

QHNZ Guidelines for EQuIP 4 Self-Assessment

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The EQulP Self-Assessment

Self-assessment is an important component of the EQulP cycle and is designed to assist organisations monitor their progress in partnership with QHNZ.

The self-assessment is an internal review of organisational structures, processes and outcomes against the EQulP framework. It enables an organisation to identify how well they are performing against the EQulP standards and criteria.

The self-assessment is an important management tool that assists organisations work through, 'what we are doing, why we are doing it and what we must do'.

The self-assessment is a regular and continual part of the EQulP process.

Please also refer to the following for further information:

- The QHNZ EQulP 4 Guide - Parts 1 to 4.
- Refer to pages 5 to 6 of these Guidelines for an Overview of the self-assessment process.
- The EQulP 4 Resource Tools for details related specifically to:
 - Day surgeries
 - Mental health services
 - Oral health
 - Community, primary care and multipurpose services
 - Hospital services.

Resource tools can be obtained from QHNZ. Please email admin@qualityhealth.org.nz or phone (04) 499 0367.

Self Assessment Process Overview

Benefits and objectives of the self-assessment

The main benefit of a self-assessment is to provide a formal and systematic assessment of an organisation's achievements against the EQulP criteria. Other benefits include:

- to provide an internal tool for quality improvement
- to assist in providing a gap analysis against the EQulP standards
- to identify organisational strengths and opportunities for improvement and incorporate them into the organisational planning process
- to enable the sharing of information within the organisation
- to increase consumer / patient satisfaction by showing the organisation's commitment to safety and quality
- to focus and energise the organisation using identified goals
- to increase involvement of staff in continuous quality improvement
- to improve understanding and evaluate systems
- to provide a communication and support channel with QHNZ
- to prepare for the accreditation survey.

Before starting a self-assessment

Prior to commencing the self-assessment there are some key issues to be considered. These include:

- ensuring there is executive support and commitment
- ensuring needed resources such as expertise and time are available
- establishing a willingness to improve as the result of the self-assessment process
- facilitating a climate of trust, with open participatory management and an organisational desire to improve
- using staff training and education to empower staff in quality and improve their input to the self-assessment.

How to start a self-assessment

- Begin the process as early as possible.
- It is a good idea to plan your self-assessment around the organisational planning periods to enable the gap analysis to inform the planning process.
- Involve as many staff and stakeholders as possible to encourage a team and organisational effort.
- Circulate as much information about EQulP and the self-assessment as you can to all staff and through continuing education, empower and encourage them to contribute.
- Many organisations have found it useful to appoint an appropriate person to take responsibility for each standard / criterion. In some cases this will be the chair of a committee or a designated member of staff with an interest in the area.
- It is suggested that 'champions' are selected to assist in preparing responses to each criterion. Alternatively, some organisations form working groups with responsibility for the EQulP process or a working group for each function or standard.
- Note that it is the quality coordinator's responsibility to coordinate the self-assessment report rather than to create it.
- Well prepared self-assessments will greatly assist the organisation in continuous quality improvement and will also assist the QHNZ surveyors in the verification procedures required for onsite surveys.

Points to remember about preparing a self-assessment

- Ensure you are familiar with the EQulP self-assessment system and the format of the self-assessment.
- Consult the Accreditation Programme Manager QHNZ if you need advice.
- Plan your reporting process carefully.
- Delegate areas of responsibility for completion.
- Ensure the reporting processes are systematic and accurate.
- Begin the self-assessment process as early as possible as evaluation can take longer than estimated.
- Keep evidence summaries brief.
- Ensure evidence noted on self-assessments is cross-referenced and is able to be verified during an onsite survey by the survey teams.

