Australian Health Service Safety and Quality Accreditation Scheme (the AHSSQA Scheme).

2. Background

The National Safety and Quality Health Service (NSQHS) Standards developed by the Australian Commission on Safety and Quality in Health Care (the Commission) were first implemented on 1 January 2013. The second version of the Standards was implemented on 1 January 2019. The second version, updated in response to the COVID-19 pandemic to strengthen the Infection Prevention and Control Standard (Standard 3), became operational on 1 January 2022. The Commission continues to update the NSQHS Standards and develop other Standards that may be more applicable to some services provided by HSPs.

3. Accreditation Compliance Procedure

3.1. General Requirements

3.1.1. Accrediting agency selection

Health Service Providers (HSPs) must select an accrediting agency from the Commission's approved accrediting agency list. HSPs intending to change their accrediting agency must submit their request in writing to Licensing and Accreditation Regulatory Unit (LARU) for consideration before any contractual arrangements are entered with a new agency.

3.1.2. Updating accreditation details

Annually, by 31 October, HSPs must ensure the following accreditation details of their public health service facilities are registered with LARU via submission of the LARU Public Health Service Facility Accreditation 2023 Registration Form:

- accreditation program/s
- scheduled assessment dates[1]

[1] Includes interim pathway assessments, announced assessments, final assessments, and mandatory re-assessments. Not applicable for services undergoing short notice assessments.

- accreditation expiry date
- accrediting agency
- key accreditation personnel and contacts.

The form must be completed and resubmitted to LARU when any of the above details change.

3.1.3. Deferral of scheduled assessments dates

HSPs must have LARU approval to defer a scheduled assessment date or extend an accreditation expiry date. The HSP Chief Executive must submit a request in writing to LARU as soon as the proposed change is apparent and prior to the accreditation expiry date. During the approval process LARU will liaise with the public health service facility and the Commission prior to a final decision.

The Department supports the Commission's recommendation that extensions will only be granted in the event of exceptional circumstances. LARU will review the requests for extension on a case-by-case basis.

3.1.4. Transition to other safety and quality Standards

HSPs must request LARU approval prior to transitioning any of their services from NSQHS Standards to other standards under the AHSSQA Scheme. The HSP Chief Executive must submit a request in writing to LARU and include the following details of the service/s proposed to transition from the NSQHS Standards:

- the type of care that is delivered by each service and
- the rationale for why the proposed alternative Standard would be more appropriate for each of these services.

3.2. Assessment Pathways

3.2.1. Interim Assessment

HSPs must ensure any new public hospital to be accredited to NSQHS Standards registers their accreditation details with LARU prior to the commencement of services.

The details required by LARU include:

- designated accrediting agency
- names of key personnel
- proposed interim assessment date when available.

The interim assessment to the NSQHS Standards must be undertaken within 10 working days of commencement of service provision to ensure they meet specified requirements. Accrediting agencies refer to the *National Safety and Quality Health Service Standards (second edition) Guide to Interim Accreditation* when assessing a new public health service facility.

Public hospitals having achieved interim accreditation must:

- undertake a further assessment to all NSQHS Standards within 12 months of the initial assessment
- notify LARU of the follow up assessment date when scheduled
- complete the follow up assessment and have full accreditation awarded within 18 months.

New public health service facilities must complete the interim assessment pathway and be awarded full accreditation before commencing the short notice assessment pathway.

3.2.2. Announced Assessments

The announced assessment is one scheduled assessment to applicable Standards by an approved accrediting agency every 3 years. In consultation with LARU and the accrediting agency, announced assessments may occur for health services who undergo accreditation to Standards other than the NSQHS Standards.

3.2.3. Short Notice Assessment

All public hospitals will be assessed under mandatory short notice assessment pathway.

The short notice assessment pathway is:

- conducted to applicable standards at least once during the 3-year accreditation cycle
- performed by an approved accrediting agency before the current accreditation cycle expires
- conducted between 6 months after the previous assessment and at least 4 months prior to the current accreditation expiry date
- to be no more than 4 years apart.