Some essential tips for completing a self-assessment

- Focus on core business and organisational issues.
- Reviewing your high volume, high risk areas is a good starting point.
- Ensure information is recent and remains applicable.
- When completing your organisation's gap analysis against the EQulP criteria, it will be important to prioritise and delegate responsibility to staff.
- Maintain a focus on what the organisation is intending to achieve for each criterion.
- A variety of methods to collect the evidence can be used. These may include
 - Routine data collections that are already under way, for example reports ACHS Clinical Indicators, QPS Benchmarking.
 - Special data collections such as surveys and focus groups where applicable
 - Asking staff including management what improvements they have been involved with or how they can demonstrate quality service.
 - Asking both staff and managers from different areas a set of question verify that processes have in fact been implemented.
 - Finding out from staff what they would like to improve and if they have a workable plan for that improvement.
 - Asking managers to ensure they can verify evidence of meeting the elements of the criteria in their area.

Electronic Assessment Tool

If you have any problems with this software please contact QHNZ on (04) 499 0367 or email eatv4@qualityhealth.org.nz for assistance.

The Planning Tool

For those clients using the Electronic Assessment Tool (EAT), a planning tool is available. The Planning Tool captures information about the organisation's quality activities. It can be used to assess compliance to the criteria elements and as an evidence map. The Planning Tool is provided as an optional function within EAT. Refer to the *QHNZ EATv4 Help Manual* for further guidance on how to use this tool.

Completing your EQiP Self-Assessment

There are five sections to the EQiP 4 self-assessment completed in EAT:

- 1 – QHNZ member's details
- 2 – Recommendations from previous survey
- 3 – Summary of supportive evidence
- 4 – Key improvements
- 5 – Plans for improvement

1 - EQiP member details

The EQiP member's details provide an overview of the organisation for surveyors and readers of the self assessment. It is an opportunity to provide a snapshot of the organisation and is updated from one self assessment to the next. This will save time at the onsite survey for the organisation and staff.

In general, it is helpful to provide details under yearly subheadings so that changes and issues can be easily tracked.

Role and Function

Include license requirements for private organisations.

Include shared services and corporate services relationships.

Example

Hospital is an inner city tertiary, referral facility. It is the leading private hospital in New Zealand in cardiac care and the only private hospital providing comprehensive cardiothoracic surgery and cardiology services. All services are supported by the highest level of intensive care. "Hospital" has 220 beds, comprised of 185 inpatient beds, a 35 bed day unit, day oncology unit and nine operating suites including, a dedicated cardiac theatre, two cardiac catheter laboratories and an endoscopy suite. The hospital specialises in cardiac services, neuro-sciences, orthopaedics, plastic, general and vascular surgery.

Changes and Issues

To the organisation in chronological order, e.g. the reporting structure and key changes to staff:

e.g. 2006 August - a new Director of Nursing was appointed to the organisation.

e.g. 2005 September - hospital and community health services were combined into a multi-purpose centre.

e.g. 2005 July - all departments were restructured into clinical streams.

Improvements

Showcase major improvements / awards in chronological order.

e.g. 2006 September - new operating theatre building was commissioned.

e.g. 2006 March - the Falls Prevention Programme introduced.

e.g. 2006 - capital improvements to the emergency department have been funded.

e.g. 2006 - clinical policy manuals developed and reviewed.

e.g. 2005 - change of service delivery models for obstetric patients.

Demographics

Comment on the size and composition of the population served by the organisation. Include major ethnic groups and the geographical and functional relationship of other organisations and health services.

e.g. **Geographical:** The Hospital is the largest by geographical area in New Zealand. It is responsible for the provision and funding of health and disability services in the region. It is one of 21 district health boards established nationally on March, 2012. The area is also serviced by a number of specialty health groups such as drug and rehabilitation, cardiac centres and nursing homes.

Population: Located in the North Island of New Zealand The HOSPITAL population measured in the 2015 census was 900,000 people. The population is ageing. The proportion of people over the age of 65 is higher than the national average.

Ethnicity: 56.1% of the HOSPITALS population is European, 12.5% is Maori, 2.5% is Pacific Island and 1.8% is Asian. Population projections predict that the population will increase to 120,000 by 2031.

Specialties

Specialties are clinical services focused on a specific discipline, condition or group of patients/clients provided by the organisation – a list is included but other specialties may be added.

Relationships

Contracted services listed should include only those which are of an ongoing nature and are for the provision of services which have significant quality and safety implications for the organisation since last survey. (Note: fire contracts should be included here.)

Education services listed should include only those which are of an ongoing nature or significant one off education for smaller organisations, e.g. external education training providers, relationships with colleges since last survey.

DRGs (Clinical profiles)

Listing the 20 most used Diagnosis Related Groups (DRGs) for the organisation allows surveyors and QHNZ to conceptualise the type of care given in your organisation. The EAT programme will automatically put the DRGs in ascending order.

Some organisations will not have 20 DRGs that are used. The EAT programme will allow less than 20 DRGs to be entered.

If you do not have DRG data, enter zero in the first column and provide a list of major diagnoses/procedures. This information is very useful to surveyors in understanding the types of patients/consumers cared for by your organisation.

Clinical indicators

This section allows organisations to list ACHS Clinical indicators that are being collected. Other non ACHS Clinical indicators being collected may also be added. May include internal and external indicators.

Statistical data

This data provides the surveyors with information on the annual throughput of the organisation and staffing levels.

Bed Days (incl. same day) = Bed utilization/same day

Same day separations = day only stays

Total separations (incl. same day) = day only stays and long stay.

Details of inspections and reviews

A quality organisation will need to implement recommendations made by an external review or accrediting body. Knowing what inspections or external reviews have been made and how many recommendations have been implemented gives the surveyors and QHNZ an idea of what improvements the organisation has made and where any deficiencies might lie. Enter only other inspections and external reviews of the organisation since the last survey or within the last three years – e.g. fire inspections.

2 - Recommendations from Previous Survey

When addressing recommendations from the previous survey, organisations will be required to use the *'Recommendations from the Previous Survey'* section in the Electronic Assessment Tool (EAT). The following information is included when addressing the recommendations:

- The position TITLE of the person responsible for the recommendation. This will then make it easier to follow-up progress over time.
- Target or completion date of the recommendation.
- The results / outcomes of the recommendations and strategies.
- Recommendation completed YES or NO or IN PROGRESS. Note that only a surveyor at an onsite survey can sign off a recommendation as actually completed.

When addressing the recommendations from previous survey suggest following these guidelines:

- Maintain a focus on outcomes / results. What outcomes / results do you expect to achieve by addressing the recommendation?
- What is the intent of the recommendation? Look beyond 'to achieve accreditation'.
- How have you incorporated the principles of EQUiP into the recommendation actions that is, customer focus, effective leadership, culture of improving, evidence of outcomes, striving for best practice?
- How will you know when the actions you are implementing are effective?
- How will you be confident in knowing that the steps you have taken have led to an improvement in your services? What are the measures or indicators are going to use to monitor these actions?
- Identify which position title is to be involved in addressing the plan.
- Timeframes and priorities will ensure a realistic plan is developed.

3 - Summary of Supportive Evidence

The Summary of Supportive Evidence is a listing of all the elements per criterion with a section allowing organisations to provide a brief summary of supportive evidence. The evidence listed relates to the rating level rather than each individual element within the rating level.

This section assists an organisation to rate itself against each criterion and do a gap analysis against the criteria.

Each criterion needs to be rated as LA, SA, MA, EA or OA. The rating for the criterion is determined by systematically working through each element and assessing whether the organisation has achieved the stated requirement in those elements. There are some cases where a specific element may not be applicable or is a Work in Progress, and a brief reason will be needed if this is the case. Note that an organisation may be achieving in areas other than the listed elements under each criterion as the elements are not limiting.

The rating levels for the self-assessment are:

LA – Little Achievement - Organisations that achieve an LA rating will have an awareness or knowledge of responsibilities and systems that need to be implemented but may have only basic systems in place. At this level there will be compliance with legislation and policy that relates to the criterion.

SA – Some Achievement - An organisation that achieves an SA rating will have achieved **all** the elements of LA and will have implemented systems for the organisation’s activities. At this level there is very little or no monitoring of outcomes or efforts at continuous improvement.