Further details on short notice assessments are published on the Commission website Fact sheet 17: Short notice accreditation assessment.

3.2.4. Transition assessment

A transition assessment may be required when a health service changes ownership (changes operational governance) to ensure the new governance structure, policies and procedures are firmly embedded into the quality management system.

LARU must be notified in the early planning stages of a proposed change in ownership or operational governance of a health service to determine if a transition assessment is required.

3.3. Accreditation Assessments

3.3.1. Initial assessment

During an initial assessment, the assessors will rate each of the Standard actions as:

- *met*
- *met with recommendations*
- *not met*
- *not applicable; or*
- *not assessed.*

The criteria for these ratings is published on the Commission website Fact Sheet 4: Rating scale.

Public health service facilities must achieve one of the following ratings: *met; met with recommendation, not assessed* or *not applicable* for each action to be awarded accreditation.

When a public health service facility is assessed as failing to meet the requirements of an action, the assessor rates the action as *not met*. *Not met* actions are risk assessed by the accrediting agency assessor. In the event the *not met* action is assessed as being a significant risk, it is the accrediting agency's responsibility to verbally notify LARU within 48 hours of the findings (refer to AS 18/09 Notification of significant risk). The agency must provide LARU with a copy of the action plan to remedy the risk as soon as practicable. On notification, LARU will liaise with the public health service facility and initiate a regulatory response (as per section 5.0 of this procedure).

3.3.2. Remediation period

When a public health service facility is awarded *not met* and/or *met with recommendation* rating/s, a remediation period of 65 business days from the initial assessment is granted.

During the remediation period the public health service facility must meet the requirements of the action plan.

A final assessment is scheduled at the end of the remediation period. The format of the final assessment process (desktop review or site visit) is determined by the accrediting agency in collaboration with the Commission. The public health service facility must advise LARU of the final assessment format and the scheduled date.

Public health service facilities that fail to remediate all *not met* actions at a final assessment will not be awarded accreditation.

3.3.3. Mandatory reassessment

A mandatory reassessment is required for public health service facilities awarded a large number of *not met* ratings and/or *met with recommendation* ratings at initial assessment before subsequently being awarded accreditation. A large number of *not met* ratings and/or *met with recommendation* ratings is defined as 16% or more of applicable (assessed) NSQHS Standard actions (approximately 24 when all actions are assessed) or 8 or more *not met* actions from the Clinical Governance Standard.

The reassessment of all actions rated *not met* and *met with recommendations* will be conducted within 6 months of the assessment cycle being completed. The assessment cycle is the period from initial and final assessment through to finalised reporting.

Public health service facilities that fail to remediate all *not met* actions at the mandatory reassessment will be granted a further 60 business days to remediate the actions. HSPs failing to remediate the *not met* actions at the final reassessment will not be awarded accreditation.

The HSP must notify LARU of this failure within 48 hours. A regulatory response will be initiated as per section 5 of this procedure.

To regain accreditation, the public health service facility must schedule an assessment with an accrediting agency to all the NSQHS Standards within 12 months of the date accreditation was withdrawn.

3.3.4. Provision of assessment reports to LARU

HSPs must adhere to the timeframes for submission of reports to LARU as set out in the Timeframes for submission of accreditation information and reporting to LARU.

At the completion of the initial accreditation assessment, the HSP must forward the Assessment Ratings Report (or so named), to LARU within 5 business days of the assessment.

All subsequent finalised assessment reports must be submitted to LARU immediately when received by the HSP.

LARU must be notified if there are expected delays in submitting these reports.

4. Notification to LARU

HSPs must notify LARU when any of following situations are evident:

- inability to comply with the requirements of the policy and procedure
- a public health service facility identifies significant risks to achieving or maintaining accreditation before, during or after assessment
- concerns regarding the contractual arrangements with the accrediting agency
- issues and/or disputes with the accrediting agency, in relation to the assessment process, performance and the agreed accreditation outcome.