MA –Moderate Achievement - An MA rating requires that all the elements of LA and SA have been achieved and that efficient systems in collecting relevant outcome data, monitoring, evaluation procedures and methods of improvement are in place.

EA – Extensive Achievement - In the EQulP 4 programme, all the elements in LA, SA and MA must be achieved. Also organisations will be able to demonstrate extensive achievement in a criterion if they satisfy one or more of the following requirements:

- internal or external benchmarking and subsequent system improvement, **and / or**
- the conduct of research that relates to that particular criterion, **and / or**
- the implementation of what would be considered to be advanced systems that relate to that criterion, **and / or**
- proven, excellent outcomes in that particular criterion.

Some organisations may be able to demonstrate achievement in more than one of these elements.

OA - Outstanding Achievement - All the elements of LA, SA, MA and EA must be achieved as well as a demonstration of leadership in this criterion. Leadership in a criterion does not necessarily mean that that organisation is the best in New Zealand. It may mean that the organisation can demonstrate that it is one of the best or is outstanding amongst its peers.

If rating OA for a criterion, it will be important to provide a one page overview in the Summary of Supportive Evidence section of EAT to demonstrate evidence of the OA level.

Handy Hints when rating a criterion:

- rate the criterion using the elements as a guide
- evaluate your progress against the elements of the criterion.

There are three response options provided for each element in the Summary of Supportive Evidence section:

Yes
Work in Progress (WIP)
Not Applicable (N/A).

A brief explanation of the evidence associated with a rating needs to be entered into the Summary of Supportive Evidence section. Organisations need to ensure that the brief evidence they include in the self-assessment is able to assist the survey team to verify the stated achievement. The organisation does not need to include all the evidence they might provide the survey team with at an onsite survey, rather a subset of this to support achievement of the rating. Include data also in the Summary of Supportive Evidence section where relevant. Aim to provide recent data from formal high volume, high risk activities undertaken for each criterion where applicable. Refer to example below.

For example, if an organisation rates MA for a criterion, then the self assessment completed for a survey event requires a “YES” or “N/A” for each element in the Summary of Supportive evidence for all LA, SA and MA elements. If “WIP” is selected for an MA element, providing a brief overview of why this element is a “WIP” for the surveyors to review at the onsite survey will be an important inclusion to ensure that the organisations rating of MA is maintained. Also a “WIP” issue may be documented in the Plans for Improvement section of the self-assessment, if appropriate.

If an ELEMENT is rated Not Applicable, a clear summary of why that element is N/A is required in the Summary of Supportive Evidence section.

If an organisation wishes to rate a criterion N/A, the organisation will need to discuss and agree with the Accreditation Programme Manager these criteria that are Not Applicable prior to the self-assessment or onsite survey being undertaken.

Example Table of Summary of Supportive Evidence

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

Rating	Elements	Yes	WIP	N/A
LA	LA <ul style="list-style-type: none"> - Policies and guidelines on assessment available in individual departments, i.e. clinical, nursing wards, allied health, refer to intranet for organisation policies - Policies available in individual departments, refer to intranet for org policies, e.g. Assessment - policy no.; Discharge planning policy- policy no.; Recommendation for Admission Guidelines- policy no. - Internal/external referral guidelines available at department level and ward level 			
	(a) Guidelines are made available for staff to assess physical, mental, spiritual and family / whanau ora needs, including the identification of 'at risk' consumers / patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(b) There is a policy for planning for transfer, discharge or death at the time of the initial episode of care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(c) Referral systems to other relevant service providers exist.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(d) There is a tikanga best practice standard that guides cultural assessment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SA	SA <ul style="list-style-type: none"> - Completed assessments in the health record- refer to medical records audits and individual depts for details (overall completion rate =94%). - Individual profession guidelines available in depts and organisation policies on intranet. - Inclusion of 'at risk' clients issues found in relevant clinical assessment form and assessment protocols. - Reviews and data related to the assessment system - refer to Quality Activities register, e.g. clinician satisfaction with the assessment tool (82% satisfaction) and client satisfaction data with the process (93% satisfaction). - Refer to patient admission pamphlets for details. - Refer to reviewed admission template. - Refer to the organisation Discharge Plan Policy no. - Orientation program of clinicians, nursing and allied health (85% attend orientation) 			
	(a) Assessment is documented and where appropriate multidisciplinary.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(b) Comprehensive assessment guidelines, based on professional standards and evidence are used.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(c) The assessment system identifies the physical, mental, spiritual and family / whanau ora needs of the consumer/patient.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(d) The needs of 'at risk' consumers/patients are identified and managed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(e) The assessment system avoids duplication by multiple providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(f) A support person/carer/whanau is involved in the assessment system where appropriate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(g) Information is provided to the consumer/patient on their health status.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(h) Re-assessment of the consumer/patient occurs when there is a change in health or functional status.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(i) Planning for discharge/transfer, commences at assessment, is multidisciplinary when appropriate, and coordinated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	(j) The assessment results, including diagnostic tests, are available in a timely way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MA	<p>MA</p> <ul style="list-style-type: none"> - Reviews and data related to the assessment and referral system-refer to organisation Quality Activities Register; 85% of assessment identified as complete; 95% of 'at risk files' have clinical risk assessment present; - Individual depts QA manuals; - GP satisfaction data (increase of 5% to 93% - 2005 to 2006); - Medical records audits (compliance with AS 2828 increased from 93% to 98% from 2005 to 2006); - Care pathways review quality activity no; - Clinical indicator data; - Audits of adverse events/incidents/near misses; total adverse events decreased by 2%(2005 to 2006); near misses decreased by 3% (2005 to 2006); - Evaluation results of admission waiting time; waiting time categories results decreased by 10%; - Pt assessment data for falls, suicide risk, self-harm, wandering, absconding, pressure ulcers in QA register; 100% of pts presenting with pressure ulcer had photographic evidence taken on admission; 94% of pts identified as a risk of fall has falls assessment completed; 100% of pts at risk of suicide had a completed assessment; 			
	<p>(a) The assessment process is evaluated and improved, as required.</p> <p>(b) Referral systems are evaluated and improved, as required.</p> <p>(c) Processes for assessing and managing 'at risk' consumers/patients are evaluated and improved as required.</p> <p>(d) Planning for discharge/transfer is evaluated to ensure it:</p> <ul style="list-style-type: none"> (i) consistently occurs (ii) is multidisciplinary if appropriate (iii) meets consumer/patient and carer/whanau needs. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EA	<p>EA</p> <p>(a) Practices for assessment, transfer, discharge and planning for death are compared with internal and external systems and improvements are made to ensure better practice.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OA	<p>OA</p> <p>(a) The organisation demonstrates it is a leader in consumer/patient assessment and planning for transfer, discharge and death.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4 - Key Improvements

The Key Improvement section of the self-assessment is designed to provide an organisation with the opportunity to summarise its quality or safety implementation initiatives in high volume, high risk or significant areas within the member organisation.

Up to 10 of the most significant recent results / outcomes with verifying data for each criterion are required. Include information for significant results / outcomes that HAVE occurred rather than PLANNED TO occur in the future. Aim to provide data, results or outcomes from formal high volume, high risk activities undertaken for each criterion. If this data has been recorded in the Summary of Supportive Evidence section there is no need to repeat information. Additional results/ outcomes can be demonstrated at survey.

This means that, particularly in larger and more complex organisations, the self-assessment will need to be selective and target issues of the greatest volume, risk and significance in relation to the criterion. Where there are multiple sites or streams, it is suggested that the results/ outcomes are mainly systemic across the whole organisation. If required the results / outcomes could be for a specific site or stream and it is suggested that repetition of similar outcomes / results which cover individual sites be avoided.

The Key Improvements section will allow members and surveyors to obtain an overview of achievement against the criterion since the last onsite survey by showing:

- key improvement (of the project)
- what did the organisation change
- the results / outcomes of the project.