The Timeframes for submission of accreditation information and reporting to LARU assists HSPs with timeframes for submission of accreditation related information to LARU.

5. Regulatory Response

5.1. Regulatory Response Initiation

LARU will notify the Department of Health CEO who may initiate a regulatory response process in the following circumstances:

- a large number of *not met* and/or *met with recommendations* ratings overall or in any standard
- a significant risk is identified by an accrediting agency during an assessment or further to an internal or external quality and safety review
- HSP identifies a risk to maintaining accreditation status
- accrediting agency identifies a risk to achieving accreditation status during assessment
- public health service facility fails to achieve accreditation.

5.2. Initial Regulatory Response

HSPs must comply with any requirements imposed as part of the regulatory response to non-compliance with the Standards or the AHSSQA Scheme.

The initial regulatory response may incorporate one or a combination of the following actions:

- provide advice, information on options or recommend strategies that could be used to address the *not met* actions within a designated time frame
- connect public health service facilities with other services that have addressed similar deficits or demonstrated exemplar practice in this area
- request a review by the public health service facility or an independent body, at the direction of the Department CEO, into significant or unreasonable delays of improvements being implemented.

5.3. Serious Persistent Non-Compliance

In the case of serious or persistent non-compliance and where required action is not taken by the HSP, the response may be escalated. At the direction of the Department CEO, one or a combination of the following actions may be initiated:

- investigation into excessive delays for the implementation of improvements to address significant risk factors
- restrict specified practices/activities in areas/units or service/s of the public health service facility where the current Standards have not been met
- suspend specific services of the public health service facility until the area/s of concern are resolved
- suspend all service delivery at a public health service facility for a designated period.

6. Guidance information

- Fact sheet 17: Short notice accreditation assessment
- National Safety and Quality Health Service Standards Guide to Interim Accreditation
- Fact Sheet 3: Mandatory reassessment of health service organisations
- Fact Sheet 4: Rating scale
- AS 18/09 Notification of significant risk.

7. Definitions

Term	Definition
Accreditation outcome	The result of the conclusion of an accreditation assessment. Accreditation may be awarded or withdrawn.
Accrediting agency	An organisation approved by the Australian Commission on Safety and Quality in Health Care to assess health service organisations against AHSSQA Scheme Standards.
Assessment Ratings Report	A report provided by the accrediting agency to the public health service facility within 5 business days of the assessment listing the action ratings.
Australian Commission on Safety and Quality in Health Care (the Commission)	A statutory authority established under the *National Health Reform Act 2011* to lead and coordinate national improvements in safety and quality in health care. The Commission, partnered with Australian, state and territory government, is responsible for the formulation of standards relating to health care safety and quality matters and coordinates national models of accreditation for health service organisations.
Australian Health Service Safety and Quality Accreditation Scheme (the AHSSQA Scheme)	The nationally mandated accreditation process formulated by the Commission under the *National Health Reform Act 2011*. This scheme clarifies the roles and responsibilities of Commission, state and territory governments, health service

Term	Definition
	organisations and accrediting agencies in relation to accreditation.
Department of Health Chief Executive Officer (CEO)	The *Health Services Act 2016*, Part 3 Division 1 refers to the overall management of the WA health system being the responsibility of the Department CEO. The Director General is the Department CEO.
Finalised assessment reports	Final versions of reports on assessment outcomes provided by accrediting agencies to HSPs
Health Service Provider	As defined in section 6 of the *Health Services Act 2016*, means a health service provider established by an order made under section 32 (1)(b) of the *Health Services Act 2016*.
Public health service facility	As defined in section 6 of the *Health Services Act 2016*, means a facility at which public health services are provided.
National safety and quality standards (the Standards)	Standards developed by the Commission with the aim to protect the public from harm and improve the quality of health service provision.
Significant risk	A risk with a high probability of a substantial, demonstrable adverse impact for patients if the practice continues. An immediate response is required to reduce the risk to patients.

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