There is no need to record routine reviews in this section, (e.g. monitoring of equipment temperatures), unless there has been a significant and sustained organisation-wide improvement.

Example Table of Key Organisational Improvements

No	Title of Key Improvements	What did you change	Result / Outcome
1	Comprehensive assessment of patients	- Assessment template reviewed, updated and implemented (Feb 06 to June 06)	- After the assessment template was reviewed and updated, staff satisfaction data showed a 20% improvement in satisfaction with the new admission form from October 2006 compared to October 2005. - incidents related to poor assessments reduced from % to % from Oct 06 vs Oct 05. - Patient complaints due to poor assessments reduced from % to % Oct 2006 vs Oct 2005.

When completing key organisational improvements, include:

- **Dates** - e.g. the 200X purchase of lifting equipment for all wards or the 200X to 200Y updated manual handling education programme for all staff.
- **Attributable** - Please note the outcome is only required to be attributable to the action taken, not scientifically proven or not proven to be the result of defined improvements, e.g. after the manual handling programme of 200X to 200Y there was a X% decline in....
- **Rates** as well as whole numbers are used eg after the falls prevention program of 200X to 200Y there was a X% decline in recorded falls . There were Z falls in 200Y.
- Include base line data where possible with recent data to demonstrate sustained achievement or further ongoing improvement.
- A customer-focused approach (internal and external customers).
- Organisation-wide or key examples rather than improvements from a very small non-core business area of the organisation, unless the improvement was very significant.
- The avoidance of generalised or subjective terms such as increased and improved, e.g. substitute "increased" with x% increase.

A simple way to verify results / outcomes for the Clinical Function for example could be to use data that demonstrates some of the following:

- Morbidity
- Mortality
- Satisfaction
- Disability / Disease
- Death
- Dissatisfaction
- Discomfort
- Dollars

In simple terms, it may help when reviewing a particular criterion to ask yourself WHY the organisation is undertaking a particular action / review.

For instance, when reviewing criterion 3.2.5 (Security management supports safe practice and a safe environment), the ultimate aim is to ensure a secure environment where staff and patients' security risks are minimised.

If reviewing a security policy for instance, ask yourself WHY you are reviewing that particular policy (e.g. to incorporate a new Ministry of Health guideline). The reason that a Ministry of Health policy is being included is to ultimately reduce security issues in the organisation.

Sometimes staff should ask themselves WHY they are doing a particular / review several times before being able to obtain a meaningful outcome / result.

- e.g. Question: Why do we do X? Answer: Because it is a hospital policy.
Question: Why is it Hospital policy? Answer: To comply with the law.
Question: Why was this law enacted? Answer: To improve patient safety etc.
Question: Why does this need to be reviewed? Answer: To determine compliance.

Then of course a method of measuring patient safety will have to be determined, e.g. from a survey or from routine data.

5 - Plans for Improvement

The Plans for Improvement section of the self assessment will provide members and surveyors with an indication of how the organisation is progressing against each criterion since the last onsite survey by providing the major areas for future improvement.

It is in this section that future actions are planned. Be specific in this section regarding what the intended improvement will be. This section can be used as an action plan for organisation-wide future actions (quality plan).

Try to determine at the start how you will know when you have achieved the desired results – in other words what is the expected outcome? This will assist staff to conceptualise the full quality cycle and it will make evaluation easier to achieve as there will be specific measurements made which will tell you if you have achieved the outcome intended.

Only 10 Organisational Plans for Improvement may be recorded against each criterion, including the position title of the person responsible and the timeframe. This will then make it easier to track progress over time.

Example Table of Plans for Improvement

No	Intended Improvement	Responsibility	Timeframe
1	Care pathway for stroke be developed to ensure multidisciplinary staff involvement	Director of Nursing	Nov 2006 (dd/mm/yy format)

- Use this opportunity to demonstrate evidence of organisation-wide intended improvements.
- Additional intended improvements can be demonstrated at survey.

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